- periodically carry out an assessment of the risks both to the Department's and the Trust's objectives and activities;
- inform the Trust of relevant Government policy in a timely manner; and
- bring concerns about the activities of the Trust to the full SHSCT Board, requiring explanations and assurances that appropriate action has been taken.

3.2.4 The responsibilities of a Departmental Accounting Officer are set out in more detail in Chapter 3 of Managing Public Money Northern Ireland (MPMNI).

3.3 The DoH Executive Board Member, the sponsor team and Finance Directorate

3.3.1 Sponsorship of SHSCT is the responsibility of DoH as a whole. The Department has allocated an Executive Board Member (EBM) Sponsor to each Arms Length Body (ALB). The EBM Sponsor has primary responsibility for overseeing sponsorship of the ALB. In particular the EBM supports the Permanent Secretary in ensuring sponsorship is applied systematically; provides an assurance that a proportionate approach to assurance and accountability is in place; manages the ALB's business planning process; and ensures that significant governance, risk management or internal control issues are escalated within the Department. The EBM sponsor also undertakes end-year appraisals for ALB Chairs and participates in ground-clearing and accountability meetings as required.

3.3.2 HSC Sponsorship Branch is the sponsor team for the SHSCT. The sponsor team, in consultation as necessary with the Departmental Accounting Officer, is the primary source of advice to the Minister on the discharge of his/her responsibilities in respect of the SHSCT, and, subject to paragraph3.3 4, is the primary point of contact for the Trust in dealing with the sponsor Department. The sponsoring team carries out its duties under the management of the EBM.

3.3.3 The sponsor Department shall advise the Minister on an appropriate framework of objectives and targets for SHSCT in the light of the Department's wider strategic aims, current PfG objectives and targets and the CPD.

3.3.4 On financial matters, the primary point of Departmental contact for the Trust is the Department's Finance Directorate. The Directorate supports the Departmental Accounting Officer on his / her responsibilities towards the Trust regarding accounting arrangements, budgetary control and other financial matters, including procurement. In doing so, Finance Directorate shall liaise as appropriate with the sponsor team.

3.4 The SHSCT Board

3.4.1 Non Executive Board Members are appointed by the Minister following an open and transparent public appointment competition carried out in line with the Code of Practice issued by the Commissioner for Public Appointments NI. The Trust Board comprises a Non-Executive Chair and seven Non-Executive Members. The Non-Executive Members include 6 Lay Members and a Lay Member with Financial experience. Appointments are normally for a four year term and are restricted to 2 terms. Notwithstanding the length of individual appointment terms, the maximum period in post must not exceed 10 years. Appointments are made in line with appropriate legislation; Health and Social Services Trusts (Membership and Procedure) Regulations (NI) 1994.

3.4.2 The SHSCT Board has corporate responsibility for ensuring that SHSCT fulfils the aims and objectives set by the sponsor Department and approved by the Minister in the light of the Department's wider strategic aims, current PfG objectives and targets and the CPD, and for promoting the efficient, economic and effective use of staff and other resources by the Trust. To this end, and in pursuit of its wider corporate responsibilities, SHSCT Board shall:

- establish the overall strategic direction of the Trust within the policy and resources framework determined by the sponsor Minister and Department;

- constructively challenge the Trust's executive team in their planning, target setting and delivery of performance;

- ensure that the sponsor Department (through the Health & Social Care Board (HSCB)) is kept informed of any changes which are likely to impact on the strategic direction of the Trust or on the attainability of its targets, and determine the steps needed to deal with such changes;

- ensure that any statutory or administrative requirements for the use of public funds are complied with; that the Trust Board operates within the limits of its statutory authority and any delegated authority agreed with the sponsor Department, and in accordance with any other conditions relating to the use of public funds; and that, in reaching decisions, the Trust Board takes into account all relevant guidance issued by DoF and the sponsor Department;

- ensure that the Trust Board receives and reviews regular financial information concerning the management of the Trust; is informed in a timely manner about any concerns about the activities of the Trust; and provides positive assurance to the sponsor Department that appropriate action has been taken on such concerns;

- demonstrate high standards of corporate governance at all times, including using the independent Audit Committee, (see paragraph 4.7) to help the Trust Board to address the key financial and other risks facing the Trust; and

- in accordance with the latest Departmental guidance, appoint a Chief Executive to the SHSCT and, in consultation with the sponsor Department, set performance objectives and remuneration terms linked to these objectives for the Chief Executive, which give due weight to the proper management and use of public monies.

3.4.3 Individual Trust Board Members shall act in accordance with their wider responsibilities as Members of the Board – namely to:

- comply at all times with the Code of Conduct and Accountability (see paragraph 3.5.5) that is adopted by SHSCT and with the rules and guidance relating to the use of public funds and to conflicts of interest;

- not misuse information gained in the course of their public service for personal gain or for political profit, nor seek to use the opportunity of public service to promote their private interests or those of connected persons or organisations; and to declare publicly and to the Trust Board any private interests that may be perceived to conflict with their public duties;

- comply with the Trust Board's rules on the acceptance of gifts and hospitality, and of business appointments; and

- act in good faith and in the best interests of the Trust.

3.4.4 The Trust Board shall provide the sponsor Department with access to all Trust Board meeting minutes. These should be provided to the sponsor team in draft form at the same time as they are circulated to Board Members. The Trust shall provide final agreed minutes to the sponsor team in a timely way

3.5 The Chairman of the SHSCT

3.5.1 The Chairman is appointed by the Minister following an open and transparent public appointment competition as outlined in paragraph 3.4.1. Appointments are made in line with appropriate legislation; Health and Social Services Trusts (Membership and Procedure) Regulations (NI) 1994 http://www.legislation.gov.uk/nisr/1994/63/pdfs/nisr_19940063_en.pdf

3.5.2 The Chairman is accountable to the Minister of the sponsor Department. The Chairman shall ensure that SHSCT's policies and actions support the wider strategic policies of the Minister; and that the Trust's affairs are conducted with probity. The Chairman shares with other Trust Board members the corporate responsibilities set out in paragraph 3.4.2, and in particular for ensuring that the Trust fulfils the aims and objectives set by the sponsor Department and approved by the Minister.

3.5.3 The Chairman has a particular leadership responsibility on the following matters:

- formulating the Trust Board's strategy for discharging its duties;
- ensuring that the Trust Board, in reaching decisions, takes proper account of guidance provided by the Minister, the sponsor Department, the HSCB or the PHA;
- promoting the efficient, economic and effective use of staff and other resources;
- encouraging and delivering high standards of regularity and propriety;
- representing the views of the Trust Board to the general public;
- ensuring that risk management is considered regularly and formally at Board meetings; and
- ensuring that the Trust Board meets at regular intervals throughout the year and that the minutes of meetings accurately record the decisions taken and, where appropriate, the views of individual Board Members. Meetings must be open to the public, the public should be advised in advance of meetings through the press or other media such as the Trust's website and the minutes must be placed on the Trust's website after formal approval.

3.5.4 The Chairman shall also:

- ensure that all members of the Trust Board, when taking up office, are fully briefed on the terms of their appointment and on their duties, rights and responsibilities, and receive appropriate induction training, including on the financial management and reporting requirements of public sector bodies and on any differences which may exist between private and public sector practice;
- advise the Department of the needs of SHSCT when Board vacancies arise, with a view to ensuring a proper balance of professional, financial or other expertise; and

- assess the performance of individual Trust Board Members. Trust Board Members will be subject to ongoing performance appraisal, with a formal assessment being completed in consultation with Trust Committee Chairs as appropriate by the Chair of the Board at the end of each year and prior to any proposed re - appointment or extension of the term of appointment of individual members taking place. Members will be made aware that they are being appraised, the standards against which they will be appraised, and will have an opportunity to contribute to and view their report. The Chair of the Board will also be appraised on an annual basis by the Departmental EBM.

- ensure the completion of the Board Governance Self Assessment Tool on an annual basis. Assurance will be provided through the mid-year assurance statement that the tool is being completed, actions are being addressed and that any exception issues will be raised with the Department.

3.5.5 The Chairman shall also ensure that Trust Board Members are made aware of the Code of Conduct for Board Members of HSC Bodies (2012) which reflects the Cabinet Office's *Code of Practice for Board Members of Public Bodies*, (FD (DFP) 03/06), including the Nolan "seven principles of public life", and also including a requirement for a comprehensive and publicly available register of Trust Board Members' interests.

3.5.6 Communications between the Board, the Minister and the Department shall normally be through the Chairman. The Chairman shall ensure that the other Trust Board Members are kept informed of such communications on a timely basis.

3.6 The Chief Executive's role as Accounting Officer

3.6.1 The Chief Executive of SHSCT is designated as the Trust's Accounting Officer by the Departmental Accounting Officer of the sponsor Department.

3.6.2 The Accounting Officer of SHSCT is personally responsible for safeguarding the public funds for which he/she has charge; for ensuring propriety and regularity in the handling of those public funds; and for the day-to-day operations and management of the Trust. The Chief Executive should aim to attend the training course 'An Introduction for Accounting Officers' within 3 months of appointment.

3.6.3 As Accounting Officer, the Chief Executive shall exercise the following responsibilities in particular:

on planning and monitoring -

- establish, with approval of the sponsor Department, as appropriate, the SHSCT's corporate and business plans in support of the Department's wider strategic aims and current PfG objectives and targets;

- inform the HSCB and the sponsor Department as appropriate of the Trust's progress in helping to achieve the Department's policy objectives and in demonstrating how resources are being used to achieve those objectives;

- ensure that timely forecasts and monitoring information on performance and finance are provided to the HSCB and the sponsor Department as appropriate, including prompt notification if overspends or underspends are likely and that corrective action is taken;

- that any significant problems, whether financial or otherwise, and whether detected by internal audit or by other means, are notified to the HSCB or the sponsor Department as appropriate in a timely fashion;

on advising the Board -

- advise the Trust Board on the discharge of its responsibilities as set out in this document, in the founding legislation and in any other relevant instructions and guidance that may be issued from time to time by DoF or the sponsor Department;

- advise the Trust Board on SHSCT's performance compared with its aims and objectives;

- ensure that financial considerations are taken fully into account by the Trust Board at all stages in reaching and executing its decisions, and that standard financial appraisal techniques are followed appropriately;

- take action in line with Section 3.8 of MPMNI if the Trust Board, or its Chairman, is contemplating a course of action involving a transaction which the Chief Executive considers would infringe the requirements of propriety or regularity, or does not represent prudent or economical administration, efficiency or effectiveness;

on managing risk and resources –

- ensure that a system of risk management is maintained to inform decisions on financial and operational planning and to assist in achieving objectives and targets;

- ensure that an effective system of programme and project management and contract management is maintained;

- ensure compliance with the Northern Ireland Public Procurement Policy;

- ensure that all public funds made available to SHSCT, including any income or other receipts, are used for the purpose intended by the Assembly, and that such monies, together with the Trust's assets, equipment and staff, are used economically, efficiently and effectively;

- ensure that adequate internal management and financial controls are maintained by SHSCT, including effective measures against fraud and theft;

- maintain a comprehensive system of internal delegated authorities that are notified to all staff, together with a system for regularly reviewing compliance with these delegations;

- ensure that effective personnel management policies are maintained;

on accounting for SHSCT's activities –

- sign the accounts and be responsible for ensuring that proper records are kept relating to the accounts and that the accounts are properly prepared and presented in accordance with any directions issued by the Minister, the sponsor Department, or DoF;

- sign a Statement of Accounting Officer's responsibilities, for inclusion in the annual report and accounts;

- sign a Governance Statement regarding SHSCT's system of internal control, for inclusion in the annual report and accounts, which details significant internal control divergences;

- sign a mid-year assurance statement on the condition of the Trust's system of internal control which details significant internal control divergences;

- ensure that effective procedures for handling complaints about SHSCT are established and made widely known within the Trust;

- act in accordance with the terms of this document and with the instructions and relevant guidance in *MPMNI* and other instructions and guidance issued from time to time by the sponsor Department and DoF - in particular, Chapter 3 of MPMNI and the Treasury document *Regularity and Propriety and Value for Money* (a copy of which the Chief Executive shall receive on appointment). Section IX of the *Financial Memorandum* refers to other key guidance;

- give evidence, normally with the Accounting Officer of the sponsor Department, if summoned before the Public Accounts Committee on the use and stewardship of public funds by SHSCT;

- ensure that an Equality Scheme is in place, reviewed and equality impact assessed as required by the Equality Commission and The Executive Office;

- ensure that Lifetime Opportunities is taken into account;

- ensure that the requirements of the Data Protection Act 1998 and the Freedom of Information Act 2000 are complied with;

- report on compliance with controls assurance and quality standards to the sponsor Department;
- ensure that a business continuity plan is developed and maintained;
- ensure that copies of adverse inspection reports are shared with the relevant policy lead in the Department;
- ensure full compliance with the requirements of relevant statutes, court rulings and departmental directions; and
- ensure that a policy on acceptance and provision of Gifts and Hospitality is in place, which sets out the principles and requirements under which gifts and hospitality can be received and in turn when such offers can be made.

3.7 The Chief Executive's role as Consolidation Officer

3.7.1 For the purposes of Whole of Government Accounts, the Chief Executive of SHSCT is normally appointed by DoF as the Trust's Consolidation Officer.

3.7.2 As the Trust's Consolidation Officer, the Chief Executive shall be personally responsible for preparing the consolidation information, which sets out the financial results and position of the SHSCT; for arranging for its audit; and for sending the information and the audit report to the Principal Consolidation Officer nominated by DoF.

3.7.3 As Consolidation Officer, the Chief Executive shall comply with the requirements of the SHSCT Consolidation Officer Letter of Appointment as issued by DoF and shall, in particular:

- ensure that the Trust has in place and maintains sets of accounting records that will provide the necessary information for the consolidation process; and

- prepare the consolidation information (including the relevant accounting and disclosure requirements and all relevant consolidation adjustments) in accordance with the consolidation instructions and directions ["Dear Consolidation Officer" (DCO) and "Dear Consolidation Manager" (DCM) letters] issued by DoF on the form, manner and timetable for the delivery of such information.

3.8 Delegation of duties

3.8.1 The Chief Executive may delegate the day-to-day administration of his/her Accounting Officer and Consolidation Officer responsibilities to other employees in SHSCT. However, he/she shall not assign absolutely to any other person any of the responsibilities set out in this document.

3.9 The Chief Executive's role as Principal Officer for Ombudsman cases

3.9.1 The Chief Executive of SHSCT is the Principal Officer for handling cases involving the Northern Ireland Commissioner for Complaints. As Principal Officer, he/she shall inform the Permanent Secretary of the sponsor Department of any complaints about the Trust accepted by the Ombudsman for investigation, and about the Trust's proposed response to any subsequent recommendations from the Ombudsman.

3.10 Consulting customers

3.10.1 SHSCT will work in partnership with its stakeholders and customers, patients, other service users and carers to deliver the services/programmes for which it has responsibility, to agreed standards. It will consult regularly, within the parameters of the Trust's Consultation Scheme, to develop a clear understanding of citizens' needs and expectations of its services, and to seek feedback from both stakeholders and customers, patients, other service users and carers and will work to deliver a modern, accessible service.

3.10.2 SHSCT shall comply with the duties and requirements relating to the duty to co-operate with the Patient and Client Council, public involvement and consultation schemes in Sections 18, 19 and 20 of the Health and Social Care (Reform) Act (Northern-Ireland) 2009 - http://www.legislation.gov.uk/nia/2009/1/pdfs/nia_20090001_en.pdf .

4. PLANNING, BUDGETING AND CONTROL

4.1 The corporate plan

4.1.1 The term corporate plan refers to the Trust's four year plan which sets out the strategic issues the Trust will deal with in that period. Consistent with the timetable for the NI Executive's Budget process reviews, SHSCT shall submit to the sponsor team a draft of its corporate plan normally covering the four years ahead. The Trust shall have agreed with the sponsor Department the issues to be addressed in the plan and the timetable for its preparation. A draft of the corporate plan should be provided to the sponsor team by 31st January in the year preceding the first year of the plan.

4.1.2 DoF reserves the right to see and agree SHSCT's corporate plan.

4.1.3 The plan shall reflect the Trust's statutory duties and, within those duties, the priorities set from time to time by the Minister. In particular, the plan shall demonstrate how the Trust contributes to the achievement of the Department's strategic aims, PfG objectives and targets and the CPD. The plan may also refer to the financial environment within which the Trust is operating.

4.1.4 The corporate plan shall set out:

- SHSCT's key objectives and associated key performance targets for the forward years, its strategy for achieving those objectives and an estimate of performance in the current year;
- alternative scenarios to take account of factors which may significantly affect the execution of the plan, but which cannot be accurately forecast;
- a forecast of expenditure and income, taking account of guidance on resource assumptions and policies provided by the sponsor Department at the beginning of the planning round. These forecasts should represent the Trust's best estimate of all its available income, not just any grant or GIA; and
- other matters as agreed between the sponsor Department and the Trust – for example - statement of purpose of organisation as per legislation, strategic aims, performance in preceding

corporate plan period, governance and accountability arrangements, links with PfG, wider ministerial/departmental priorities and the CPD.

4.1.5 The main elements of the plan, including the key performance targets, shall be agreed between the sponsor Department and SHSCT in the light of the sponsor Department's decisions on policy and resources taken in the context of the Executive's wider policy and spending priorities and decisions.

4.1.6 In line with paragraph 4.1.1 the corporate plan should be submitted to the sponsor Department for approval.

4.2 The Trust Delivery Plan

4.2.1 The first year of the corporate plan, amplified as necessary, shall provide the basis of the Trust Delivery Plan (TDP) for the relevant forthcoming year. The Trust and the HSCB should agree on a timeframe for submission and agreement of the TDP, which shall include key targets and milestones for the year immediately ahead and shall be linked to budgeting information, so that resources allocated to achieve specific objectives can readily be identified by the sponsor Department.

4.2.2 The TDP should include reference to Specific, Measurable, Attainable, Realistic and Time-bound objectives that:

- support the delivery of PfG Commitments;
- support the delivery of Departmental policy and strategy;
- deliver on the functions etc. specified in SHSCT's founding legislation setting out the purposes for which the Trust was created and the functions/services it is to deliver;
- address known areas of underperformance, the findings of inquiries etc.; and
- respond to particular events, serious adverse incidents and near misses; and support the training and development of staff.

4.2.3 DoF reserves the right to ask to see and agree SHSCT's TDP.

4.2.4 The TDP is for formal approval by the HSCB.

4.3 Publication of plans

4.3.1 The corporate plan and the TDP shall be published by the Trust and made available on its website. A summary version shall be made available to staff.

4.4 Reporting performance to the sponsor Department

4.4.1 SHSCT shall operate management information and accounting systems which enable it to review in a timely and effective manner its financial and non-financial performance against the budgets and targets set out in its agreed corporate plan and TDP.

4.4.2 The Trust shall take the initiative in informing the HSCB and the sponsor Department of changes in external conditions which make the achievement of objectives more or less difficult, or which may require a change to the budget or objectives as set out in the corporate plan or TDP.

4.4.3 The Trust's performance against the CPD's objectives and targets shall be reported to the Department on a monthly basis, through formal reporting arrangements with the HSCB and the PHA. Performance will be reviewed formally twice yearly through the formal accountability review process by officials of the sponsor Department. The Minister may meet the Trust Board as appropriate to discuss the Trust's performance, its current and future activities, and any policy developments relevant to those activities.

4.4.4 The Sponsor Department may, at its discretion, request evidence of progress against key objectives at any time.

4.4.5 Senior Departmental officials will hold biannual Ground Clearing meetings with SHSCT. The purpose of these meetings is to discuss the Trust's overall performance, its current and future activities, any policy developments relevant to those activities, safety and quality, financial performance, corporate control/risk management performance, and other issues as determined by the Department. Issues identified at the Ground Clearing meeting which cannot be resolved at the meeting or through other avenues will be escalated for discussion to the Accounting Officer Accountability meeting with the Chair and Chief Executive of the SHSCT.

4.4.6 The SHSCT's performance against key targets shall be reported in its annual report and accounts [see Section 5.1 below].

4.5 Budgeting procedures

4.5.1 SHSCT's budgeting procedures are set out in the *Financial Memorandum* at Appendix 2 to this Management Statement.

4.6 Internal audit

4.6.1 SHSCT shall establish and maintain arrangements for internal audit in accordance with the Public Sector Internal Audit Standards (PSIAS).

4.6.2 The sponsor Department shall:-

- have input to SHSCT planned internal audit coverage;
- agree arrangements for the receipt of audit reports, assignment reports, the Head of Internal Audit's annual report and opinion etc;
- agree arrangements for the completion of Internal and External Assessments of the Trust's internal audit function against PSIAS including advising that the sponsor Department reserves a right of access to carry out its own independent reviews of internal audit in SHSCT; and
- have the right of access to all documents prepared by the Trust's internal auditor, including where the service is contracted out. Where the SHSCT's audit service is contracted out the Trust should stipulate this requirement when tendering for the services.

4.6.3 SHSCT shall consult the Business Services Organisation (BSO) to ensure that the latter is satisfied with the competence and qualifications of the Head of Internal Audit and that the requirements for approving the appointment are in accordance with Public Sector Internal Audit Standards (PSIAS) and relevant DoF guidance.

4.6.4 The sponsor Department will review the Trust's terms of reference for internal audit service provision. The Trust shall notify the sponsor Department of any subsequent changes to internal audit's terms of reference.

4.6.5 The sponsor team will have an annual meeting with SHSCT's internal audit to discuss the Trust's audit plan and strategy.

4.7 Audit Committee

4.7.1 SHSCT shall set up an independent Audit Committee as a committee of its Board, in accordance with current Cabinet Office Guidance and in line with the Audit and Risk Assurance Committee Handbook

4.7.2 The audit committee's meeting agendas and minutes shall be forwarded as soon as possible to the sponsorship team. Audit Committee papers should be provided to the sponsor team for the purposes of paragraph 4.7.5.

4.7.3 The Audit Committee should complete the National Audit Office Checklist on an annual basis. Assurance on completion of the checklist will be provided through the mid-year assurance statement. Any exception issues should be reported to the Department.

4.7.4 The sponsor team will review SHSCT's Audit Committee terms of reference. The Trust shall notify the sponsor Department of any subsequent changes to the Audit Committee's terms of reference.

4.7.5 The sponsor team will attend at least one Trust Audit Committee meeting per year as an observer and will not participate in any Audit Committee discussion.

4.8 Fraud

4.8.1 SHSCT shall report immediately to the Counter Fraud and Probity Services (CFPS) within the BSO all frauds (proven or suspected), including attempted fraud. CFPS shall then report the frauds immediately to the Sponsor Department, DoF and the Comptroller & Auditor General. In addition the Trust shall forward to CFPS the annual fraud return, commissioned by DoF, on fraud and theft suffered by the Trust.

4.8.2 SHSCT must have an Anti Fraud Policy and Fraud Response Plan in place. These should be reviewed at least every 5 years and sent to CFPS for review. The Trust shall notify the sponsor Department of any subsequent changes to the policy or response plan.

4.9 Additional departmental access to SHSCT

4.9.1 In addition to the right of access referred to in paragraph 4.6.2 above, the sponsor Department shall have a right of access to all SHSCT's records and personnel for purposes such as sponsorship audits and operational investigations (See also paragraphs 3.4.4 and 4.7.2 access to Board and Audit Committee minutes).

5. EXTERNAL ACCOUNTABILITY

5.1 The annual report and accounts

5.1.1 After the end of each financial year SHSCT shall publish as a single document an annual report of its activities together with its audited annual accounts. The report shall also cover the activities of any corporate bodies under the control of the Trust. A draft of the report shall be submitted to the sponsor Department in line with the timescale set by the Department before the proposed publication date although it is expected that the Department and the Trust will have had extensive pre-publication discussion on the content of the report prior to formal submission to the Department.

5.1.2 The report and accounts shall comply with the most recent version of the Government Financial Reporting Manual (FReM) issued by DoF. The accounts shall be prepared in accordance with any relevant statutes and the specific Accounts Direction issued by the sponsor Department.

5.1.3 The report and accounts shall outline SHSCT's main activities and performance during the previous financial year and set out in summary form its forward plans. Information on performance against key financial targets shall be included in the notes to the accounts, and shall therefore be within the scope of the audit.

5.1.4 The report and accounts shall be laid before the Assembly and made available, in accordance with the guidance on the procedures for presenting and laying the combined annual report and accounts as prescribed in the relevant Finance Director (FD) letter issued by DoF.

5.1.5 Due to the potential accounting and budgetary implications, any changes to accounting policies or significant estimation techniques underpinning the preparation of annual accounts requires the prior written approval of Finance Directorate in the sponsor Department.

5.2 External audit

5.2.1 The C&AG audits SHSCT's annual accounts and passes the accounts to Finance Directorate in the sponsor Department who shall lay them before the Assembly. For the purpose of audit the C&AG has a statutory right of access to relevant documents as provided for in Articles 3 and 4 of the Audit and Accountability (Northern Ireland) Order 2003.

5.2.2 The C&AG will liaise with SHSCT on the arrangements for completing the audit of its accounts. This will either be undertaken by staff of the NIAO or a private sector firm appointed by the C&AG to undertake the audit on his behalf. The final decision on how such audits will be undertaken rests with the C&AG, who retains overall responsibility for the audit.

5.2.3 The C&AG has agreed to share with the sponsor Department relevant information identified during the audit process, including the report to those charged with governance, at the end of the audit. This shall apply, in particular, to issues which impact on the Department's responsibilities in relation to financial systems within SHSCT. The C&AG will also consider, where asked, providing Departments and other relevant bodies with reports which Departments may request at the commencement of the audit and which are compatible with the independent auditor's role.

5.3 VFM examinations

5.3.1 The C&AG may carry out examinations into the economy, efficiency and effectiveness with which SHSCT has used its resources in discharging its functions. For the purpose of these examinations the C&AG has statutory access to documents as provided for under Articles 3 and 4 of the Audit and Accountability (Northern Ireland) Order 2003. Where making payment of a grant, or drawing up a contract, SHSCT should ensure that it includes a clause which makes the grant or contract conditional upon the recipient or contractor providing access to the C&AG in relation to documents relevant to the transaction. Where subcontractors are likely to be involved, it should also be made clear that the requirements extend to them.

6. STAFF MANAGEMENT

6.1 General

6.1.1 The decision to create or fill a Director or Assistant Director position within SHSCT is subject to approval by the Permanent Secretary of the Department of Health. This position will be kept under review by the Department. Similarly, no change to the remuneration of Senior Executives can be made without prior approval by the Permanent Secretary of the Department. Any request for approval in connection with this paragraph should be addressed to the Departmental Director of Workforce Policy.

6.1.2 Within the arrangements approved by the Minister and DoF, SHSCT shall have responsibility for the recruitment, retention and motivation of its staff. To this end the Trust shall ensure that:

- its rules for the recruitment and management of staff create an inclusive culture in which diversity is fully valued; where appointment and advancement is based on merit; and where there is no discrimination on grounds of gender, marital status, domestic circumstances, sexual orientation, race, colour, ethnic or national origin, religion, disability, community background or age;

- the level and structure of its staffing, including grading and numbers of staff, are appropriate to its functions and the requirements of efficiency, effectiveness and economy;

- the performance of its staff at all levels is satisfactorily appraised and the Trust's performance measurement systems are reviewed from time to time;
- its staff are encouraged to acquire the appropriate professional, management and other expertise necessary to achieve the Trust's objectives;
- proper consultation with staff takes place on key issues affecting them;
- adequate grievance and disciplinary procedures are in place;
- whistle blowing procedures consistent with the Public Interest (Northern Ireland) Order 2003 are in place; and
- a code of conduct for staff is in place based on Annex 5A of Public Bodies: A Guide for NI Departments (available at www.afmdni.gov.uk).

7. REVIEWING THE ROLE OF SHSCT

7.1 The role of SHSCT may be reviewed at the discretion of the sponsor Department, particularly to align with the outcomes of the strategic transformation agenda. Chapter 9 of the Public Bodies: a Guide for Northern Ireland Departments refers.

SIGNED ON BEHALF OF THE DEPARTMENT OF HEALTH

Personal Information redacted by the USI

PERMANENT SECRETARY

DATE: 10/5/17

SIGNED ON BEHALF OF SHSCT

Personal Information redacted by the USI

CHIEF EXECUTIVE

DATE: 26/9/17

Appendix 1

1. Documentary requirements

Documentation to be sent to the Sponsor Branch (except where elsewhere is specified, in which case cc to Sponsor Branch)

Monthly (or as the occasion arises)

- Board meeting agenda and draft minutes for each meeting as and when issued to Board members, and when requested, specific papers prepared for Board meetings
- Audit Committee agenda and papers (including draft minutes for each meeting as and when issued to Committee members
- Monthly financial monitoring returns, to Finance Directorate in the Department

Bi-annual

- Corporate Risk Register every six months
- DAC returns, to Finance Directorate in the Department

Annually

- Annual Governance Statement
- Mid-year Assurance Statement (by end-October)
- Annual report on Compliance with Controls Assurance Standards, to Governance Unit in the Department
- Annual Internal Audit work-plan
- Internal Audit Progress Report
- Annual Fraud return, to Finance Directorate in the Department

- The Head of Internal Audit's Annual Mid Year Assurance statements
- Register of Board members' interests
- Reports to Those Charged with Governance provided by NIAO to the Department's Permanent Secretary
- The annual report, with the draft submitted to the Department two weeks before the publication date (*separate timetable for the annual accounts, Governance Statement etc, set by Finance Directorate*)
- The Assurance Framework

Once and then when revised

- Code of Conduct for Board members, to Workforce Policy Directorate in the Department
- Audit Committee Terms of Reference
- Complaints procedure
- Anti-Fraud Policy
- Fraud Response Plan
- Whistle-blowing procedures
- Grievance and Disciplinary procedures
- Gifts & Hospitality Policy
- Equality scheme
- Publication scheme
- Consultation Scheme
- Business Continuity Plan

As specified

- Corporate Plan for approval

Once

- Adverse inspection reports by external bodies (e.g. RQIA, MHRA) to relevant policy leads in the Department.
- Internal Audit reports with less than satisfactory assurance.

Southern Health and Social Care Trust

Quality Care - for you, with you

STANDING ORDERS

including RESERVATION AND DELEGATION of POWERS

February 2021

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SECTION A – STANDING ORDERS

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Foreword

The Southern Health and Social Care Trust (the Trust) is required to have Standing Orders, Schedules of Powers Reserved to the Board and Powers Delegated by the Board and Standing Financial Instructions.

The Standing Orders, Reserved and Delegated Powers and Standing Financial Instructions provide a comprehensive business framework for the Trust and enable the organisation to discharge its functions.

The Chair, Board Members and all members of staff shall be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions required to comply fully with the regulations.

The Standing Financial Instructions are the “business rules” that Directors and employees (including employees of third parties contracted by the Trust) must follow when acting on behalf of the Trust. They detail the financial responsibilities, policies and procedures adopted by the Trust and are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Standing Orders, Schedules of Powers Reserved to the Board and the Powers Delegated by the Board adopted by the Trust.

In light of the unique situation with Covid-19, the Standing Orders have been updated and subsequently approved by the Trust Board at its meeting on 30th June 2020.

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Chair	**Chief Executive**

Southern Health and Social Care Trust

Quality Care - for you, with you

SECTION A

STANDING ORDERS

1. INTRODUCTION

1.1 Statutory Framework

The Southern Health and Social Care Trust (the Trust) is a statutory body which came into existence on 1st April 2007 under the Southern Health and Social Care Trust (Establishment) Order (Northern Ireland) 2006.

(1) The principal place of business of the Trust is Southern Health and Social Care Trust, Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, Craigavon, BT63 5QQ.

(2) The Trust is provided for under Article 10(1) of the Health and Personal Social Services (NI) Order 1991.

(3) The functions of the Trust are conferred by this legislation.

(4) As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee.

(5) Schedule 3 of the HPSS (NI) Order 1991 specifies the duties, powers and status of HSC Trusts.

(6) The Codes of Conduct and Accountability require the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals.

(7) The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

1.2 Functions of the Trust

The Trust has a range of statutory duties and shall, as a corporate body, exercise the functions assigned to it, including the specific duty set out in Section 21 of the Health and Social Care (Reform) Act (NI) 2009 to exercise its functions with the aim of improving the health and social well-being of, and reducing health inequalities, between those for whom it provides, or may provide, health and social care.

1.3 Health and Social Care Framework

(1) In addition to the statutory requirements, the Minister for Health, through the Department of Health, issues directions and guidance. Where appropriate, these are incorporated within the Trust's Standing Orders or other corporate governance documentation. Principal examples are the Codes of Conduct and Accountability and the HPSS Code of Practice on Openness.

(2) The Code of Accountability requires that, inter alia, Boards draw up a schedule of decisions reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The Code also requires the establishment of Audit and Remuneration Committees with formally agreed terms of reference.

(3) The Code of Conduct draws attention to the requirement for public service values to be at the heart of Health and Social Care (HSC) in Northern Ireland. High standards of corporate and personal conduct are essential. Moreover, as the HSC is publically funded, it is accountable to the Northern Ireland Assembly for the services provided and for the effective and economical use of taxpayers' money. It also sets out measures to deal with possible conflicts of interest in Board members.

(4) The Code of Practice on Openness in the HPSS sets out the requirements for public access to information and for the conduct of Board meetings. The Trust is required to ensure

appropriate compliance with the Freedom of Information Act (2000).

(5) The Management Statement/Financial Memorandum (MS/FM) establishes the framework agreed with the Department of Health within which the Trust operates, 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.

The associated Financial Memorandum sets out in greater detail certain aspects of the financial provisions which the Trust observes. However, the MS/FM do not convey any legal powers or responsibilities. The MS/FM will be reviewed by the Department of Health at least every 5 years.

A copy of the MS/FM will be given to all newly appointed Board members and senior executive staff on appointment. A copy of the MS/FM will be tabled for the information of Board members at least annually at a meeting of the Board. Amendments made to the MS/FM will be brought to the attention of the full Board on a timely basis.

(6) The Trust will comply with all existing legislation, Department of Health Framework Document, Management Statement/Financial Memorandum, Code of Conduct and Code of Accountability for Board Members of HSC bodies, Circulars and Regulations insofar as these impact upon Health and Social Care functions, activities and conduct. Where these are replaced or updated throughout the year, the new provision shall apply.

1.4 Performance Framework

The performance framework for the Trust is determined by the Department of Health in light of its wider strategic aims and of current Programme for Government objectives and Commissioning Plan Direction.

Enhanced performance management arrangements, defined in the draft Performance Management Framework for the Health and Social Care (HSC) system, identify the key features of the enhanced system for managing performance and accountability including:-

- The need for a broad suite of clinically agreed population health and well-being outcome measures;
- Targets must be deliverable and drive improvement;
- Clarifying accountability roles and responsibilities to focus on performance improvement;
- Internal Trust accountability processes to be strengthened;
- Effective service improvement support; and
- Effective escalation measures.

The key targets, standards and actions for the Trust are defined by the Department of Health within 'Objectives and Goals for Improvement' and approved by the Minister.

The Department of Health has strengthened its assurance and accountability arrangements in business planning of its Arm's Length Bodies and, as such, the Trust is required to reflect these within its annual Business Plans (including the Trust Delivery Plan and Corporate Plan).

Consistent with the timetable for the Northern Ireland Executive budget process reviews, the Trust shall submit to the Department of Health, a draft of its Corporate Plan normally covering the four years ahead. The Trust's planning process (including the Corporate Plan and the Trust Delivery Plan) outlines the Trust's key objectives and associated key performance targets for the forward years, its strategy for achieving those objectives and an estimate of performance

in the current year. The Corporate Plan shall be published by the Trust and made available on its website.

At the end of each financial year, the Trust shall publish, as a single document, an annual report of its activities together with its audited annual accounts. The report shall also cover the activities of any corporate bodies under the control of the Trust.

The Trust has a number of financial targets and policies within which it is obliged to operate. These are as follows:

- To break even on an annual basis by containing its Net Expenditure to within 0.25% of the Revenue Resource Limit;
- To promote financial stability;
- To operate within the Resource Limits, both Capital and Revenue set by the HSCB and Department of Health;
- To pay non HSC trade creditors in accordance with applicable terms and appropriate Government Accounting guidance. This includes a target of 95% of payments to be made within 30 calendar days of the receipt of goods or undisputed invoice and promotion of achievement of a 10 working day payment target.

1.5 Delegation of Powers

The Trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Orders relating to the Arrangements for the Exercise of Functions (SO 5), the Trust is given powers as follows:

"Subject to such directions as may be given by the Department of Health, the Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee, sub-committee or joint committee appointed by virtue of Standing Order 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit or as the Minister for Health may direct". Delegated Powers are covered in a

separate document (Reservation of Powers to the Board and Delegation of Powers). (See circular HSS (PDD) 8/94).

1.6 Governance

Trust Boards are required to have in place integrated governance structures and arrangements that will lead to good governance and to ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, social care, information and research governance aspects. This will better enable the Board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, social care, quality, safety and financial objectives.

1.7 Interpretation and Definitions of Terms

1.7.1 Save as otherwise permitted by law, at any meeting the Chair of the Board shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive and/or the Secretary to the Board).

1.7.2 Any expression to which a meaning is given in the HPSS (NI) Order 1991 and the Health and Social Care (Reform) Act (Northern Ireland) 2009 shall have the same meaning in these Standing Orders and Standing Financial Instructions and in addition:

1.7.3 **"Accounting Officer"** shall be the Chief Executive who is personally responsible for safeguarding the public funds of which he/she has charge; for ensuring propriety and regularity in the handling of those public funds; and for the day to day operations and management of the Trust.

1.7.4 **"Trust"** means the Southern Health and Social Care Trust.

1.7.5 **"Board"** means the Chair, executive and non-executive members of the Trust collectively as a body.

1.7.6 **"Budget"** means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

1.7.7 **"Budget holder"** means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

1.7.8 **"Chair of the Board (or Trust)"** is the person appointed by the Minister to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Board" shall be deemed to include the member of the Board deputising for the Chair if the Chair is absent from the meeting or is otherwise unavailable.

1.7.9 **"Chief Executive"** means the chief officer of the Trust.

1.7.10 **"Commissioning"** means the process for determining the need for and for obtaining the supply of healthcare, social care and related services by the Trust within available resources.

1.7.11 **"Committee"** means a committee or sub-committee created and appointed by the Trust either for its own good governance or by Department of Health direction or by legislation.

1.7.12 **"Committee members"** means persons formally appointed by the Board to sit on or to chair specific committees.

1.7.13 **"Contracting and procuring"** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

1.7.14 **"Director of Finance"** means the Chief Financial Officer of the Trust.

1.7.15 **"Funds held on trust"** shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept

under powers derived under Article 16 of the HPSS (NI) Order 1991. Such funds may or may not be charitable.

1.7.16 **"Member"** means executive or non-executive member of the Board as the context permits. Member in relation to the Board does not include its Chair.

1.7.17 **"Associate Member"** means a person appointed to perform specific statutory and non-statutory duties which have been delegated by the Trust Board for them to perform and these duties have been recorded in an appropriate Trust Board minute or other suitable record.

1.7.18 **"Membership, Procedure and Administration Arrangements Regulations"** means HSS Trusts (Membership and Procedure) Regulations (Northern Ireland) 1994.

1.7.19 **"Nominated officer"** means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

1.7.20 **"Officer"** means employee of the Trust or any other person holding a paid appointment or office with the Trust.

1.7.21 **"Secretary"** means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust's compliance with the law, Standing Orders, and Department of Health guidance.

1.7.22 **"SFIs"** means Standing Financial Instructions.

1.7.23 **"SOs"** means Standing Orders.

1.7.24 **"Vice-Chair"** means the non-executive member appointed by the Board to take on the Chair's duties if the Chair is absent for any reason.

2. THE TRUST BOARD: COMPOSITION OF MEMBERSHIP, TENURE AND ROLE OF MEMBERS

2.1 Composition of the Membership of the Trust Board

In accordance with Health and Social Services Trusts (Membership and Procedure) Regulations (NI) 1994, the composition of the Board shall be:-

(1) A Non-Executive Chair;

(2) Seven Non-Executive members to include six Lay Members and a Lay Member with financial experience;

(3) Up to 5 executive members (but not exceeding the number of non-executive members) including:

- the Chief Executive;
- the Director of Finance;
- the Medical Director;
- the Director of Nursing;
- the Director of Social Work

The Trust Board shall have not less than 8 members (unless otherwise determined by the Minister for Health and set out in the Trust's Establishment Order or such other communication from the Department).

2.2 Appointment of Chair and Members of the Trust Board

The Chair and Non-Executive Directors of the Trust are appointed by the Minister following an open and transparent public appointment competition carried out in line with the Code of Practice issued by the Commissioner for Public Appointments NI.

2.3 Terms of Office of the Chair and Members

The regulations setting out the period of tenure of office of the Chair and members and for the termination or suspension of office of the Chair and members are contained in Part 2, Articles 7 - 9 of the HSS Trusts

(Membership and Procedure) Regulations (NI) 1994. Appointments are normally for a four year term and are restricted to two terms. Notwithstanding the length of individual appointment terms, the maximum period in post must not exceed 10 years.

2.4 Appointment and Powers of Vice-Chair

(1) Subject to Standing Order 2.4 (2) below, the Chair and members of the Trust may appoint one of their numbers, who is not also an executive member, to be Vice-Chair, for such period, not exceeding the remainder of his term as a member of the Trust, as they may specify on appointing him/her.

(2) Any member so appointed may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair. The Chair and members may thereupon appoint another member as Vice-Chair in accordance with the provisions of Standing Order 2.4 (1).

(3) Where the Chair of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Vice-Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform those duties, be taken to include references to the Vice-Chair.

2.5 Joint Members

(1) Where more than one person is appointed jointly to a post mentioned in Part 2, regulation 6 of the HSS Trusts (Membership and Procedure) Regulations (NI) 1994, those persons shall count for the purpose of Standing Order 2.1 as one person.

2.6 Corporate role of the Board

(1) All business shall be conducted in the name of the Trust.

(2) All funds received in trust shall be held in the name of the Trust as corporate trustee.

(3) The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in Standing Order No. 3.

(4) The Board shall define and regularly review the functions it exercises on behalf of the Minister.

2.7 Role of Members

The Board will function as a corporate decision-making body, executive and non-executive Members will be full and equal members. Their role as members of the Trust Board will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

(1) Chair

The Chair is responsible for leading the Board and for ensuring that it successfully discharges its overall responsibility for the organisation as a whole.

The Chair is accountable to the Minister through the Departmental Accounting Officer. The Chair shall ensure that the Trust's policies and actions support the wider strategic policies of the Minister and that the Trust's affairs are conducted with probity.

The Chair has a particular leadership responsibility on:-

- Formulating the Board's strategy for discharging its duties;
- Ensuring that the Board, in reaching decisions, takes proper account of guidance provided by the Minister, the sponsor department, the HSCB or the PHA;
- Ensuring that risk management is regularly and formally considered at Board meetings;
- Promoting the efficient, economic and effective use of staff and other resources;

- Encouraging and delivering high standards of regularity and propriety;
- Representing the views of the Board to the general public;
- Ensuring that the Board meets at regular intervals throughout the year and that the minutes of meetings accurately record the decisions taken and, where appropriate, the views of individual Board members. Meetings must be open to the public, the public should be advised in advance of meetings through the press or other media such as the Trust's website and the minutes must be placed on the Trust's website after formal approval.

The Chair shall also:

- Ensure that all members of the Board, when taking up office, are fully briefed on the terms of their appointment and on their duties, rights and responsibilities, and receive appropriate induction training, including on the financial management and reporting requirements of public sector bodies and on any differences which may exist between private and public sector practice;

- Advise the Department of the needs of the Trust when Board vacancies arise, with a view to ensuring a proper balance of professional, financial or other expertise; and

- Assess the performance of individual Board Members. Board Members will be subject to ongoing performance appraisal, with a formal assessment being completed in consultation with Committee Chairs as appropriate by the Chair of the Board at the end of each year and prior to any proposed re - appointment or extension of the term of appointment of individual members taking place. Members will be made aware that they are being appraised, the standards against which they will be appraised, and will have an opportunity to contribute to and view their report. The Chair of the Board will also be appraised on an annual basis by the Departmental EBM.

- Ensure the completion of the Board Governance Self Assessment Tool on an annual basis. Assurance will be

provided through the mid-year assurance statement that the tool is being completed, actions are being addressed and that any exception issues will be raised with the Department.

- The Chair shall also ensure that Trust Board Members are made aware of the Code of Conduct for Board Members of HSC Bodies (2012) including the Nolan "seven principles of public life", and the requirement for a comprehensive and publicly available register of Board Members' interests. Communications between the Board, the Minister and the Department shall normally be through the Chair. The Chair shall ensure that the other Board Members are kept informed of such communications on a timely basis.

- The Chair shall be responsible for the operation of the Board and chair all Board meetings when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of appointment and with these Standing Orders.

- The Chair shall work closely with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

(2) Non-Executive Members

Non Executive members are appointed by the Minister to bring an independent judgement to bear on issues of strategy, performance, key appointments and accountability, through the Department to the Minister and to the local community.

The Non-Executive members shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of, or when chairing a committee of the Trust, which has delegated powers.

The Non Executive members shall also undertake specific functions agreed by the Board including an oversight of staff, relations with the general public and the media, participation in professional conduct and competency enquiries, staff disciplinary appeals and procurement of information management and technology. This exercise of such functions shall be in a non executive capacity.

(3) **Chief Executive**

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she is the **Accounting Officer** for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accounting Officer Memorandum for Trust Chief Executives.

The Chief Executive shall be directly accountable to the Chair and Non Executive Members of the Board for ensuring Board decisions are implemented, that the organisation works effectively in accordance with government policy and public service values, and for the maintenance of proper financial stewardship.

The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action fulfilling the decisions of the Board.

(4) **Executive Board Members**

Executive Board Members are senior members of Trust staff who have been appointed to lead each of its major professional and corporate functions. They shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

(i) **Director of Finance**

The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members

and for the supervision of financial control and accounting systems. He/she shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

(ii) **Medical Director**

The Medical Director shall take executive responsibility for all professional medical issues.

(iii) **Executive Director of Nursing**

The Executive Director of Nursing shall take executive responsibility for all professional nursing issues.

(iv) **Executive Director of Social Work**

The Executive Director of Social Work shall take executive responsibility for all professional social work issues.

(5) **Other Directors**

Directors shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation. They shall be in attendance at all meetings.

2.8 Lead Roles for Board Members

The Chair will ensure that the designation of lead roles or appointments of Board members as required by the Department of Health or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Board Member with responsibilities for Infection Control, Child Protection Services, Clinical Social Care Governance etc).

2.9 Functions of the Board

The Board has corporate responsibility for ensuring that the organisation fulfills the aims and objectives set by the Department and approved by the Minister in light of the

Department's wider strategic aims, current Programme for Government objectives and targets and the Commissioning Plan Direction, and for promoting the efficient, economic and effective use of staff and other resources by the Trust. To this end, and in pursuit of its wider corporate responsibilities, the Board shall:-

- Establish the overall strategic direction of the Trust within the policy and resources framework determined by the Department and Minister;

- Constructively challenge the Trust's Executive Team in their planning, target setting and delivery of performance;

- Ensure that the Department (through the Health and Social Care Board (HSCB) is kept informed of any changes which are likely to impact on the strategic direction of the Trust or on the attainability of its targets, and determine the steps needed to deal with such changes;

- Ensure that any statutory or administrative requirements for the use of public funds are complied with; that the Board operates within the limits of its statutory authority and any delegated authority agreed with the sponsor Department, and in accordance with any other conditions relating to the use of public funds; and that, in reaching decisions, the Trust Board takes into account all relevant guidance issued by Department of Finance and the Department;

- Ensure that the Trust Board receives and reviews regular financial information concerning the management of the Trust; is informed in a timely manner about any concerns about the activities of the Trust; and provides positive assurance to the sponsor Department that appropriate action has been taken on such concerns;

- Demonstrate high standards of corporate governance at all times, including using the independent audit committee, to help the Board to address the key financial and other risks facing the Trust; and

- Appoint a Chief Executive to the Trust and, in consultation with the sponsor Department, set performance objectives and remuneration terms linked to these objectives for the Chief Executive, which give due weight to the proper management and use of public monies.

- Act in good faith and in the best interests of the Trust.

2.10 Schedule of Matters reserved to the Board and Scheme of Delegation

The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved to the Board' and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

These matters are to be regarded as a guideline to the minimum requirement and shall not be interpreted so as to exclude any other issues which it might be appropriate, because of their exceptional nature, to bring to the Board.

The Chair, in consultation with the Chief Executive, shall determine whether other issues outwith the 'Schedule of Matters Reserved to the Board' shall be brought to the Board for consideration.

3. MEETINGS OF THE TRUST BOARD

3.1 The Code of Practice on Openness in the HPSS sets out the requirements for public access to information and for the conduct of Board meetings. The Trust is required to ensure appropriate compliance with the Freedom of Information Act (2000).

In order to meet the social distancing requirements of Covid-19, the Board is unlikely to meet in person for the foreseeable future and so will meet by virtual means. As a result of this, the Trust will make alternative arrangements for public and staff involvement by virtual means.

3.2 Calling meetings

(1) Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine. The Board shall determine the minimum number of meetings to be held each year.

(2) The Chair of the Trust may call a meeting of the Board for a special purpose at any time.

(3) One third or more members of the Board may requisition a meeting in writing. If the Chair refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

The Board shall agree an annual schedule of meetings to be held in public which shall be posted on the Trust website: www.southerntrust.hscni.net

3.3 Notice of Meetings and the Business to be transacted

(1) Before each meeting of the Board a written notice specifying the business proposed to be transacted shall be delivered to every member and to everyone on the Board distribution list and posted on the Trust website at least five working days before the meeting. Lack of service of such a notice on any member shall not affect the validity of a meeting.

(2) In the case of a meeting called by members in default of the Chair, those members shall sign the notice and no business shall be transacted at the meeting other than that specified in the notice.

(3) No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 3.7.

(4) A member desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least 10 working days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 working days before a meeting may be included on the agenda at the discretion of the Chair.

(5) Before each meeting of the Board a public notice in accordance with circular HSS (PPM) 4/2001 shall be issued detailing the time and place of the meeting. The public part of the agenda shall be posted on the Trust website www.southerntrust.hscni.net at least one week before the meeting (required by section 54 of the Health and Personal Social Services Act (Northern Ireland) 2001).

Any member of the public may request access to a paper on the agenda. Papers will be made available, on request, as soon as practicable after the meeting.

3.4 Agenda and Supporting Papers

The Agenda will be sent to members at least 5 working days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will be dispatched no later than three working days before the meeting, save in emergency.

3.5 Petitions

Where a petition has been received by the Trust, the Chair shall include the petition as an item for the agenda of the

next meeting providing it is appropriate for consideration by the Board. The Chair shall advise the meeting of any petitions that are not granted and the grounds for refusal.

3.6 Notice of Motion

With reference to matters included in the notice of meetings, a member of the Board may amend or propose a motion in writing to the Chair at least 5 clear days before the meeting. The Chair shall include in the agenda for the meeting all notices so received that are in order and permissible under the appropriate regulations. This paragraph shall not prevent any motion being withdrawn or moved, without notice, on any business mentioned on the agenda for the meeting.

3.7 Emergency Motions

Subject to the agreement of the Chair, and subject also to the provision of Standing Order 3.8, a member of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

3.8 Motions: Procedure at and during a meeting

A motion may be proposed by the Chair of the meeting or any member present. It must also be seconded by another member.

The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

When a motion is under discussion, or immediately prior to discussion, it shall be open to a member to move:-

- an amendment to the motion;

- the adjournment of the discussion or the meeting;
- that the meeting proceeds to the next business;
- that the motion should be now put;
- a motion resolving to exclude the public (including the Press).

In those cases where the motion is either that the meeting proceeds to the next business or that the question be now put, to ensure objectivity, only a member who has not previously taken part in the debate may put motions.

When an adjourned item of business is re-commenced or a meeting is reconvened, any provisions for deputations or speaking rights, not previously undertaken, or other arrangements shall be treated as though no interruption had occurred.

Withdrawal of Motion or Amendments

The proposer may withdraw a motion or an amendment once moved and seconded with the concurrence of the seconder and the consent of the Chair.

Motion to Rescind a Resolution

Notice of motion to amend or rescind any resolution (or the general substance of any resolution) that has been passed within the preceding six calendar months, shall bear the signature of the member who gives it and also the signature of three other members, and before considering any such motion of which notice shall have been given, the Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

When any such motion has been dealt with by the Board, it shall not be appropriate for any member other than the Chair to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.9 Chair of meeting

At any meeting of the Board the Chair, if present, shall preside. If the Chair is absent from the meeting, the deputising arrangements in place for the Chair shall take effect. If the Chair is absent temporarily on the grounds of a declared conflict of interest, such Non Executive Director, in line with the deputising arrangements, shall preside.

3.10 Chair's ruling

The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

3.11 Quorum

(i) No business shall be transacted at a meeting unless at least half of the whole number of the Chair and members (including at least two members who are also executive Members of the Trust and two members who are not) is present.

(ii) An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

(iii) If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest, that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.12 Voting

(i) Every item or question put to a vote at a meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the Chair of the meeting shall have a second or casting vote.

(ii) At the discretion of the Chair, all questions put to the vote shall be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the members present so request.

(iii) If at least one third of the members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).

(iv) If a member so requests, their vote shall be recorded by name.

(v) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.

(vi) An Officer who has been appointed formally by the Board to act up for an Officer Member during a period of incapacity or temporarily to fill an Officer Member vacancy, shall be entitled to exercise the voting rights of the Officer Member.

(vii) An Officer attending the Trust Board meeting to represent an Officer Member during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Officer Member. An Officer's status when attending a meeting shall be recorded in the minutes.

(i) For the voting rules relating to joint members see Standing Order 2.5.

3.13 Suspension of Standing Orders

(i) Except where this would contravene any statutory provision or any direction made by the Department of Health, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board are present (including at least one member who is an Officer Member of the Trust and one member who is not) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes.

(ii) A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and members of the Board.

(iii) No formal business may be transacted while Standing Orders are suspended.

(iv) The Audit Committee shall review every decision to suspend Standing Orders.

3.14 Variation and amendment of Standing Orders

These Standing Orders shall not be varied except in the following circumstances:

- upon a notice of motion under the appropriate Standing Order;
- upon a recommendation of the Chair or Chief Executive included on the agenda for the meeting;
- that two thirds of the Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Executive members vote in favour of the amendment;
- providing that any variation or amendment does not contravene a statutory provision or direction made by the Department for Health.

3.15 Record of Attendance

The names of the Chair and Directors/members present at the meeting shall be recorded.

3.16 Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate.

A copy of the approved minutes will be posted on the Trust website www.southerntrust.hscni.net following their approval at the next ensuing meeting.

The minutes shall be provided to the Department in draft form at the same time as they are circulated to Board members. A copy of the final approved minutes shall be provided to the Department in a timely way.

3.17 Committee Minutes

The minutes of all Board Committee meetings shall be brought to the public Board meeting for information immediately following Committee approval except where confidentiality needs to be expressly protected.

3.18 Admission of the public and the media

See Standing Order 3.1. In order to meet the social distancing requirements of Covid-19, the Board is unlikely to meet in person for the foreseeable future and so will meet by virtual means. As a result of this, members of the public, the media and staff will be unable to attend or observe in person. The Trust will make alternative arrangements for public and staff involvement by virtual means.

The Chair shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press and broadcasting media, such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board resolving as follows:-

"*That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public'*. Section 23 (2) of the Local Government Act (NI) 1972.

Matters to be dealt with by the Trust Board following the exclusion of representatives of the press, and other members of the public shall be confidential to the members of the Board.

Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers or minutes marked 'Confidential' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

In order to avoid undue disruption to Board meetings, television crews/press photographers or other media representatives can have access for a maximum of ten minutes prior to the meeting commencing. This will be subject to agreement of the Chair and members.

Nothing in these Standing Orders shall require the Board to allow members of the public, or press representatives and broadcasting media to record proceedings in any manner whatsoever.

3.19 Observers at Trust Board meetings

See Standing Order 3.1 and 3.18

The Board will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board's meetings and may change, alter or vary these terms and conditions as it deems fit.

3.20 Procedures for Addressing the Board

(i) Deputations from any meeting, association, public body or an individual may be permitted to address a meeting of the Board, subject to the following conditions:

- The subject is on the agenda;
- The Board Assurance Manager has received 3 working days notice, in writing, of the intended deputation, its purpose and a brief synopsis of content. The presentation/speaking notes must be submitted to the Board Assurance Manager in advance of the meeting. The Chair will decide on the appropriateness of the presentation.

(ii) The specified notice may be waived at the discretion of the Chair. Any deputation will be confined to a presentation by not more than 2 persons, per agenda item, and not to exceed 10 minutes duration. The Chair may at his/her discretion vary the number of individuals permitted to address the meeting. The Chair will decide if a Trust response is appropriate and there will be no right of reply by the speaker. The decision of the Chair will be final on this matter.

The Chair will also consider requests for questions from the public based on the following conditions:

- all questions must be relevant to an item included on the agenda
- individuals will be restricted to a maximum of 2 questions each

- once a question is answered by a member of Trust Board, as directed by the Chair, there will be no further discussions on this question; and
- the decision of the Chair will be final in relation to public questions

(iii) The Trust recognises the important statutory role the Patient and Client Council has in relation to representing the interests of the public in all matters of health and social care within the Trust's area. The Trust will therefore, grant the right for the Council to request attendance at any Trust Board meeting to raise specific agenda items. The Chair may at his/her discretion allow the Council to be heard during Board discussion of the item in questions.

4. APPOINTMENT OF COMMITTEES AND SUB- COMMITTEES

4.1 Appointment of Committees

Subject to such directions as may be given by the Minister, the Board may appoint committees of the Trust.

The Board shall determine the membership and terms of reference of committees and sub-committees and shall if it requires to, receive and consider reports of such committees. The Terms of Reference pertaining to each Board Committee are included at Appendix 1.

4.2 Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the Trust. In which case the term "Chair" is to be read as a reference to the Chair of other committee as the context permits, and the term "member" is to be read as a reference to a member of other committee also as the context permits. (There is no requirement to hold meetings of committees established by the Trust in public.)

4.3 Terms of Reference

Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Minister for Health. Each Committees' Terms of Reference will be reviewed annually by the Committee and approved by the Board.

4.4 Delegation of powers by Committees to Sub-Committees

Where committees are authorised to establish sub-committees they may not delegate executive powers to the

sub-committee unless expressly authorised by the Trust Board.

4.5 Approval of Appointments to Committees

The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither members nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board as defined by the Minister for Health. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

4.6 Appointments for Statutory functions

Where the Board is required to appoint persons to a committee and/or to undertake statutory functions as required by the Minister for Health and where such appointments are to operate independently of the Board such appointment shall be made in accordance with the regulations and directions made by the Minister for Health.

4.7 Committees established by the Trust Board

Trust Board sub-committees will be held by virtual means for the foreseeable future. The committees, sub-committees, and joint-committees established by the Board are:

4.7.1 Audit Committee

In accordance with current Cabinet Office Guidance and in line with the Department of Finance Audit and Risk Assurance Committee Handbook NI (April 2018), Codes of Conduct and Accountability (2012), an Audit Committee will be established and constituted to provide the Trust Board with an independent and objective view of internal control by a review on its financial systems, financial information and compliance with laws, guidance, and regulations governing the HSC. The Terms of Reference will be

reviewed annually by the Committee and approved by the Trust Board.

The Committee will be comprised exclusively of non-executive directors, with a minimum of three, of which one must have significant, recent and relevant financial experience. A quorum shall be two members. None of these members should be the Chair or members of the Remuneration Committee. The Committee will meet on at least four occasions per year.

A Department of Health representative will attend at least one Audit Committee meeting per year as an observer and will not participate in any Audit Committee discussion.

The Committee should complete the National Audit Office Checklist on an annual basis. Assurance on completion of the checklist will be provided through the mid-year assurance statement. Any exception issues should be reported to the Department.

4.7.2 Remuneration and Terms of Service Committee

In line with the requirements of the Codes of Conduct and Accountability, a Remuneration and Terms of Service Committee will be established and constituted.

The Committee will be comprised exclusively of the Chair and at least two Non-Executive Directors.

The primary responsibility of the Remuneration and Terms of Service Committee is to make recommendations to the Board on all aspects of remuneration and terms and conditions of employment for the Chief Executive and other Senior Executives. The purpose of the Committee will be set out in a formal terms of reference that will be available to the public on request. Meetings should be held as a minimum, once per year, to review remuneration matters or deal with specific matters. Further meetings may be arranged at the discretion of the Chair, as necessary.

4.7.3 Endowment and Gift Funds Committee

In line with its role as a corporate trustee for any funds held in trust, either as charitable or non charitable funds, the Trust Board will establish a Trust Endowment and Gift Funds Committee to administer those funds in accordance with any statutory or other legal requirements.

The Committee will be comprised three Non-Executive Directors, the Director of Acute Services and the Director with responsibility for Estates Services. The Director of Finance will be in attendance. A quorum shall be 3 members.

The provisions of this Standing Order must be read in conjunction with Standing Order 2.8 and the Standing Financial Instructions.

4.7.4 Governance Committee

In line with its responsibility for integrated governance, the Board will establish a Governance Committee to oversee the effective development and implementation of integrated governance arrangements and ensure compliance with statutory or other legal requirements.

Within the Audit and Risk Assurance Committee Handbook (2018), there is a strong emphasis on risk and assurance for the Trust and this is delivered by both the Governance and Audit Committees.

The Governance Committee will support the Board in all aspects of corporate and clinical and social care governance with financial governance the responsibility of the Audit Committee.

The Committee will be comprised exclusively of non-executive directors, with a minimum of three. A quorum shall be two. The Committee will meet on at least four occasions per year.

4.7.5 Patient and Client Experience Committee

The Trust Board will establish a Patient and Client Experience Committee to provide assurance that the Trust's services, systems and processes provide effective measures of patient/client and community experience and involvement. The Committee will also be responsible for identifying opportunities for development to deliver ongoing improvements in those areas impacting on the user experience of care.

The Committee will be comprised of non-executive directors, with a minimum of three and up to four Personal and Public (PPI) Panel members. A quorum shall be three members, two of which must be non executive directors. The Committee will meet on at least four occasions per year.

4.7.6 Performance Committee

The Trust Board will establish a Performance Committee to assist the Board in exercising one of its key functions of overseeing the delivery of planned results by monitoring performance against objectives and ensuring corrective actions are taken when necessary within agreed timelines.

The Committee will be comprised exclusively of non-executive directors, with a minimum of four. A quorum shall be two. The Committee will meet on at least four occasions per year.

5. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS FOR DELEGATION BY THE BOARD

5.1 Delegation of Functions to Committees, Officers or other bodies

5.1.1 Subject to such directions as may be given by the Department of Health, the Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee, sub-committee appointed by virtue of Standing Order 4, or by an officer of the Trust, or by another body as defined in Standing Order 5.1.2 below, in each case subject to such restrictions and conditions as the Board thinks fit.

5.1.2 Section 13, Schedule 3 of the HPSS (NI) Order 1991 allows for functions of the Trust to be carried out in the following ways:-

(i) by another Trust;

(ii) jointly with any one or more of the following: Health and Social Care Trusts, Boards, agencies or a Centre of Procurement Expertise (in respect of procurement and logistics);

5.1.3 Where a function is delegated by these Regulations to another Trust, then that Trust or health service body exercises the function in its own right; the receiving Trust has responsibility to ensure that the proper delegation of the function is in place. In other situations, i.e. delegation to committees, sub-committees or officers, the Trust delegating the function retains full responsibility.

5.2 Emergency Powers and urgent decisions

The powers which the Board has reserved to itself within these Standing Orders (see Standing Order 2.10) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chair after having consulted at least two non-executive members. The exercise of such powers by the Chief Executive and Chair shall be reported

to the next formal meeting of the Trust Board in public session for formal ratification.

5.3 Delegation to Committees

5.3.1 The Board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or sub-committees, or joint-committees, which it has formally constituted in accordance with directions issued by the Minister for Health. The constitution and terms of reference of these committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by the Board in respect of its sub-committees.

5.3.2 When the Board is not meeting as the Trust in public session it shall operate as a committee and may only exercise such powers as may have been delegated to it by the Trust in public session.

5.4 Delegation to Officers

5.4.1 Those functions of the Trust which have not been retained as reserved by the Board or delegated to other committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive may delegate the day-to-day administration of his/her Accounting Officer and Consolidation Officer responsibilities to other nominated officers in the Trust. However, he/she shall not assign absolutely to any other person any of the responsibilities set out in the Management Statement/Financial Memorandum.

5.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying the areas for delegation which shall be considered and approved by the Board. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board.

5.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Director of Finance or any other Lead Director to provide information and advise the Board in accordance with

statutory or Department of Health requirements. Outside these statutory requirements, the roles of the Director of Finance and all other Lead Directors shall be accountable to the Chief Executive for operational matters.

5.5 Schedule of Matters Reserved to the Trust and Scheme of Delegation of powers

5.5.1 The arrangements made by the Board as set out in the "Schedule of Matters Reserved to the Board" and "Scheme of Delegation" of powers shall have effect as if incorporated in these Standing Orders.

5.6 Duty to report non-compliance with Standing Orders and Standing Financial Instructions

If for any reason these Standing Orders or the Standing Financial Instructions are not complied with in any significant or material respect, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All members of the Trust Board and staff have a duty to disclose any significant or material non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6. CODES OF CONDUCT AND ACCOUNTABILITY

Introduction

The Code of Conduct and Code of Accountability for Board Members of Health and Social Care Bodies (2012), provide the basis on which HSC bodies should seek to fulfill the duties and responsibilities conferred upon them by the Department of Health. All members must subscribe to these Codes and will be judged upon the way the codes are observed.

The HSC Code of Conduct (2016) incorporates the principles contained within the Code of Conduct for HPSS Managers 2013 and supercedes it. It is applicable to all HSC employees, including managers, and sets out the core standards of conduct expected by all HSC staff.

6.1 Openness and Public Responsibilities

The Code of Conduct advises that there should be a willingness to be open and to actively involve the public, patients, clients and staff as the need for change emerges. The reasons for change should be fully explained and views from the public, patients and clients sought and taken into account before decisions are reached.

Health and social care business should be conducted in a way that is socially responsible and forges an open relationship with local communities and conducts dialogue with clients, patients and their carers about the planning and provision of the services provided. Health and Social Care bodies should demonstrate to the public that they are concerned with the wider health and social wellbeing of the population.

The duty of confidentiality of personal and individual patient/client information must be respected at all times.

6.2 Declaration of Interests

6.2.1 Requirements for Declaring Interests

Board members and all staff should act impartially and should not be influenced by social, political or business relationships. They should not use information gained in the course of their public service for personal gain or for political purposes nor seek to use the opportunity of public service to promote private interests or those of connected persons, firms, businesses or other organisations. Where there is a potential for private, voluntary, charitable etc. interests to be material and relevant to HSC business, the relevant interest should be declared.

The Trust has a Conflicts of Interest Policy in place to promote high standards in public life and ensure that Board members and staff follow the characteristics of propriety as defined in the Nolan Principles. This policy sets out the standards of conduct expected of Board members and 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. In accordance with the Policy, all Board members and staff shall declare such interests. A heavier 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 are required to provide an annual declaration return – this includes a nil return where there are no interests to declare.

6.2.2 Interests which are relevant and material

(i) Interests which should be regarded as "relevant and material" are:

a) Directorships, including Non-Executive Directorships held in private companies or Private Limited Companies (with the exception of those of dormant companies);

b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the Trust;

c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the Trust;

d) A position of trust in a charity or voluntary organisation involved in the field of health and social care;

e) Any connection with a voluntary or other organisation contracting for Trust services;

f) Any other commercial interest in the decision before the meeting.

6.2.3 Advice on Interests

If Board members have any doubt about the relevance of an interest, this should be discussed with the Chair of the Trust or with the Trust's Board Secretary.

Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

6.2.4 Recording of Interests in Trust Board minutes

Where there is a potential for private, voluntary, charitable etc. interests to be material and relevant to HSC business, the relevant interest should be declared by the Board member and recorded in the Board minutes and entered into the register which is publically available. Where a conflict of interest is established or perceived, the Board member shall withdraw and play no part in the relevant discussion.

6.2.5 Publication of declared interests in Annual Report

Where a Board member has an interest in any body which has transacted with the Trust, then the financial quantification of that transaction(s) shall be published in the Trust's Annual Report and Accounts for the year in question, together with an appropriate description of the members' interest.

6.2.6 **Conflicts of interest which arise during the course of a meeting**

During the course of a Board meeting, if a conflict of interest is established, the Board member concerned should, as soon as he/she is able after its commencement, disclose the fact. It shall be disclosed in a manner that cannot be perceived to influence subsequent discussion or decision. The member shall withdraw from the meeting and play no part in the relevant discussion or decision.

6.3 Register of Interests

6.3.1 The Chief Executive will ensure that a Register of Interests is established to record formally any declarations of interests of Board and staff members.

6.3.2. These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

6.3.3 The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

6.4 Definition of terms used in interpreting director or indirect pecuniary interests

Please refer to HSS Trusts (Membership and Procedure) Regulations (Northern Ireland) 1994.

6.5 Standards of Business Conduct

6.5.1 Trust Policy

All Trust staff and Board members must comply with the Trust's Policy on Gifts, Hospitality and Sponsorship and Conflicts of Interests Policy.

The Trust's Gifts, Hospitality and Sponsorship Policy provides advice 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. All offers of gifts, prizes, invitations, hospitality, sponsorship of courses, conferences and meetings valued at over £50 must be recorded on the register.

The Code of Conduct for HSC Employees (September 2016) also refers.

6.5.2 Canvassing of and Recommendations by Members in Relation to Appointments

i) Canvassing of members of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

ii) Members of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

6.5.3 Relatives of Members or Officers

i) Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

ii) The Chair and every member and officer of the Trust shall disclose to the Trust Board any relationship between himself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Trust Board any such disclosure made.

iii) On appointment, members (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other member or holder of any office under the Trust.

7. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

7.1 Custody of Seal

The Chief Executive's office has responsibility for the safe-keeping and use of the Trust Common Seal.

The seal is kept in a secure location within Trust Headquarters.

The use of the seal is controlled by the Chief Executive's office and authority to use the seal is restricted to the Office Manager for the Chief Executive or Board Assurance Manager.

7.2 Sealing of Documents

Documents should only be sealed following a resolution by the Trust Board. In exceptional circumstances, a document shall be sealed in advance of a resolution by the Trust Board and retrospective resolution sought at the following Trust Board meeting. Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of a Director of the Trust and of the Chief Executive/or other officer at Director level nominated by the Chief Executive and shall be attested by them. The Chair may also sign. Those present must not be from the originating department seeking application of the Trust seal.

7.3 Register of Sealing

A register is maintained by the Office Manager for the Chief Executive of all documents sealed.

7.4 Signature of documents

Where the signature of any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Director.

Southern Health and Social Care Trust

Quality Care - for you, with you

SECTION B

SCHEME OF RESERVATION AND DELEGATION OF POWERS

1.1 SCHEDULE OF POWERS RESERVED TO THE BOARD

The 'Schedule of Powers reserved to the Board' is sub-divided to correspond with the seven key functions of the Board for which it is held accountable by the Department of Health on behalf of the Minister. These are:-

1. To set the strategic direction of the organisation within the overall policies and priorities of the Government and the HSC, define its annual and longer term objectives and agree plans to achieve them;

2. To oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary;

3. To ensure effective financial stewardship through value for money, financial control and financial planning and strategy;

4. To ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation;

5. To appoint the Chief Executive and consider the appraisal and remuneration of the Chief Executive and Directors;

6. To ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs;

7. To ensure that the Trust has robust and effective arrangements in place for clinical and social care governance and risk management.

These matters are to be regarded as a guideline to the minimum requirement and shall not be interpreted as to exclude any other issues which it might be appropriate, because of their exceptional nature, to bring to the Board.

The Chair, in consultation with the Chief Executive shall determine whether other issues outwith the following schedules of reserved powers shall be brought to the Board for consideration.

RESERVED TO / DELEGATED TO	AREAS INCLUDED IN SCHEME OF RESERVATION AND DELEGATION
Trust Board	**General Enabling Provision** The Board may determine any matter, for which it has delegated or statutory authority, in full session within its statutory powers.
Trust Board	**Regulations and Control** 1. HSC Trust Boards must comply with legislation and guidance issued by the Department of Health on behalf of the Minister for Health, respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money. 2. Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 3. Suspend Standing Orders. 4. Vary or amend the Standing Orders. 5. Ratify any urgent decisions taken by the Chair and Chief Executive in public session in accordance with SO 5.2 6. Approve a scheme of delegation of powers from the Board to committees.

RESERVED TO / DELEGATED TO	AREAS INCLUDED IN SCHEME OF RESERVATION AND DELEGATION
TRUST BOARD	**Set Strategic Direction** 1. Establish the overall strategic direction of the Trust and approve any associated plans. 2. Approve Outline and Final Business Cases with capital costs in excess of £300,000 and/or revenue costs which are in excess of £300,000 per annum on a recurrent or non-recurrent basis. 3. Approve budgets on an annual basis. 4. Ratify proposals for acquisition, disposal or change of use of land and/or buildings. 5. Approve PFI proposals. 6. Receive and approve update on 4-Year Corporate Plan on an annual basis.
TRUST BOARD	**Monitor Performance** 1. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements. Monitoring returns required by the Department of Health shall be reported, at least in summary, to the Board. This includes an annual monitoring report on the delivery of statutory functions with a mid-year return on Corporate Parenting.

RESERVED TO / DELEGATED TO	AREAS INCLUDED IN SCHEME OF RESERVATION AND DELEGATION
	2. Receive reports as are required by statute or Department of Health regulation and other such reports as the Board sees fit from committees in respect of their exercise of powers delegated and take action on as appropriate. 3. Receive reports on financial performance against budget and Trust Delivery Plan, including progress in meeting specific strategic, HSCB and DoH objectives and targets. 4. Receive and approve the Trust's Equality Scheme Report for submission to Equality Commission.
TRUST BOARD	**Financial Stewardship** **Annual Reports and Accounts** 1. Receipt and approval of the Trust's Annual Report and Annual Accounts. 2. Receipt and approval of the Trustees Annual Report and Accounts for Endowment & Gift funds. 3. Receipt and approval of the Accounts for patients'/residents property. 4. Approve the opening of bank accounts and Trust banking arrangements. 5. Approve proposals in individual cases for the write off of losses or making of special payments in line with HSC delegated limits and requirements.

RESERVED TO / DELEGATED TO	AREAS INCLUDED IN SCHEME OF RESERVATION AND DELEGATION
	Audit 1. Receipt of the annual Report to those charged with Governance from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee. Receipt of an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.
TRUST BOARD	**Corporate Governance and Personal Behaviour and Conduct** 1. Comply with the Codes of Conduct and Accountability 2. Require and receive the declaration of Board members' interests that may conflict with those of the Trust 3. Require and receive the declaration of officers' interests that may conflict with those of the Trust. 4. Comply with the Trust's Policy on Gifts, Hospitality and Sponsorship 5. Disclose relationships between self and candidates for staff appointment 6. Act in good faith and in the interests of the Trust
TRUST BOARD	**Appointments/ Dismissal** 1. Appoint and dismiss committees (and individual members) that are directly accountable to the Board. 2. Appoint, appraise, discipline and dismiss Senior Executives (subject to SO 2.2). 3. Confirm appointment of members of any committee of the Trust as representatives on outside bodies. 4. Approve recommendations of the Remuneration Committee regarding directors and senior executives.

RESERVED TO / DELEGATED TO	AREAS INCLUDED IN SCHEME OF RESERVATION AND DELEGATION
TRUST BOARD	**Public Engagement** **1.** Hold meetings in public **2.** Invite and receive views from the public on proposals for strategic change
TRUST BOARD	**Governance – inclusive of Clinical and Social Care and Risk Management** 1. Approval of Annual Governance Statement and Mid Year Assurance Statement 2. Approval of Board Assurance Framework and Corporate Risk Register on an annual basis 3. Complete Board Governance Self-Assessment on an annual basis

1.2 DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
SO 4.7.1 SFI 2.1.1	AUDIT COMMITTEE	**The Committee will:** 1. Advise the Board on internal and external audit services. 2. Oversee the maintenance of an effective system of integrated governance, risk management and internal control. 3. Review the adequacy of all risk and control related disclosure statements, in particular the Mid-Year Assurance Statement and the Governance Statement, together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board. 4. Review the adequacy of the policies for ensuring compliance with relevant regularity, legal and code of conduct requirements, including consideration of revised versions of the Trust's Standing Orders and Standing Financial Instructions. 5. Review the annual schedule of losses and compensation payments and making recommendations to the Board regarding their approval. 6. Review and approval of the policies and procedures for all work related to bribery, fraud and corruption as required by the Counter Fraud and Probity Service at the Business Services Organisation for onward submission to the Trust's Policy Scrutiny Committee for ratification. 7. Review the Trust's Annual Report and the audited Financial Statements prior to submission to the Board. 8. Review and approval of the Internal Audit Strategy, operational plan and more detailed programme of work, ensuring this is consistent with the audit needs of the organization.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		9. Review the findings of other significant assurance functions, both internal and external to the organisation 10. Review, on an annual basis, Post Project Evaluations completed on projects with a capital/revenue value in excess of £300,000. 11. Review the Trust Procurement Board Annual Report including all approved Direct Award Contracts 12. Receive regular updates in relation to fraud cases under investigation. 13. Complete National Audit Office checklist on an annual basis and develop an action plan 14. Receive Value for Money reports from C&AG
SO 4.7.2 SFI 10.1.1	REMUNERATION AND TERMS OF SERVICE COMMITTEE	**The Committee will:** 1. Advise the Board about appropriate remuneration and terms of service for the Chief Executive and other Senior Executives, including all aspects of salary and arrangements for termination of employment and other contractual terms 2. Ensure decisions to create or fill Director or Assistant Director positions have been approved by the Permanent Secretary and no change to the remuneration of Senior Executives is made without prior approval of the Permanent Secretary 3. Ensure robust objectives, performance measures and evaluation processes are in place within the Trust in respect of Senior Executives 4. Make recommendations to the Board on succession planning and on the remuneration, allowances and terms of service of the Chief Executive and on the advice of the Chief Executive, other Senior Executives to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		to the provisions of any national arrangements for such staff. 5. The Committee shall report its recommendations to the Board for approval.
S.O. 4.7.4	GOVERNANCE COMMITTEE	The Committee will: 1.Review the structures in place to support the effective implementation and continued development of integrated governance across the Trust. 2. Assess the assurance systems for effective risk management which provide a planned and systematic approach to identifying, evaluating and responding to risks and providing assurance that responses are effective. 3. Consider principal risks and significant gaps in controls or or assurances and ensure these are appropriately escalated to Trust Board. 4. Evaluate sources of independent and objective assurance as to robustness of key processes across all areas of governance. 5. Review the adequacy of all governance and risk management and control related disclosure Statements (in particular the Governance Statement) 6. Make recommendations to the Board recognising that financial governance is primarily dealt with by the Audit Committee 7. Receive minutes from the Trust's Mid Year and End Year Ground Clearing meetings with the Department of Health.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
S.O.4. 7.3 and SFI 19	ENDOWMENT AND GIFTS FUNDS COMMITTEE	The Committee will: 1. Oversee the administration, including banking arrangements, of Endowment and Gift (E&G) Funds, their investment and disbursement. 2. Satisfy itself that E&G Funds are managed in line with the Trust's Standing Financial Instructions, Departmental guidance and legislation. 3. Ratify the creation of a new fund by the Director of Finance where funds and/or other assets are received and where the wishes of the donor cannot be accommodated within the scope of an existing fund. 4. Make recommendations on the potential for rationalisation of funds within statutory guidelines. 5. Ensure that assets in ownership of, or used by the E&G fund will be maintained with the Trust's general estate and inventory of assets. 6. Ensure that funds are not unduly or unnecessarily accumulated. 7. Ensure that a Trustees report is produced as part of the production of annual accounts for Endowments & Gifts. 8. Ensure expenditure form E&G funds is subject to appropriate value for money considerations, including proper procurement procedures where applicable. 9. Ensure that annual accounts are prepared in accordance with Department of Health guidelines and submitted to the Trust Board with agreed timescales. 10. Authorise appropriate policies and procedures in relation to E&G Funds

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
S.O. 4.7.5	PATIENT AND CLIENT EXPERIENCE COMMITTEE	The Committee will 1. Provide assurance to the Trust Board that the Trust's services, systems and processes provide effective measures of patient, client and carer experience and involvement. 2. Identify gaps and areas of opportunity for development to ensure continuous, positive improvement to the patient, client and carer experience. 3. Review and analyse trends emerging from users' feedback on their experience of care. Reviews and analysis of trends will focus on themes, service areas and professional matters. 4. Assess the evidence that effective learning and improvement is occurring in relation to the user and carer experience. 5. Receive assurances of the quality and breadth of the training and development provided to staff to deal appropriately with patients, clients and carers. 6. Review progress of the Trust's Continuous Improvement Plan in relation to the patient, client and carer experience. 7. Receive assurances on the development of the Trust's approach to learning from patient and client experience. 8. Review progress of the Trust's Carers Action Plan. 9. Receive updates on the development of the Trust's approach to learning from the patient, client and carer experience. 10. Make recommendations to the Trust Board for consideration.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
4.7.6	PERFORMANCE COMMITTEE	The Committee will 1. Oversee the Trust's Performance Management Framework ensuring that there are effective and regularly reviewed structures in place to support the effective implementation and continued development of integrated performance management arrangements across the Trust. 2. Ensure there is sufficient independent and objective assurance as to the robustness of key processes across all areas of performance. 3. Identify risks and gaps in control and assurance and seek assurance that risks are mitigated and being managed effectively. 4. Highlight potential risks that could impact on the Trust's ability to deliver on its strategic direction and bring these to the attention of the Trust Board and the HSCB and PHA. 5. Review the monitoring information in sufficient detail to advise the Trust Board, with confidence, concerning the performance of the Trust. 6. Receive reports on significant performance improvement initiatives within the Trust and review progress. 7. Ensure timely reports are made to the Trust Board, including recommendations and remedial action taken or proposed with timeframes, if there is an internal failing in systems or services.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		8. Ensure recommendations considered appropriate by the Committee are made to the Trust Board. 9. Review the findings of other significant assurance functions, both Internal and external to the organisation, and consider the implications for the performance of the organisation. These will include, but will not be limited to any reviews by Department of Health, commissioned bodies or professional bodies with responsibility for the performance of staff or functions.

1.3 CHIEF EXECUTIVE'S SCHEME OF DELEGATION

This refers to Section 5.4 of the Standing Orders

DELEGATED TO	DUTIES TO BE DELEGATED / RESERVED
CHIEF EXECUTIVE	Accountable through Department of Health Accounting Officer to Parliament / NI Assembly for stewardship of Trust resources
CHIEF EXECUTIVE	As Accounting Officer, is personally responsible for safeguarding the public funds of which he/she has charge for: • Ensuring propriety and regularity in the handling of public funds • Day to day operations and management of the Trust • Selection and appraisal of programmes and projects • Adhering to affordability and sustainability in the use of resources • Achieving value for money and avoiding waste and extravagance in the organisation's activities • Having appropriate control over major project or policy initiatives • Managing opportunity and risk to achieve the right balance commensurate with Trust business and risk appetite • Applying learning from experience • Accurately account for the organisation's financial position and transactions

DELEGATED TO	DUTIES TO BE DELEGATED / RESERVED
CHIEF EXECUTIVE	Ensure that proper records are kept relating to the accounts of the Trust and that the accounts of the Trust are prepared under principles and in a format directed by the Department of Health. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs.
CHIEF EXECUTIVE	Sign a Mid-Year Assurance Statement on the condition of the Trust's system of internal control which details significant internal control divergences. Sign the Performance Report and Accountability Report within the Annual Report. The Accountability Report includes the Governance report, Remuneration and staff report and Accountability and Audit report.
CHIEF EXECUTIVE	For the purposes of the whole of Government Accounts, act as the Trust's Consolidation Officer and be personally responsible for :- • Preparing the consolidation information, which sets out the financial results and position of the Trust; for arranging for its audit; and for sending the information and the audit report to the Principal Consolidation Officer nominated by the Department of Finance. • Ensuring that the Trust has in place and maintains sets of accounting records that will provide the necessary information for the consolidation process; and • Prepare the consolidation information in accordance with the consolidation instructions and directions.

DELEGATED TO	DUTIES TO BE DELEGATED / RESERVED
CHIEF EXECUTIVE	Give evidence, normally with the Accounting Officer of the Department of Health, if summoned before the Public Accounts Committee on the use and stewardship of public funds by the Trust.
DIRECTOR OF **F**INANCE	Day to day administration of the Accounting and Consolidation Officer responsibilities.
CHIEF **E**XECUTIVE	Implement requirements of corporate governance.
CHIEF EXECUTIVE	Supported by Director of Finance, ensure appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.
CHIEF EXECUTIVE	As the Principal Officer for handling cases involving the Northern Ireland Commissioner for Complaints, inform the Permanent Secretary of the Department of Health of any complaints about the Trust accepted by the Ombudsman for investigation, and about the Trust's proposed response to any subsequent recommendations from the Ombudsman.
CHIEF EXECUTIVE AND MEDICAL DIRECTOR	Supported by the Medical Director, ensure that a system of risk management is maintained to inform decisions on financial and operational planning and to assist in achieving objectives and targets.
CHIEF EXECUTIVE	Ensure that an effective system of programme and project management and contract management is maintained.
CHIEF EXECUTIVE	Ensure compliance with the NI Public Procurement Policy
CHIEF EXECUTIVE	Ensure that all public funds made available to the Trust including any income for any receipts are used for the purpose intended by the Assembly and that such

DELEGATED TO	DUTIES TO BE DELEGATED / RESERVED
	monies, together with the Trust's assets, equipment and staff are used economically, efficiently and effectively.
CHIEF EXECUTIVE	Ensure that adequate internal management and financial controls are maintained by the Trust including effective measures against fraud and theft.
CHIEF EXECUTIVE	Maintain a comprehensive system of internal delegated authorities that are notified to all staff, together with a system for regularly reviewing compliance with these delegations.
DIRECTOR OF **H**UMAN **R**ESOURCES & **O**RGANISATIONAL **D**EVELOPMENT	Ensure that effective personnel management policies are maintained.
CHIEF EXECUTIVE	**Planning and Monitoring** 1. Establish, with approval of the Department, as appropriate, the Trust's corporate and business plans in support of the Department's wider strategic aims and current PfG objectives and targets. 2. Inform the HSCB and the sponsor Department as appropriate of the Trust's progress in helping to achieve the Department's policy objectives and in demonstrating how resources are being used to achieve those objectives 3. Ensure that timely forecasts and monitoring information on performance and finance are provided to the HSCB and the Department as appropriate including prompt notification if overspends or underspends are likely and that corrective action is taken.

DELEGATED TO	DUTIES TO BE DELEGATED / RESERVED
	4. Ensure that any significant problems, whether financial or otherwise, and whether detected by internal audit or by other means, are notified to the HSCB or the Department as appropriate in a timely fashion.
CHIEF EXECUTIVE	**Advising the Board** 1. Ensure that appropriate advice is given to the Board on the discharge of its responsibilities according to relevant legislation and guidance that may be issued from time to time from the Department of Finance or the Department. 2. Advise the Board on the Trust's performance compared with its aims and objectives. 3. Ensure that financial considerations are taken fully into account by the Trust Board at all stages in reaching and executing its decisions, and that standard financial appraisal techniques are followed appropriately. **4.** Take action if the Board, or its Chair, is contemplating a course of action that raises an issue involving a transaction which the Chief Executive considers would infringe the requirements of propriety or regularity or does not represent prudent or economical administration, efficiency or effectiveness.

MEDICAL **D**IRECTOR	Ensure that effective procedures for handling complaints about the Trust are established and made widely known within the Trust.
CHIEF EXECUTIVE AND **D**IRECTOR OF **H**UMAN **R**ESOURCES AND **O**RGANISATIONAL **D**EVELOPMENT	Ensure the Trust's Equality Scheme is in place, reviewed and equality impact assessed as required by the Equality Commission and The Executive Office
DIRECTOR OF **P**ERFORMANCE AND **R**EFORM	Ensure that the requirements of the GDPR 2018 and the Freedom of Information Act 2000 are complied with
CHIEF EXECUTIVE	Ensure that a business continuity plan is developed and maintained
CHIEF EXECUTIVE AND MEDICAL DIRECTOR	Ensure that copies of adverse inspection reports are shared with the relevant policy lead in the Department
CHIEF EXECUTIVE	Ensure full compliance with the requirements of relevant statutes, court rulings and departmental directions
DIRECTOR OF **F**INANCE	Ensure that a policy on acceptance of provision of Gifts and Hospitality is in place.
CHIEF EXECUTIVE	Maintain a Register of Interests
CHIEF EXECUTIVE	Keep seal in safe place and maintain a register of sealing.

1.6 SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES TO BE DELEGATED OR RESERVED
1.1.3	DIRECTOR OF FINANCE	Approval of all financial procedures.
1.1.4	DIRECTOR OF FINANCE	Advice on interpretation or application of SFIs.
1.1.6	ALL MEMBERS OF TRUST BOARD AND TRUST EMPLOYEES	Have a duty to disclose any significant / material non-compliance with the Standing Financial Instructions to the Director of Finance as soon as possible.
1.2.3	CHIEF EXECUTIVE	Responsible as the Accounting Officer to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Control.
1.2.3	CHIEF EXECUTIVE AND DIRECTOR OF FINANCE	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
1.2.4	CHIEF EXECUTIVE	To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.
1.2.5	DIRECTOR OF FINANCE	Responsible for: • Implementing the Trust's financial policies and coordinating corrective action; • Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented; • Ensuring that sufficient records are maintained to explain Trust's transactions and financial position; • Providing financial advice to members of Board and staff; • Design, implementation and supervision of systems of internal financial control • Maintaining such accounts, certificates etc as are required for the Trust to carry out its statutory duties.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES TO BE DELEGATED OR RESERVED
1.2.6	ALL MEMBERS OF TRUST BOARD AND TRUST EMPLOYEES	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.
1.2.7	CHIEF EXECUTIVE	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.
2.1.1	AUDIT COMMITTEE	Provide independent and objective view on internal control and probity.
2.1.2	CHAIR OF AUDIT COMMITTEE	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.
2.1.3	DIRECTOR OF FINANCE	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed.)
2.2.1	DIRECTOR OF FINANCE	Decide at what stage to involve police in cases of misappropriation and other irregularities; to ensure an internal audit strategic plan produced and to ensure an annual internal audit report is prepared for consideration by Audit Committee.
2.3	HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with Public Sector Internal Audit Standards and best practice.
2.4	AUDIT COMMITTEE	Ensure an effective External Audit.
2.5	CHIEF EXECUTIVE AND DIRECTOR OF FINANCE	Monitor and ensure compliance with Department of Health Directions on fraud, bribery and corruption including ensuring an Anti Fraud Policy and Fraud Response plan is in place which is reviewed at least every 5 years

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES TO BE DELEGATED OR RESERVED
2.5.3	DIRECTOR OF FINANCE	Ensure the Trust has a nominated Fraud Liaison Officer and will provide an annual report to Audit Committee on counter fraud work within the Trust.
4.2.1	CHIEF EXECUTIVE	Compile and submit to the Board a Trust Delivery Plan which takes into account financial targets and forecast limits of available resources. The Trust Delivery Plan will contain: • a statement of the significant assumptions on which the plan is based; • details of major changes in workload, delivery of services or resources required to achieve the plan. • Details of the Trust's priorities and objectives
4.2.2 & 4.2.3	DIRECTOR OF FINANCE	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.
4.2.5	DIRECTOR OF FINANCE	Ensure adequate training is delivered on an on going basis to budget holders.
4.3.1	CHIEF EXECUTIVE	Delegate management of budget to budget holders.
4.3.2	CHIEF EXECUTIVE AND BUDGET HOLDERS	Must not exceed the budgetary total or virement limits set by the HSC Board.
4.4.1	DIRECTOR OF FINANCE	Devise and maintain systems of budgetary control.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES TO BE DELEGATED OR RESERVED
4.4.2	BUDGET HOLDERS	Ensure that a) no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Trust Board or its delegated representative; b) approved budget is not used for any other than specified purpose subject to rules of virement; c) no permanent employees are appointed without the approval of the Chief Executive or delegated officer, other than those provided for within available resources and manpower establishment. d) attend training as deemed necessary
4.4.3	CHIEF EXECUTIVE	Identify and implement cost improvements and income generation initiatives in accordance with the TDP and a balanced budget.
4.5.1	CHIEF EXECUTIVE	Submit monitoring returns
5.1	DIRECTOR OF FINANCE	Preparation of annual accounts and reports.
6.1 – 6.3	DIRECTOR OF FINANCE	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of those authorized to sign cheques or other orders drawn on Trust bank accounts. (Trust Board approves arrangements.)
7.1	DIRECTOR OF FINANCE	Ensuring that there are appropriate systems in place for recording, invoicing, collection and coding of income due to the Trust.
7.2.2	DIRECTOR OF FINANCE	Approving and reviewing the level of all fees and charges other than those determined by statute or Department of Health.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES TO BE DELEGATED OR RESERVED
7.2.4	ALL EMPLOYEES	Duty to inform Director of Finance of money due from transactions which they initiate/deal with.
7.4	DIRECTOR OF FINANCE	Responsible for prescribing systems and procedures to the handling of cash and negotiable securities on behalf of the Trust
8.6.1	CHIEF EXECUTIVE	Ensure that the Trust has appropriate systems in place for controlling the risks associated with purchasing activities
8.6.2	DIRECTOR OF FINANCE	Compile and submit to the Trust Board a Trust Procurement Strategy
8.6.3	DIRECTOR OF FINANCE	Prepare a Procurement Plan and submit for approval by the Trust Board or other nominated Committee.
8.6.6	DIRECTOR OF FINANCE	Ensure that adequate training and documented procedures are available to Trust employees commensurate with their roles and responsibilities. These procedures will include appropriate guidance on procurement, management of contracts and the management of contractor performance.
8.6.7	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.
8.6.8	DIRECTOR OF FINANCE	Report to the Audit Committee annually, any contracts > £5k awarded where competitive tendering was not undertaken.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES TO BE DELEGATED OR RESERVED
8.6.9	ALL EMPLOYEES	Ensure that: (a) Comply fully with Trust guidance on procurement and contract management (b) Complete a declaration of objectivity and interests when participating in a tender evaluation (c) Accept tender which provide the best value for money overall i.e. the optimum combination of whole life cost, quality and sustainability
8.7	DIRECTOR OF FINANCE	Responsible for managing the relationship with COPEs
8.8	DIRECTOR OF FINANCE	Responsible for ensuring compliance with procurement guidance for Estate services
8.9	DIRECTOR OF PHARMACY	Responsible for ensuring Trust participation in the Regional Pharmaceutical Contracting Executive Group and monitoring and reporting to Trust Procurement Board on the Regional Pharmaceutical Procurement Service.
8.11.3	CHIEF EXECUTIVE	Will nominate an officer to participate in the tender evaluation and adjudicate the contract on behalf of the Trust. In so doing, the Chief Executive will delegate authority to that officer to award the contract on behalf of the Trust.
8.15.1	CHIEF EXECUTIVE	The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES TO BE DELEGATED OR RESERVED
9.1.1	CHIEF EXECUTIVE	Must ensure the Trust enters into suitable Service and Budget Agreements (SBAs) with service commissioners for the provision of health and social care services
9.3	CHIEF EXECUTIVE	As the Accounting Officer, ensure that regular reports are provided to the Trust Board detailing actual and forecast income from the SBA
10.1.1	TRUST BOARD	Establish a Remuneration & Terms of Service Committee
10.1.2	REMUNERATION COMMITTEE	Advise the Board on and make recommendations on the remuneration and terms of service of the CE and other senior executives to ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements; Monitor and evaluate the performance of individual senior executives; Advise on and oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments.
10.1.3	REMUNERATION COMMITTEE	Report in writing to the Board its advice and its basis for decisions on remuneration and terms of service of directors and senior executives.
10.1.5	TRUST BOARD	Approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees and officers not covered by Departmental direction or the Remuneration Committee.
10.2.2	CHIEF EXECUTIVE/ DIRECTOR OF FINANCE	Approval of variation to funded establishment of any department.
10.3	CHIEF EXECUTIVE	Approves staff, including agency staff, appointments and re-grading.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES TO BE DELEGATED OR RESERVED
10.4.4	DIRECTOR OF FINANCE	Payroll responsibilities include: a) specifying timetables for submission of properly authorised time records and other notifications; b) final determination of pay and allowances; c) making payments on agreed dates; d) agreeing method of payment e) issuing instructions/guidance.
10.4.6	NOMINATED MANAGERS	Submit time records in line with timetable. Complete contract amendments and other notifications in required form. Submitting claims for reimbursement of expenses in agreed format and in line with agreed timetables.
10.4.7	DIRECTOR OF FINANCE	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
10.5.1	NOMINATED MANAGER	Ensure that all employees are issued with a Contract of Employment in a form approved by the Trust Board and which complies with employment legislation; and Deal with variations to, or termination of, contracts of employment; and ensuring compliance with the EU Directives on contract workers.
11.1 & 11.1.2	CHIEF EXECUTIVE	Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions for the supply of goods, services and minor works, the maximum level of each requisition and the system for authorisation above that level. Authorisation limits for Non Pay expenditure are contained in the Trust Authorisation and Approvals Framework.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES TO BE DELEGATED OR RESERVED
11.1.3	CHIEF EXECUTIVE	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
11.1.5	DIRECTOR OF FINANCE	Ensuring that there are appropriate systems in place for processing and payment of non pay expenditure
11.1.10	DIRECTOR OF FINANCE	a) Advise the Board regarding the thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; b) Prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds; c) Be responsible for the prompt payment of all properly authorised accounts and claims; d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable; e) A timetable and process for submission of accounts for payment; f) Instructions to employees regarding the handling and payment of accounts within the Business Services Organisation; g) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received.
11.2.2	CHIEF EXECUTIVE	Authorise who may use and be issued with official orders.
11.2.3	DIRECTOR OF FINANCE	Shall be responsible for the prompt payment of accounts and claims.
11.2.4	APPROPRIATE OFFICER	Make a written case to support the need for a prepayment.
11.2.4	DIRECTOR OF FINANCE	Approve proposed prepayment arrangements.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES TO BE DELEGATED OR RESERVED
11.2.4	BUDGET HOLDER	Ensure that all items due under a prepayment contract are received (and immediately inform DoF if problems are encountered).
11.2.5	MANAGERS AND OFFICERS	Ensure that they comply fully with the guidance and limits specified by the Director of Finance.
11.2.6	CHIEF EXECUTIVE AND DIRECTOR OF FINANCE	Ensure that the arrangements for financial control and financial audit of design and construction contracts and property transactions comply with the guidance. The technical audit of these contracts shall be the responsibility of the relevant Director.
11.2.9	DIRECTOR OF FINANCE	Will issue guidance on the use of consultants in line with DoH guidance
12.1	DIRECTOR OF FINANCE	Prepare procedural instructions concerning payment of grants in accordance with Department of Health guidance
12.4	MANAGERS AND OFFICERS	Comply with guidance on grant payments
13.3	DIRECTOR OF FINANCE	Ensure cash balances are kept at a minimum level
13.5	DIRECTOR OF FINANCE	Will advise the Board on investments and report, periodically, on performance of same.
13.6	DIRECTOR OF FINANCE	Prepare detailed procedural instructions on the operation of investments held.
14.1.1 & 14.1.2	CHIEF EXECUTIVE	Capital investment programme: a) ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on business plans b) responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost; c) ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences; d) ensure that a business case is produced for each proposal.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES TO BE DELEGATED OR RESERVED
14.1.2	DIRECTOR OF FINANCE	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.
14.1.3	CHIEF EXECUTIVE	Issue procedures for management of contracts involving stage payments.
14.1.4	DIRECTOR OF FINANCE	Advise on procedures for the operation of the construction industry taxation deduction scheme.
14.1.5	DIRECTOR OF FINANCE	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
14.1.6	CHIEF EXECUTIVE	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a scheme of delegation for capital investment management.
14.1.7	DIRECTOR OF FINANCE	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
14.2.1	DIRECTOR OF FINANCE	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
14.2.1	TRUST BOARD	Proposal to use Private Finance must be specifically agreed by the Board.
14.3	CHIEF EXECUTIVE	Obtain approval from Department of Health for all property and finance leases.
14.4.1	CHIEF EXECUTIVE	Maintenance of asset registers (on advice from DoF).
14.4.5	DIRECTOR OF FINANCE	Approve procedures for reconciling balances on non current assets accounts in ledgers against balances on asset registers.
14.5.1	CHIEF EXECUTIVE	Overall responsibility for control of non current assets.
14.5.2	DIRECTOR OF FINANCE	Approval of asset control procedures.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES TO BE DELEGATED OR RESERVED
14.5.3 & 14.5.4	MANAGERS AND OFFICERS	Responsibility for security of Trust assets including notifying discrepancies to DoF, and reporting losses in accordance with Trust procedure.
15.2	CHIEF EXECUTIVE	Delegate overall responsibility for control of stores (subject to DoF responsibility for systems of control) to nominated officers. Further delegation for day-to-day responsibility subject to such delegation being recorded.
15.2.2	NOMINATED OFFICERS	Security arrangements and custody of keys for any stores
15.2.3	DIRECTOR OF FINANCE	Responsible for systems of control and procedures over stores and receipt of goods.
15.2.4	DIRECTOR OF FINANCE	Agree stocktaking arrangements.
15.2.5	DIRECTOR OF FINANCE	Approve alternative arrangements where a complete system of stores control is not justified.
15.2.6	DIRECTOR OF FINANCE	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.
15.2.6	NOMINATED OFFICERS	Operate system for slow moving and obsolete stock, and report to DoF evidence of significant overstocking.
15.3.1	CHIEF EXECUTIVE	Identify persons authorised to requisition and accept goods from the regional warehouse maintained by BSO PaLS
16.1.1	DIRECTOR OF FINANCE	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
16.2.1	DIRECTOR OF FINANCE	Prepare procedures for recording and accounting for losses and special payments in line with Department of Health guidance

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES TO BE DELEGATED OR RESERVED
16.2.2	ALL STAFF	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the DoF.
16.2.3	DIRECTOR OF FINANCE	Where a criminal offence is suspected, DoF must inform the PSNI.
16.2.4	DIRECTOR OF FINANCE OR NOMINATED OFFICER	Notify Counter Fraud and Probity Services (CFPS) within BSO of all frauds (proven or suspected), including attempted fraud. Complete annual fraud return.
16.2.5	TRUST BOARD	Approve write off of losses (within limits delegated by Department of Health).
16.2.7	DIRECTOR OF FINANCE	Consider whether any insurance claim can be made.
16.2.8 & 16.2.10	DIRECTOR OF FINANCE	Maintain losses and special payments register and report to Audit Committee annually
17.1.1	DIRECTOR OF FINANCE	Responsible for accuracy and security of computerised financial data.
17.1.2	DIRECTOR OF FINANCE	Satisfy himself/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organization, assurances of adequacy must be obtained from them prior to implementation.
17.2.1 & 17.2.2	DIRECTOR OF FINANCE	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. Seek periodic assurances from the provider that adequate controls are in operation.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES TO BE DELEGATED OR RESERVED
17.3	DIRECTOR OF PERFORMANCE AND REFORM	Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.
17.4	DIRECTOR OF FINANCE	Where computer systems have an impact on corporate financial systems satisfy himself that: a) systems acquisition, development and maintenance are in line with corporate policies; b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management rail exists; c) Finance staff have access to such data; Such computer audit reviews are being carried out as are considered necessary.
18.2	CHIEF EXECUTIVE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
18.3	DIRECTOR OF FINANCE	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of.
18.16	DIRECTOR OF FINANCE	Responsible for investing patients' and clients monies in accordance with Department of Health guidance
18.17	DEPARTMENTAL MANAGERS	Inform staff of their responsibilities and duties for the administration of the property of patients/clients.
18.18	DIRECTOR OF FINANCE	Responsible for seeking consent from RQIA to hold monies in excess of limit set by Department of Health

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES TO BE DELEGATED OR RESERVED
19.1	DIRECTOR OF FINANCE	Shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately.
19.3	DIRECTOR OF FINANCE	Arrange for the administration of all Charitable Trust Funds
19.11	DIRECTOR OF FINANCE	Responsible for all aspects of management of the investment of Charitable Trust Funds
19.13	DIRECTOR OF FINANCE	Ensure appropriate banking services are available to the Charitable Trust fund.
19.15 & 19.16	DIRECTOR OF FINANCE	Ensure that regular reports are made available to the E&G Committee and will prepare the Trustee's report and Annual Accounts in line with Department of Health guidelines and timetables
20.1	DIRECTOR OF FINANCE	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff
20.2	CHIEF EXECUTIVE	Ensure a written record is maintained of any gifts, bequests or donations and of their estimated value and whether they are disposed of or retained
21	CHIEF EXECUTIVE	Retention of document procedures in accordance with Department of Health guidance.
22	CHIEF EXECUTIVE	Ensure Trust has a risk management programme, which must be approved and monitored by the Trust Board
23	DIRECTOR OF FINANCE	Ensure Trust Board aware of extant finance guidance from Department of Health

Southern Health and Social Care Trust

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STANDING FINANCIAL INSTRUCTIONS

June 2018

Southern Health and Social Care Trust

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STANDING FINANCIAL INSTRUCTIONS

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3.0	Trust Board	7th June 2018	

Southern Health and Social Care Trust

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CONTENTS

Southern Health and Social Care Trust

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1. INTRODUCTION

KEY POINTS

- Standing Financial Instructions identify the **key financial responsibilities** which apply to everyone working for the Trust
- Trust Board exercises financial supervision and control via a number of measures
- The Chief Executive and Director of Finance will delegate financial responsibilities but remain accountable for financial control.
- **Employees are responsible for**: Trust property, avoiding loss, exercising econmony and efficiency in use of resources, complying with the Trust's Standing Orders, Standing Financial Instructions, Financial Procedures and Scheme of Delegation.

1.1 General

1.1.1 Each Trust shall agree Standing Financial Instructions (SFIs) for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Standing Orders (SOs). **They are the "business rules" that Directors and employees (including employees of third parties contracted by the Trust) must follow when acting on behalf of the Trust.**

1.1.2 These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Standing Orders, Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust.

1.1.3 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance. **SFIs are mandatory on all Members, Directors and employees of the Trust.**

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance must be sought before acting. The user of these

Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

1.1.5 The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

1.1.6 **Overriding Standing Financial Instructions** – If for any reason these Standing Financial Instructions are not complied with, full details and any justification for non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Trust and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.

1.2 Responsibilities and delegation

1.2.1 The Trust Board

The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain best value for money);

(d) defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Delegation document.

(e) ensuring that it receives and reviews regular financial information concerning the management of the Trust and is informed in a timely manner about any concerns about the activities of the Trust.

1.2.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Scheme of Reservation and Delegation of Power's document within Standing Orders. All other powers have been delegated to the Chief Executive or such other committees as the Trust has established.

1.2.3 **The Chief Executive and Director of Finance**

The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accounting Officer, to the Permanent Secretary for the Department of Health(DoH). The Chief Executive is personally responsible for safeguarding the public funds of which he/she has charge; for ensuring propriety and regularity in the handling of those public funds; and for the day to day operations and management of the Trust. In addition he/she should ensure that the Trust as a whole is run on the basis of the standards (in terms of governance, decision making and financial management) as set out in Managing Public Money Northern Ireland (MPMNI). The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.2.4 It is a duty of the Chief Executive to ensure that Members of the Board and, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Instructions.

1.2.5 **The Director of Finance**

The Director of Finance is responsible for:

(a) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Director of Finance include:

(d) the provision of financial advice to other members of the Board and employees;

(e) the design, implementation and supervision of systems of internal financial control;

(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.2.6 **Board Members and Employees**

All members of the Board and employees, severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources;

(d) conforming to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Trust's Scheme of Delegation.

1.2.7 **Contractors and their employees**

Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.2.8 For all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Director of Finance.

2. AUDIT

KEY POINTS

- Audit Committee is a sub-committee of the Trust Board which will provide an independent and objective view of internal control in the organization;
- It will rely on work performed by Internal Audit and External Audit and other appropriate assurance functions;
- The Director of Finance is responsible for ensuring there are arrangements to review evaluate and reports on the effectiveness **of internal financial control**;
- The Director of Finance is responsible for assessing, identifying, evaluating and responding to fraud, bribery and corruption risks and reporting on counter fraud work annually to the Audit Committee.

2.1 Audit Committee

2.1.1 In accordance with Standing Orders and the Code of Conduct and Code of Accountability for Board Members of Health and Social Care bodies (2012), the Board shall formally establish an Audit Committee, with clearly defined terms of reference and follow current Cabinet Office Guidance and the Department of Finance Audit and Risk Assurance Committee Handbook NI (April 2018), which will provide an independent and objective view of internal control by a review of:

(a) the adequacy of all risk and control related disclosure statements (in particular the Mid-Year Assurance Statement and the Governance Statement, together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board

(b) the adequacy of the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

(c) the adequacy of the policies for ensuring compliance with relevant regularity, legal and code of conduct requirements, including the Trust's Standing Orders and Standing Financial Instructions

(d) the adequacy of the policies and procedures for all work related to fraud and corruption as required by the Counter Fraud and Probity Service at the Business Services Organisation

(e) the annual schedule of losses and compensation payments and will make recommendations to the Board regarding their approval

(f) Post Project Evaluations on major projects and programmes

(g) All approved Direct Award Contracts in the financial year

(h) The Committee's terms of reference on an annual basis and submit to the Board for approval. Any subsequent changes to the Committee's terms of reference will be reported to the sponsor team (Department of Health).

In carrying out its work, the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these functions. It will also seek reports and assurances from other Trust Committees, directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

The Committee shall ensure that there is an effective internal audit function established by management that meets the Public Sector Internal Audit Standards (PSIAS) and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

(a) consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal;

(b) review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework

(c) consideration of the Head of Internal Audit's annual report, major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources;

(d) ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organization;

(e) annual review of the effectiveness of internal audit.

The Committee shall review the work and findings of the External Auditor appointed by the NI Audit Office and consider the implications of, and management's responses to, their work. This will be achieved by:

(a) consideration of the performance of the External Auditor;

(b) discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan;

(c) discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust;

(d) review of all External Audit reports, including consideration of the Report to those charged with Governance before submission to the Board and any work carried out outside the annual audit plan, together with the appropriateness of management responses.

2.1.2 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the DoH. (To the Director of Finance in the first instance.)

2.1.3 It is the responsibility of the Director of Finance to ensure an adequate Internal Audit service is provided and the Audit Committee shall be involved in the selection process when/if an Internal Audit service provider is changed.

2.2 Director of Finance

2.2.1 The Director of Finance is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) ensuring that the Internal Audit is adequate and meets the mandatory Public Sector Internal Audit Standards (PSIAS) and with reference to DoH guidance detailing Internal Audit arrangements between a sponsoring Department and its Arm's Length Bodies;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities in accordance with the Trust's Fraud Response Plan;

(d) ensuring that an internal audit strategic plan covering a three year period is produced from which an annual operational plan is derived;

(d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee. The report must cover:

(i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the DoH including for example compliance with control criteria and standards;
(ii) major internal financial control weaknesses discovered;
(iii) progress on the implementation of internal audit recommendations;
(iv) progress against plan over the previous year.

2.2.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or members of the Board or employee of the Trust;

(c) the production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and

(d) explanations concerning any matter under investigation.

2.3 Role of Internal Audit

2.3.1 Internal Audit will review, appraise and report upon:

(a) the effectiveness of the governance and risk management arrangements of the organisation;

(b) the adequacy and effectiveness of the systems of financial, operational and management controls and their operation in practice in relation to the identified business risks;

(c) the suitability, accuracy, reliability and integrity of financial and other management information and the means used to identify, measure, classify and report such information;

(d) the extent of compliance with policies, standards, plans and procedures established by the organization and the extent of compliance with DoH guidance, laws and regulations, including reporting requirements;

(e) the integrity of processes and systems to ensure that controls offer adequate protection against error, fraud and loss of all kinds;

(f) Instances of suspected fraud and irregularity (preliminary phase of fraud investigations, in conjunction with Management and the BSO Counter Fraud and Probity Unit);

(g) The extent to which the assets and interests of the organisation are acquired economically, accounted for and safeguarded from loss of all kinds;

(h) Value for money considerations, where appropriate and relevant;

(i) The follow up action taken to remedy weaknesses identified by Internal Audit;

(j) Head of Internal Audit is required to provide an annual opinion on risk management, control and governance arrangements. This opinion is based upon and limited to, the internal audit work performed during the year, as approved by the Audit Committee.

2.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

2.3.3 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

2.3.4 The Head of Internal Audit shall be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the Public Sector Internal Audit Standards (PSIAS). The reporting system shall be reviewed at least every three years.

2.4 External Audit

2.4.1 The Comptroller and Auditor General (C&AG) for Northern Ireland is the appointed External Auditor of the Trust, who may outsource the delivery of the External Audit programme to an appropriately qualified private sector organisation.

2.4.2 If there are any problems relating to the service provided by an outsourced External Auditor, then this should be raised with the External Auditor and referred on to the NIAO if the issue cannot be resolved. The Director of Finance will notify the Audit Committee and Board of any such instances.

2.4.3 Value for Money Audit work is directed by the nominated DoH Senior Officer. The costs of such assignments are borne by the DoH.

2.4.4 The C&AG has a statutory right of access to all relevant documents as provided for in Articles 3 and 4 of the Audit and Accountability (NI) Order 2003.

2.5 Fraud and Corruption

2.5.1 In line with their responsibilities, the Trust Chief Executive and Director of Finance shall monitor and ensure compliance with all legislation or guidance issued by the DoH on fraud, bribery and corruption.

2.5.2. The Director of Finance is responsible for:

a. Assessing, identifying, evaluating and responding to risks of bribery or fraud. Fraud should be considered as a risk in the risk register;

b. Ensuring appropriate arrangements are in place for deterring, preventing, detecting and investigating fraud or bribery;

c. Ensuring that the Trust's Audit Committee formally considers the anti-fraud measures in place;

d. Reporting immediately all suspected or proven frauds, including attempted fraud to the Business Services organisation who will report it to the DoF and C&AG as soon as they are discovered, irrespective of value;;

e. Complying with all guidance issued by DoH;

f. Developing an anti-fraud policy and fraud response plan which is updated at least every five years and sent to Counter Fraud and Probity Services at BSO for review.

2.5.3 The Director of Finance shall nominate a suitable person to carry out the duties of the Fraud Liaison Officer as specified by the DoH Counter Fraud Policy and guidance.

2.5.4 The Fraud Liaison Officer shall report to the Director of Finance and shall work with staff in the Counter Fraud and Probity service in the Business Services Organisation (BSO) in accordance with the DoH Counter Fraud Policy.

2.5.5 The Director of Finance will provide a written report to the Audit Committee, at least annually, on counter fraud work within and on behalf of the Trust.

3. RESOURCE LIMIT CONTROL

KEY POINTS

- The Trust is required to operate within the revenue and capital budgets delegated to it by the DHSSPS/HSC Board.
- The Trust is required to work closely with Commissioners, the DHSSPS and other HSC organisations to demonstrate efficient use of resources, manage cost pressures and gain approval for service developments and enhancements.

3.1 The Trust's current and capital expenditure form part of the DoH Department's Resource Delegated Expenditure Limit (DEL) and Capital DEL respectively.

3.2 The Trust shall not, without prior written DoH approval, enter into any undertaking to incur any expenditure which falls outside the Trust's delegations or which is not provided for in the Trust's annual budget as approved by the DoH or the HSC Board on its behalf. 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.

3.3 The Trust shall not, without prior written DoH approval, enter into any undertaking to incur any expenditure outside its remit or which may be likely to bring either the Trust or the DoH into disrepute.

3.4 The Trust is obliged to act in line with the guidance as set out in the HSC Finance Regime.

This states that the Trust is obliged to:

- contain expenditure within the overall resources allocated subject to any ring fencing constraints;
- maintain a constructive dialogue with other HSC organisations;
- ensure that their services are offered at a price which reflects economic and efficient use of resources, and complies fully with financial requirements;
- provide evidence to Commissioners on input costs in areas with no agreed output measure and agree SBA investment levels;
- comply with SBA investment decisions taken in the context of the gap between provider's costs and benchmark costs and which strike a balance between best practice benchmarks and providers costs in year;
- work with Commissioners to develop a strategy to address gaps between provider costs and best practice benchmarks;
- identify slippage on ring fenced resources for redeployment by Commissioners;
- take a joint risk sharing approach with Commissioners to the management of cost pressures identified;
- work jointly with Commissioners to profile services, incorporating bridging finance milestones and timeframes within SBA;
- work with the Department and Commissioners to manage the service implications of the Capital programme;
- commission services from the independent sector as part of an agreed strategy which acknowledges and accounts for the short and long run implications for the statutory sector;
- undertake service developments or enhancements only with the approval of Commissioners except in the most exceptional of circumstances.

3.5 The Trust must obtain the approval of the DoH and the Department of Finance (DoF) for any transactions which set precedents, are

novel, potentially contentious or could cause repercussions elsewhere in the public sector. DoH and DoF approval must be obtained even where such transactions are within the Trust's delegated limits.

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 Trust 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.

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4. REVENUE RESOURCE LIMIT, PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

KEY POINTS

- The Chief Executive will submit to the HSC Board a Trust Delivery Plan which takes into account financial targets and forecast limits of available resources;
- The Director of Finance will prepare and submit budgets for approval by Trust Board in line with the Trust Delivery Plan
- The Chief Executive delegates the management of budgets to budget holders to permit the performance of a defined range of activities
- The Director of Finance reports monthly on performance against budget to Trust Board
- **Budget holders are responsible for:**
  - Remaining within budget
  - Using the budget for the purpose intended
  - Not appointing permanent employees outside available resources
  - Attending budgetary training

4.1 Revenue Resource Limit (RRL)

The Director of Finance will:

(a) periodically review the basis and assumptions used for distributing the Revenue Resource Limit and ensure that these are reasonable and realistic and secure the Trust's entitlement to funds;

(b) at the start of each financial year submit to the HSC Board for approval a Financial Plan within the TDP showing the total RRL and other forecast receipts and will include a budget of estimated payments and receipts together with a profile of expected expenditure and draw down of any HSCB/Departmental funding and/or other income over the year.

(c) regularly update the Trust on significant changes to the initial Revenue Resource Limit and the uses of such funds.

4.2 Preparation and Approval of Plans and Budgets

4.2.1 The Chief Executive will compile and submit to the HSC Board a Trust Delivery Plan (TDP) which takes into account financial targets and forecast limits of available resources. The TDP will contain:

(a) a statement of the significant assumptions on which the plan is based, taking into account its approved funding provision and any forecast receipts;

(b) details of the organisation's priorities and objectives

(c) details of major changes in workload, delivery of services or resources required to achieve the plan.

4.2.2 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the Trust Delivery Plan;

(b) accord with workload and manpower plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds;

(e) identify potential risks.

4.2.3 The Director of Finance shall monitor financial performance against budget and plan, review them on a monthly basis and report to the Trust Board.

4.2.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

4.2.5 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets effectively.

4.3 Budgetary Delegation

4.3.1 The Chief Executive may delegate the management of budget to budget holders to permit the performance of a defined range of

activities. This delegation must be in writing and accompanied by a clear definition of:

(a) the amount of the budget;
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement only within total Revenue or total Capital (non virement between revenue and capital);
(e) achievement of planned levels of service;
(f) the provision of regular reports.

4.3.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the HSC Board.

4.3.3 All Budget Holders must ensure that the necessary Business Case preparation and approvals have been obtained before committing to recurrent revenue expenditure in new service commissioning or to support any other proposed investment. Failure to obtain the required approvals will mean that the expenditure has been incurred without the required authority and is a serious matter. Budget Holders should refer to the latest DoH and Trust guidance on Business Cases in respect of completing business cases, the NI Guide on Expenditure Appraisal and Evaluation and the delegations issued by the DoH in HSC (F) 52/2016 or subsequent revisions.

4.3.4 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement. Where resources allocated for a particular purpose are not required or not required in full, for that purpose, approval of the HSC Board/DoH DOH must be obtained before any redistribution within the Trust.

4.3.5 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance.

4.3.6 All Budget Holders are required to regularly review all projected expenditure and identify to the Director of Finance on a timely basis, where inescapable expenditure has the potential to breach their delegated budget.

4.4 Budgetary Control and Reporting

4.4.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Trust Board in a form approved by the Board containing income and expenditure to date showing trends and forecast year-end position;

(b) regular reports to the Trust Board in a form approved by the Board containing capital project spend and projected outturn against plan with explanations of any material variances from plan;

(c) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(d) investigation and reporting of variances from financial, workload and manpower budgets;

(e) monitoring of management action to correct variances; and

(f) arrangements for the authorisation of budget transfers.

4.4.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement/additional funding is not incurred without the prior consent of the Trust Board or its delegated representative;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(c) no permanent employees are appointed without the approval of the Chief Executive, or his/her delegated representative, other than those provided for within the available resources and manpower establishment as approved by Trust Board;

(d) They attend such training as deemed necessary by the Director of Finance.

4.4.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the TDP and a balanced budget.

4.5 Monitoring Information to DoH

4.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring information is submitted to DoH for:

- Trust cash management
- Draw down of GIA
- Expenditure for that month

- Forecast out-turn by resource headings; and
- Other data required for the DoF outturn and Forecast outturn return

5. ANNUAL ACCOUNTS AND REPORTS

KEY POINTS

- The Director of Finance will prepare financial returns and the Annual Report and Accounts for the Trust as required by the DoH.
- The Annual Report and Accounts will be subject to audit by the Comptroller and Auditor General, laid before the NI Assembly and presented in a public meeting of the Trust.
- The Annual Report and Accounts are part of the Publication Scheme of the Trust.

5.1 The Director of Finance, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by the DoH and the Department of Finance (FReM), the Trust's accounting policies, and relevant financial reporting standards;

(b) prepare and submit as a single document an audited annual report of the Trust's activities together with its audited consolidated annual accounts to the DoH certified in accordance with current timetable and guidelines;

(c) submit financial returns to the DoH for each financial year in accordance with the timetable prescribed by the DoH.

5.2 The Trust's annual accounts and annual report must be audited by the Comptroller and Auditor General to the NI Assembly. The Trust's audited annual accounts and annual report must be presented to a public meeting and made available to the public after laying before the NI Assembly. This document must comply with the DoH Manual for Accounts, FReM and any other relevant guidance.

5.3 The Trust shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our

Trust that we make publicly available. This will include the Annual Report and Accounts.

6. BANK ACCOUNTS

KEY POINTS

- The Director of Finance is responsible for managing the Trust's banking arrangements and ensuring detailed instructions on their operation are in place.
- The Trust Board will approve the banking arrangements.

6.1 General

6.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements, including setting clarity for the interface with the BSO where it provides banking services on behalf of the Trust. Accounting Officers are responsible for the credit risk to which public funds are exposed when held in commercial banks. The Director of Finance is also responsible for advising the Trust Board on the provision of banking services and operation of accounts. This advice will take into account guidance and directions issued from time to time by the DoH. The Trust's Accounting Officer is responsible for ensuring that the Trust's banking arrangements are in accordance with the requirements for Managing Public Money Northern Ireland (MPMNI).

6.1.2 The Trust Board shall approve the banking arrangements.

6.2 Bank Accounts

6.2.1 The Director of Finance is responsible for:

(a) operation of bank accounts;

(b) establishing separate bank accounts for the Trust's non-public funds administered by the Trust;

(c) ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made;

(d) reporting to the Trust Board all arrangements made with the Trust's bankers for accounts to be overdrawn;

(e) monitoring compliance with DoH guidance on the level of cleared funds;

(f) setting the parameters for the BSO within the Service Level Agreement (SLA) for any of the above as appropriate.

6.3 Banking Procedures

6.3.1 The Director of Finance will prepare detailed instructions on the operation of bank accounts which must include:

a. the conditions under which each bank account is to be operated, including the use of electronic banking;

b. those authorised to sign cheques or other orders drawn on the Trust's accounts;

c. the limit to be applied to any overdraft;

d. when and how payment by cheque, credit card or direct debit is acceptable;

e. record keeping, including bank reconciliations;

f. adequate records are maintained of payments and receipts and adequate facilities are available for the secure storage of cash;

g. setting the parameters for the BSO within the Service Level Agreement (SLA) for any of the above as appropriate.

6.3.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated.

6.4 Tendering and Review

6.4.1 The Director of Finance will review the commercial banking arrangements of the Trust at least every two years to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business, in co-operation with other HSC organisations. It is expected that the Trust will avail of the regional HSC banking contract, save in exceptional circumstances.

6.4.2 Competitive tenders for HSC banking business should be sought at least every 3 to 5 years or extended period as agreed by the Trust.

The results of the tendering exercise should be reported to the Trust Board.

7. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

KEY POINTS

- The Director of Finance is responsible for ensuring that BSO Accounts Receivable Shared Services have appropriate procedures in place for the recording, invoicing, debt management, receipting and coding of all income due to the Trust;
- The Director of Finance is responsible for ensuring Trust staff have appropriate guidance regarding the above;
- The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges;
- **Trust staff** must promptly advise of income due to the Trust and follow the appropriate procedures to ensure an invoice is raised;
- The Director of Finance is responsible for ensuring adequate security arrangements are in place over stationery, safes, safe keys, cash, cheques etc.

7.1 Income Systems

7.1.1 The Director of Finance is responsible for ensuring, via the Service Level Agreement with the BSO, that there is compliance with agreed systems for the proper recording, invoicing, collection and coding of all monies due.

7.1.2 The Director of Finance is responsible for the prompt banking of all monies received whether by Trust cash offices or by BSO on its behalf.

7.1.3 The Director of Finance will seek annual assurance from the BSO on the reliability of the information processed by BSO for accounting purposes on behalf of the Trust.

7.1.4 The Director of Finance will ensure that the BSO is subject to audit of its systems, controls and processes on an annual basis and that the Trust is made aware of any assurance levels less than satisfactory.

7.1.5 The Director of Finance is responsible for designing, maintaining and training Trust staff in, appropriate financial procedures regarding the above.

7.1.6 The Director of Finance will ensure that the Trust receives regular reports in an agreed format in relation to all areas of income, debt and banking that are managed by BSO on the Trust's behalf.

7.2 Fees and Charges

7.2.1 All fees or charges for any services supplied by the Trust, including services provided between HSC 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.

7.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the DOH or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

7.2.3 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.

7.2.4 All employees must inform the Director of Finance and BSO promptly of money due to the Trust arising from transactions which they initiate/deal with, including all contracts, leases, rent, tenancy agreements, private or chargeable patient undertakings and other transactions.

7.2.5 Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered, the following guidance should be applied:

- Trust guidance on Gifts, Hospitality & Sponsorship Policy
- Trust guidance on Conflicts of Interest Policy;
- Charitable Trust Funds procedures.

7.2.6 Receipts arising from fines and taxes should be surrendered to DoH and do not provide additional spending power for the Trust.

7.2.7 Receipts arising from the sale of goods and services, rent of land and dividends normally can be retained by the Trust and provide additional spending power for the Trust.

If there is any doubt about the correct treatment of a receipt, the Trust will consult the DoH.

7.3 Debt Recovery

7.3.1 The Director of Finance is responsible for ensuring that the BSO complies with the appropriate recovery action on all outstanding debts. For those debts not managed by the BSO, the Director of Finance is responsible for ensuring appropriate procedures are in place for recovery action.

7.3.2 Income not received should be dealt with in accordance with losses and special payments procedures and DoH guidance.

7.3.3 Salary overpayment recovery should be initiated in line with DoH guidance, BSO Payroll Shared Services procedures and Trust policy.

7.4 Security of Cash, Cheques and other Negotiable Instruments

7.4.1 The Director of Finance is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust;

(e) obtaining assurance from BSO that suitable arrangements for the above exist, where relevant, within the Accounts Receivable Shared Services Centre.

7.4.2 Funds managed by the Trust shall not under any circumstances be used for the encashment of private cheques or IOUs.

7.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

7.4.4 All unused cheques and other orders will be subject to the same security precautions as are applied to cash.

7.4.5 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

7.4.6 Any shortfall in cash, cheques or other negotiable instruments must be reported to the Director of Finance or Trust Fraud Liaison Officer as soon as it is discovered.

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8. PROCUREMENT AND CONTRACTING PROCEDURE

KEY POINTS

- **Procurement is defined as** "the process of acquisition, usually by means of a contractual arrangement after public competition, of goods, services, works and other supplies by the public service.";
- The Trust must use the existing Centres of Procurement Expertise for the procurement of works, goods and services.
- Social care, independent healthcare and pharmaceutical procurement do not have established Centres of Procurement Expertise but other arrangements are in place.
- The Chief Executive is responsible for preparing the Trust Procurement strategy and bringing it to Trust Board for approval. This task is delegated to the Director of Finance. The Director of Finance will prepare an Annual Procurement Plan.
- The Director of Finance is responsible for ensuring that the Trust has appropriate systems in place for controlling risks associated with purchasing activities.
- **Trust managers and officers must:**
  - Ensure they comply fully with Trust guidance on procurement (including Direct Award Contracts) and contract management;
  - Complete a declaration of objectivity and interest if participating in an evaluation process;
  - Accept tenders from suppliers who provide the lowest cost or the best value for money, being the optimum combination of whole life cost and quality.

8.1 Duty to comply with Standing Orders and Standing Financial Instructions

8.1.1 The procedure for making all contracts by or on behalf of the Trust shall comply with the Standing Orders and Standing Financial Instructions (except where Standing Order No. 3.13 Suspension of Standing Orders is applied).

8.2 Northern Ireland Public Procurement Policy, EC Directives Governing Public Procurement, DOH Mini-Code Guidanceand DoH HSC (F) circulars and other professional Estates guidance.

8.2.1 Northern Ireland Public Procurement Policy 2002 (as amended); Procurement Guidance Notes and any other guidelines or guidance issued by DoH, Central Procurement Directorate (CPD) and the Procurement Board prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions. The Trust shall also ensure that it complies with any relevant UK and EU or other international procurement rules.

8.3 Scope of Procurement

8.3.1 As per the Northern Ireland Public Procurement Policy 2002 (as amended), Public Procurement is defined as "the process of acquisition, usually by means of a contractual arrangement after public competition, of goods, services, works and other supplies by the public service".

8.3.2 These Standing Orders and Standing Financial Instructions encompass the procurement of any works, goods, service and personnel from any external supplier in the market place awarded through Direct Award Contract, Quotations, Tenders or Open Competition.

8.3.3 It does not cover:

- The supply of services provided internally within the HSC e.g. commissioning of care from services from HSC bodies, supply of administration, finance, personnel, IT support and arrangements with CoPEs;

- Expenditure which is regulated by Departmental directive, such as Personal and Social Services Expenditure on boarded out

- adults, patient travelling expenses, or others, such as business rates and water and sewerage.

8.4 Procurement through a Centre of Procurement Expertise

8.4.1 The Trust's procurement activity will be carried out by means of a Service Level Agreement (SLA) with a recognized 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.

8.4.2 DOH The Accounting Officer may decide on the level of internal delegation required for the 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.

8.5 Pharmaceutical Procurement

8.5.1 The Trust shall use the Regional Pharmaceutical Procurement Service, which is a regional shared service operated by the Northern Health and Social Care Trust in collaboration with BSO PaLS. The Regional Pharmaceutical Contracting Executive Group (RPCEG) is responsible for approving the award of contracts for pharmaceuticals and dressings across HSCNI.

8.5.2 The Trust's Director of Pharmacy will be permitted to approve procurement outside of the above arrangements in circumstances where the relevant tender process is underway but not concluded or in other exceptional circumstances.

8.6 Procurement Arrangements

8.6.1. <u>General</u>

The Chief Executive will ensure that the Trust has appropriate systems in place for controlling the risks associated with purchasing activities. These include:

a. Establishing and documenting accountability, ensuring appropriate top level commitment;

b. Implementing a procurement strategy and work plan;

c. Demonstrating legal compliance;

d. Pursuing best practice and demonstrating best value for money;

e. Managing effective relationships with key suppliers, customers and other stakeholders;

f. Following an appropriate, documented procurement process;

g. Managing contracts and contractor performance;

h. Professional competence;

i. Monitoring and review of overall performance management;

j. Audit.

8.6.2 The Director of Finance will, on behalf of the Chief Executive, compile and submit to the Trust Board a Trust Procurement Strategy which takes into account key strategic procurement requirements to deliver better and more efficient procurement.

8.6.3 The Director of Finance will, on behalf of the Chief Executive, prepare a Procurement Plan and submit for approval by the Trust Board or other nominated Committee. Such plans will:

(a) be in accordance with the aims and objectives set out in the Trust Procurement Strategy;

(b) be produced following discussion with appropriate CoPEs and other stakeholders;

(c) be prepared within the limits of available funds;

(d) identify potential risks;

(e) Cover all areas of externally sourced expenditure on works, equipment, goods, supplies, service and personnel.

8.6.4 The Director of Finance shall monitor performance against the work plan with key stakeholders, review it on a quarterly basis and report to the Board or its nominated committee.

8.6.5 Senior staff from key areas involved in procurement must provide information as required by the Director of Finance to enable a plan to be compiled and progress monitored.

8.6.6 The Director of Finance has a responsibility to ensure that adequate training and documented procedures are available to Trust employees

commensurate with their roles and responsibilities. These procedures will include appropriate guidance on procurement, management of contracts and the management of contractor performance.

8.6.7 The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

8.6.8 The Director of Finance will produce a report each year detailing any contracts above £5,000 in which competitive tendering was not employed. This report will be presented to the Audit Committee. This report will be sent to DoH every six months.

8.6.9 **Duties of Managers and Officers**

a. Managers and officers acting on behalf of the Trust must ensure that they comply fully with the Trust guidance on procurement (including Direct Award Contracts) and contract management.

b. Prior to participation in an evaluation process those Officers participating in the evaluation will be required to complete a Declaration of Objectivity and Interests.

c. Officers participating in an evaluation must accept tenders from suppliers who provide the best value for money overall. This is defined as the most advantageous combination of costs, quality and sustainability to meet customer and Trust 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 customer's requirements; and sustainability means economic, social and environmental benefits. Finding value for money involves an appropriate allocation of risk.

8.7 Use of Centres of Procurement Expertise

8.7.1 The Director of Finance is responsible for managing the procurement and logistics service with the Business Services Organisation, including setting clarity for the BSO within the Service Level Agreement (SLA) and for advising the Trust Board on the provision of procurement and logistics services. This advice will take into account guidance and directions issued from time to time by the DOH.

8.7.2 The Director of Human Resources and Organisational Development is responsible for managing the procurement of construction works and design services with the Central Procurement Directorate, adherence to the Estates Procedure Manual by the Trust and for advising Trust Board on the provision of construction works and design services. This advice will take into account guidance and directions issued from time to time by the DoH and CPD.

The Director of Finance and Director of Human Resources and Organisational Development are responsible for ensuring the following is in place within these CoPEs:

(a) Clear and appropriately detailed specifications are used for all purchases;

(b) The purchase of all works, goods and services conform to an appropriate method of procurement;

(c) All potential suppliers are identified through the use of pre-determined criteria that ensure regularity and propriety;

(d) tenders and awards contracts are evaluated through the use of pre-determined criteria that ensure the delivery of best value, where best value is defined as "the most advantageous combination of cost, quality and sustainability to meet customer requirements";

(e) All contracts for goods, works and services are managed and regularly monitored and reviewed;

(f) Up to date legislation and guidance relevant to the management of purchasing is used;

(g) Performance indicators are in place and regularly reviewed;

(h) The service is subject to audit to ensure that an appropriate and effective system of managing purchasing is in place and the necessary levels of controls and monitoring are implemented.

8.8 Trust Estates Procurement and Contract Management

The Director of Human Resources and Organisational Development is responsible for ensuring compliance by the Trust with the Estates Procedure Manual, DoH Mini-code or other relevant guidance as appropriate and for ensuring appropriate monitoring procedures are in place.

8.9 Pharmacy Procurement and Contract Management

The Director of Pharmacy is responsible for ensuring Trust participation in the RPCEG and for reporting on the activities of the Regional Pharmaceutical Procurement Service to the Trust Procurement Board.

8.10 Competition

8.10.1 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 and services to be acquired.

8.10.2 Contracts shall be placed on a competitive basis and tenders accepted from suppliers who provide best value for money overall.

8.10.3 Where a contract is awarded to an economic operator without competition, this is referred to 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 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)

8.11 Authorisation of Tenders and Competitive Quotations

8.11.1 Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided in accordance with delegated limits set out in the Trust's Scheme of delegation.

8.11.2 Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in the minutes of the relevant meeting.

8.11.3 Where the contract to be awarded is a multi-Trust or Regional Contract then the Chief Executive shall nominate in advance a Trust employee(s) to participate in the tender evaluation and adjudicate the contract on behalf of the Trust. In doing so the Chief Executive shall delegate authority to that officer(s) to award the contract on behalf of the Trust.

8.12 Private Finance for capital procurement

8.12.1 The Trust may consider the use of private sector financing for major capital schemes. In such cases, the Trust shall follow the advice and guidance of the DoH, CPD and the Department of Finance in relation to the process to be followed.

8.12.2 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.

8.12.2 Any proposal to utilize private sector finance must be agreed by the Trust Board and the decision recorded in the minutes of the relevant meeting.

8.13 Shared Services

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 share service provisioning.

The Trust 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.

8.14 Health and Social Care Service Agreements

Service agreements between HSC organisations shall not be regarded for any purpose as giving rise to contractual rights or liabilities, but it any dispute arises with respect to such an arrangement, either party may refer the matter to the DoH for determination.

8.15 In-house Services

8.15.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

8.15.2 Appropriate groups shall be established within the Trust to manage the tender process and to present an in-house bid. All groups shall work independently of each other. No member of the in-house tender group may participate in the evaluation of tenders.

8.15.3 The evaluation team shall make recommendations to the Trust Board.

8.15.4 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

8.16 Applicability of SFI's on Procurement and Contracting to Charitable Trust Funds and Patient's Property

These Instructions shall not only apply to expenditure from Public funds but also to works, services and goods purchased from the Trust's

Charitable Trust funds, Patients' property monies and from other funds provided to the Trust.

9. HSC SERVICE AND BUDGET AGREEMENTS FOR THE PROVISION OF SERVICES

KEY POINTS

- The Chief Executive is responsible for the ensuring the Trust enters into suitable Service and Budget Agreements (SBA) with service commissioners for the provision of health and social care services. They should aim to implement the agreed priorities contained in the Trust Delivery Plan.

9.1 Service and Budget Agreements (SBAs)

9.1.1 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable Service and Budget Agreements (SBA) with service commissioners for the provision of health and social care services.

9.1.2. All SBAs should aim to implement the agreed priorities contained within the Trust Delivery Plan (TDP) and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into

account:

- the standards of service quality expected;
- the relevant service framework (if any);
- the provision of reliable information on cost and volume of services;
- the Performance Assessment Framework;
-

- the SBAs build where appropriate on existing Investment Plans; and

- that SBAs are based on integrated care pathways.

9.2 Involving Partners and jointly managing risk

Where possible, SBAs will be developed in conjunction with clinicians, social workers, nursing staff, users, carers, public health professionals, allied health professionals and managers. They will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the services required. The SBA will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

9.3 Reports to Board on SBAs

The Chief Executive, as the Accounting Officer, shall ensure that regular reports are provided to the Trust Board detailing actual and forecast income from the SBA.

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10. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE TRUST BOARD, SENIOR EXECUTIVES AND EMPLOYEES

KEY POINTS

- The Remuneration and Terms of Service Committee is a sub-committee of the Trust Board and make recommendations to the Trust Board about appropriate remuneration and terms of service for the Chief Executive and other senior executives;
- The funded establishment of any department may not be varied without the approval of the Chief Executive;
- The Trust Board will approve procedures presented by the Chief Executive or his nominated officer for the determination of commencing pay rates, conditions of service etc., for employees;
- The Director of Finance is responsible for ensuring that appropriate arrangements are in place for payroll processing, that proper controls exist and are operating effectively;
- **Trust nominated managers** have delegated responsibility for:
  - Submitting accurate time records and other notifications in accordance with agreed timetables and in a prescribed format;
  - Submitting manual or electronic contractual amendments on time and in a prescribed format
  - Submitting appropriate claims for reimbursement in accordance with agreed timetables and in a prescribed format.
- All employees will be issued with a contract of employment in an approved form which complies with employment legislation.

10.1.1 In accordance with Standing Orders, the Trust Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

10.1.2 The Committee will:

(a) make recommendations to the Trust Board in writing about appropriate remuneration and terms of service for the Chief Executive and other senior executives including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) arrangements for termination of employment and other contractual terms;

(b) make such recommendations to the Trust Board on the succession planning, remuneration, allowances and terms of service of the Chief Executive and other senior executives, to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(c) monitor and evaluate the performance and development of the Chief Executive and individual senior employees remunerated on a senior executive pay scale;

(d) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

10.1.3 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of officer members in matters not already directed by the Department. Any change to the remuneration of Senior Executives must have prior approval of the Permanent Secretary of the DoH and the DoF Minister. Minutes of the Board's meetings shall record such decisions.

10.1.4 Recruitment exercises to fill vacant or new senior positions in the SHSCT should proceed only where there are exceptional circumstances which have been agreed by the Permanent Secretary of the DoH in advance.

10.1.5 The Trust Board will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by either Departmental direction or by the Committee.

10.1.6 The Trust will pay allowances to the Chairman and non-executive members of the Board in accordance with the instructions issued by the Minister for Health and in line with DOH guidance.

10.2 Funded Establishment

10.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.

10.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive or Director of Finance.

10.2.3 The Director of Finance will ensure that appropriate controls are in place to ensure the funded establishment is not exceeded without prior authority of the Chief Executive.

10.3 Staff Appointments

10.3.1 No officer or Member of the Trust Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive or his/her nominated officer; and

(b) within the limit of their approved budget and funded establishment as confirmed by the Director of Finance.

10.3.2 The Trust Board will approve procedures presented by the Chief Executive or his nominated officer, for the determination of commencing pay rates, terms and conditions of service (including pension), etc., for employees.

10.3.3 Any proposal by the Trust to move from existing pension arrangements, or to pay redundancy, or compensation for loss of office, requires the approval of the DoH and DoF. Proposals on severance payments must comply with MPMNI and any related DoF/DoH guidance.

10.4 Processing Payroll

10.4.1 The processing of Trust payroll is outsourced to the Business Services Organisation. The Director of Finance will ensure that there is an appropriate Service Level Agreement and monitoring arrangements in place with the BSO to ensure his responsibilities with regard to payroll processing are addressed and that proper controls are in place and are operating effectively.

10.4.2 The Director of Finance will seek annual assurance from the BSO on the reliability of the information processed by BSO for accounting purposes on behalf of the Trust.

10.4.3 The Director of Finance will ensure that the BSO systems, controls and processes are subject to audit on an annual basis and that the Trust is made aware of any assurance levels that are assessed as less than satisfactory.

10.4.4 The Director of Finance is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances including travel and subsistence in accordance with DoH guidance;

(c) making arrangements for ensuring payment on agreed dates;

(d) agreeing method of payment.

10.4.5 The Director of Finance will agree and ensure the issue of instructions, including by the BSO, as appropriate, regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of pay and allowances, including travel and subsistence to employees and non-executive appointees;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the General Data Protection Regulations;;

(g) methods of payment available to various categories of employee and officers;

(h) procedures for payment by manual cheque or bank credit to employees and officers;

(I) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(m) a system to ensure the recovery from those in and leaving the employment of the Trust of sums of money and property due by them to the Trust;

(n) A system to ensure all statutory returns e.g. HMRC are completed.

10.4.6 Appropriately nominated managers have delegated responsibility for:

(a) submitting manual or electronic time records, and other notifications in accordance with agreed timetables, and in the form prescribed by the Director of Finance;

(b) submitting manual or electronic termination/contract amendment forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination, retirement or other contractual change. Where an employee fails to report for duty or to fulfill obligations in circumstances that suggest they have left without notice, the Director of Finance must be informed immediately;

(c) Submitting manual of electronic claims for re-imbursement of travel and subsistence expenses or other allowances in the prescribed form and in accordance with agreed timetables.

10.4.7 Regardless of the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

10.5 Contracts of Employment

10.5.1 The Trust Board shall delegate responsibility to a nominated officer for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Trust Board and which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment.

(c) Ensuring compliance with the EU directives on contract workers

Southern Health and Social Care Trust

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11. NON-PAY EXPENDITURE

KEY POINTS

- The Trust Board will approve the level of non-pay expenditure on an annual basis.
- The Chief Executive will set out the list of managers who are authorized to place requisitions for the supply of goods and services and minor works, the financial limit of each requisition and the system for authorization above that level;
- Non pay expenditure should be committed in accordance with procurement guidance;
- The Director of Finance is responsible for ensuring that appropriate arrangements are in place for processing payments, that proper controls exist and are operating effectively;
- The Director of Finance is responsible for issuing procedural instructions and guidance on obtaining goods, works and services and certification of associated accounts and claims;
- The Director of Finance is responsible for the prompt payment of accounts and claims and in accordance with Government Accounting guidance.
- **Trust managers and officers** must ensure they:
    - Apply the principles of economic appraisal, with appropriate and proportionate effort, to all decisions and proposals concerning spending;
    - Adhere to procurement guidance
    - Order all goods, services or works on an official order, except works and services executed in accordance with contract and purchases from petty cash or the low value purchase card;
    - Do not split orders to avoid financial thresholds;
    - Do not place orders for items for which there is no budget provision, unless authorized by the Director of Finance;
    - Only use verbal orders in exceptional circumstances;
    - Do not take goods on loan/trial in circumstances that could commit the Trust to a future uncompetitive purchase;
    - Restrict purchases from petty cash and adequate records are maintained;
    - Do not issue orders to any firm which has made an offer of gifts/rewards or benefits to Directors or employees;
    - Notify the Director of Finance of staff changes to the list of approved signatories in the Trust.

11.1 Delegation of Authority

11.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

11.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services and minor works;

(b) the maximum level of each requisition and the system for authorisation above that level;

(c) The list of managers who are authorized to use the Government purchasing card

11.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

11.1.4 Non-pay expenditure should be committed in accordance with the Northern Ireland Public Procurement Policy (as amended), Procurement Guidance Notes, DoH circulars and other relevant guidance.

11.1.5 The processing of Trust payments is outsourced to the Business Services Organisation. The Director of Finance will ensure that there is an appropriate Service Level Agreement and monitoring arrangements in place with the BSO to ensure his responsibilities with regard to the processing of payments (non-payroll) are addressed and that proper controls are in place and are operating effectively.

11.1.6 The Director of Finance will seek annual assurance from the BSO on the reliability of the information processed by BSO for accounting purposes on behalf of the Trust.

11.1.7 The Director of Finance will ensure that the BSO systems, controls and processes are subject to audit on an annual basis and that the Trust is made aware of any assurance levels that are assessed as less than satisfactory.

11.1.8 The Director of Finance is responsible for designing, maintaining and training Trust staff in, appropriate financial procedures regarding the above.

11.1.9 The Director of Finance will ensure that the Trust receives regular reports in an agreed format in relation to all areas of payments that are managed by BSO on the Trust's behalf.

11.1.10 The Director of Finance will:

(a) advise the Board regarding the procurement within limits above which quotations (competitive or otherwise) or formal tenders must be obtained; the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;

(b) prepare procedural instructions or guidance that reflects the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims in accordance with applicable terms, MPMNI and any guidance issued by DoH;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of those senior employees who are authorised to certify invoices (including specimens of their signatures) and to authorise expenditure;

(ii) Certification, either manually or electronically that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;

- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- where appropriate, the expenditure is in accordance with regulations including taxation and all necessary authorisations have been obtained;

- the account is arithmetically correct;

- the account is in order for payment.

(iii) A timetable and process for submission to the BSO accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the processes for requesting payments of invoices/accounts by the Accounts Payable Shared Service Centre.

(e) be responsible for ensuring that payment for goods and services is only made by BSO once the goods and services are received.

11.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

11.2.1 Requisitioning

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust i.e. the optimum combination of whole life cost and quality (or fitness for purpose) to meet the Trust's requirements. In so doing, the advice of the Centre of Procurement Expertise on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance (and/or the Chief Executive) shall be consulted. Requisitions should be placed using the FPL E-Procurement system for goods and services.

11.2.2 Official orders

Official Orders, either manual or electronic must:

(a) be consecutively numbered;

(b) be in a form approved by the Director of Finance;

(c) state the Trust's terms and conditions of trade;

(d) only be issued to, and used by, those duly authorised by the Chief Executive;

(e) Only be approved by those with delegated authority.

11.2.3 System of Payment and Payment Verification

a. The Director of Finance shall be responsible for the prompt payment of accounts and claims once appropriately authorized by Trust officers.

b. The Director of Finance will ensure that there is an appropriate Service Level Agreement and monitoring arrangements in place with the BSO to ensure his responsibilities with regard to the processing of payments (non payroll) are addressed and that proper controls are in place and are operating effectively.

c. The Director of Finance will ensure this outsourced service is subject to an annual audit.

d. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with the Government Accounting guidance.

e. The Director of Finance shall ensure that all appropriate steps are taken to approve and release invoices for payment without unnecessary delay.

11.2.4 Prepayments

Prepayments are only permitted where exceptional circumstances apply and require the approval of DoF. This excludes normal regular expenditure such as rates, telephone rentals, insurance or other rental agreements. Occasions where advance payments are acceptable, with examples are listed in MPMNI. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages;

(b) The appropriate officer must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

Any proposal for deferred payments is considered novel and contentious and must have DoF approval.

11.2.5 Duties of Managers and Officers

Managers and officers acting or on behalf of the Trust must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

(a) They apply the principles of economic appraisal, with appropriate and proportionate effort, to all decisions and proposals concerning spending or saving public money, following Trust issued guidance in this regard. Appraisal must be applied irrespective of whether the relevant public expenditure or resources involve capital or revenue, is large or small or is above or below Trust delegated limits

(b) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

(c) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

(d) contracts awarded without competition are supported by a Direct Award Contract in line with DOH guidance;

(e) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the DOH;

(f) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(ii) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(iii) conventional hospitality, such as lunches in the course of working visits;

(This provision needs to be read in conjunction with the principles outlined in the Trust's policy on Gifts, Hospitality and Sponsorship Policy)

(g) all goods, services, or works are ordered on an official order; except for small inexpensive items of expenditure processed by petty cash or the low value purchase card.

(h) orders must not be split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) verbal orders must only be issued very exceptionally – by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed the next working day by an official order and clearly marked "Confirmation Order";

(j) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

(k) goods must not be taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(l) changes to the list of employees and officers authorised to certify invoices are notified to the Director of Finance;

(m) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance;

(n) petty cash records are maintained in a form as determined by the Director of Finance.

(o) purchases using the Government purchasing card are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance;

11.2.6 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of design and construction contracts and property transactions comply with the guidance contained within the Estates Procurement Manual and the Land Transactions Handbook. The technical audit of these contracts shall be the responsibility of the relevant Director.

Lending, Guarantees, Indemnities: Contingent Liabilities; Letters of Comfort

11.2.7 The Trust shall not, without the consent of DOH, lend money, charge any asset or security, give any guarantees or indemnities of letters of comfort, or incur any other contingent liability.

Gifts

11.2.8 DoH and Department of Finance approval is needed for any gifts above delegated limits. Gifts include the transfer of assets or leases at below market value. Public money must not be used to make gifts to staff.

Gifts must be noted in the annual report and accounts.

Use of consultants

11.2.9 Director of Finance will issue Trust guidance on the use of consultants in line with DoH and DoF guidance on the Use of Consultants.

11.2.10 Director of Finance will prepare and submit to DoH quarterly statement on status of all consultancies completed and /or started in each financial year.

12. GRANTS AND OTHER BODIES

KEY POINTS

- Payments to community and voluntary organisations shall comply with procedures laid down by the Director of Finance and in accordance with DoH guidance.

12.1 Payments to community and voluntary organisations shall comply with procedures laid down by the Director of Finance which shall be in accordance with DoH guidance.

12.2 Grants to other bodies for the provision of services to patients or clients shall, regardless of the source of funding, incorporate the principles set out in DoH guidance.

12.3 The Trust shall comply with the five main principles that apply to the management and administration of grant making. These are:

- Regularity – funds should be used for the authorized purpose;
- Propriety - funds should be distributed fairly and free from undue influence;
- Value for Money – funds should be used in a manner that minimises costs, maximises outputs and always achieves intended outcomes;
- Proportionate Effort – resources consumed in managing the risks to achieve and demonstrate regularity, propriety and value for money should be proportionate to the likelihood and impact of the risks materialising and losses occurring;
- Clarity of responsibility and accountability – within partnership working arrangements there should be clear documented lines of responsibility and accountability of each partner involved. Those who delegate responsibility should ensure that there are suitable means of monitoring performance.

  The Trust shall take proportionate and appropriate steps to assess the financial and economic standing of any organization 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)

  The Trust will consider whether state aid rules apply where any funding is being given favouring a particular company or sector. Advice will be sought from DoH.

  The Trust will not make a loan to a third party without the approval of DoH. The terms and conditions of any such grant or loan will include a requirement on the recipient organization to prepare financial statements and ensure its records in relation to the grant/loan are readily available for inspection by the Trust, DoH or External Auditor.

  Where the Trust has financed expenditure on capital assets by third parties, the DoF will set conditions and make appropriate arrangements

to ensure that assets are not disposed of without the Trust's prior consent.

12.4 Duties of Managers and Officers

Managers and officers acting or on behalf of the Trust must ensure that they comply fully with the guidance

13. CASH MANAGEMENT

KEY POINTS

- Grant in aid is paid in instalments to the Trust on the basis of need;
- The Director of Finance is responsible for ensuring that cash balances in the Trust are kept to a minimum;
- The Director of Finance is responsible for advising the Trust Board on the performance of any investments held;
- The Trust is not normally allowed to borrow.

13.1. Grant in aid will be paid to the Trust in regular instalments on the basis of need.

13.2 The Director of Finance is responsible for submitting a written application to the DoH forecasting cash requirements and for drawing down grant in aid according to need as detailed in MPMNI. This includes setting clarity for the BSO where it provides these cash management services on behalf of the Trust. The forecast GIA included in DoH spring supplementary estimates cannot be exceeded.

13.3 The Director of Finance is responsible for ensuring that cash balances are kept at a minimum level consistent with the efficient operation of the Trust. Any interest earned on overnight deposits cannot necessarily be retained by the Trust but may have to be returned to DoH. Depending on the budgeting treatment of the receipt and its impact on the Trust's cash requirement, it may lead to a commensurate reduction in GIA or required to be surrendered. GIA not drawn down at the end of the year will lapse. However, where draw down of GIA is delayed to avoid excess cash balances at year end, the DoH will make available in the next financial year (subject to approval) any such GIA required to meet any liabilities at year end such as creditors.

13.4 Temporary cash surpluses must be held only in such public or private sector investments as authorised by the Trust Board. The Trust should not build up cash balances or net assets in excess of what is required for operational purposes.

13.5 The Director of Finance is responsible for advising the Board on investments and shall report periodically to the Board, or delegated sub-committee, concerning the performance of investments held. Funds held in bank accounts or as financial investments may be a factor for consideration when GIA is determined.

13.6 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

13.7 Normally the Trust will not be allowed to borrow. The Director of Finance will seek the approval of the DoH and where appropriate DoF to ensure that it has any necessary authority and budgetary cover for any borrowing or the expenditure financed by such borrowing. Any expenditure by the Trust financed by borrowing counts towards DEL.

13.8 The Trust will not enter into any other unconventional financial arrangement without the approval of the DoH and DoF.

14. CAPITAL INVESTMENT, PRIVATE FINANCING, ASSET REGISTERS AND SECURITY OF ASSETS

KEY POINTS

- The Chief Executive will ensure there is an adequate economic appraisal of capital expenditure proposals in line with all relevant guidance;
- For every capital expenditure proposal, the Chief Executive will ensure there is a business case, that the Director of Finance has certified the costs and revenue consequences, and that DHSSPS approval has been secured where appropriate;
- Only major capital schemes costing in excess of £50 million require testing for PFI;
- The Chief Executive must obtain DoH approval for all property and finance leases;
- The Chief Executive is responsible for the overall control of assets and maintenance of asset registers, advised by the Director of Finance concerning asset control procedures;
- **Each employee** has responsibility for the security of property of the Trust and reporting any loss of assets in accordance with the procedure for reporting losses.

14.1 Capital investment

14.1.1 The Chief Executive:

(a) shall ensure that there is an adequate economic appraisal of capital expenditure proposals in line with the Northern Ireland Guide to Expenditure Appraisal and Evaluation (NIGEAE), HM Treasury guidance and DoH circulars.

(b) Shall ensure that there is an approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(c) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

(d) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences.

14.1.2 For every capital expenditure proposal (including IT) the Chief Executive shall ensure:

(a) that a business case (in line with the DoH guidance) is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) the involvement of appropriate Trust personnel and external agencies;

(iii) appropriate project management and control arrangements, including post project evaluation;

(b) that the Director of Finance has certified professionally to the whole life costs and revenue consequences detailed in the business case.

(c) that Departmental approval is obtained for projects costing more than the Trust's delegated limit for capital or IT schemes.

14.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of the Land Transactions Handbook.

14.1.4 The Director of Finance shall advise on procedures to be put in place for the operation of the construction industry tax deduction scheme in accordance with HM Revenue and Customs guidance.

14.1.5 The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

14.1.6 The approval of a capital programme will not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to procurement

(c) approval to accept a successful tender

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with DOH guidance and the Trust's Standing Orders.

14.1.7 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the current delegated limits for capital schemes as issued by DOH.

14.2 Private Finance

14.2.1 The Trust should normally test for private finance when considering capital procurement where the capital threshold is £50 million or above. When the Trust proposes to use finance which is to be provided other than through its Allocations, the following procedures shall apply:

a) The Director of Finance shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector;

b) The Director of Finance will consult with the DoH over the accounting and budgeting treatment for a PFI. Where judgement over the level of control is difficult, the DoH will consult with the Department of Finance;

(c) The proposal must be specifically agreed by the Trust Board and other relevant bodies.

14.3 Leasing

14.3.1 The Chief Executive must obtain DOH approval for all property and finance leases. The DOH must have DEL provision for finance leases.

14.3.2 Before entering into a new lease or extending an existing lease term, the Director responsible for Estates, must at expiry or break options, submit to DoH a proportionate business case at least 12 months before either the lease expiry date or landlord/tenant notice date, whichever is earlier. The Director of Finance will demonstrate that the lease offers value for money and ensure that is appropriately demonstrated in the business case through analysis of options, including outright purchase. Business cases must be submitted for DoH approval in the first instance.

14.4 Asset Registers

14.4.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted on a rolling basis.

14.4.2 The Trust shall maintain an asset register recording non-current assets. The minimum data set to be held within these registers shall be as specified in the Capital Accounting Manual and any other DOH guidance.

14.4.3 Additions to the asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads;

(c) lease agreements in respect of assets held on the Trust's Statement of Financial Position and capitalised.

14.4.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorised documents and invoices (where appropriate). Attention is drawn to the recent guidance on limiting the holdings of land and buildings to the minimum required for the performance of present and clearly foreseen responsibilities as per DOH guidance.

14.4.5 The Director of Finance shall approve procedures for reconciling balances on non-current asset accounts in ledgers against balances on asset registers.

14.4.6 The value of each asset shall be indexed to current values in accordance with methods specified in the Capital Accounting Manual issued by the DOH.

14.4.7 The value of each asset shall be depreciated and/or impaired using methods and rates as specified in the Capital Accounting Manual issued by the DOH.

14.4.8 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.

14.5 Security of Assets

14.5.1 The overall control of non-current assets is the responsibility of the Chief Executive.

14.5.2 Asset control procedures (including non-current assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. See SFI No. 7 for the control of cash, cheques and negotiable instruments.

This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

14.5.3 All discrepancies revealed by verification of physical assets to the asset register shall be notified to the Director of Finance.

14.5.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Trust Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to HSC property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

14.5.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Trust Board members and employees in accordance with the procedure for reporting losses.

14.5.6 Where practical, assets should be marked as Trust property.

15. STORES AND RECEIPT OF GOODS

KEY POINTS

- The Chief Executive delegates the control of stores to **designated officers** in the Trust;
- **Designated officers** are responsible for security arrangements and the custody of keys for any stores;
- The Director of Finance will set out procedures and systems to control and regulate stores, including a physical check of items in the store at least annually;
- **Designated officers** are responsible for the review of slow moving and obsolete items in the stores and adherence to the procedures for the reporting of losses.

15.1 General position

15.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to a minimum of an annual stock take;

(c) valued at the lower of cost and net realisable value, in accordance with the Trust's accounting policy.

15.2 Control of Stores, Stocktaking, condemnations and disposal

15.2.1 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance.

The areas of delegation include:
- Pharmacy
- Laboratory
- Community Aids and appliances
- Fuel
- Estates maintenance.
- Ward stocks
- Linen stores
- Catering stores

15.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/officer. Wherever practicable, stocks should be marked as health service property.

15.2.3 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores and losses.

15.2.4 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

15.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

15.2.6 The designated Manager/Officer shall be responsible for a system approved by the Director of Finance, for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 16 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

15.3 Goods supplied by Centres of Procurement Expertise (COPEs)

15.3.1 For goods supplied via central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note and notify the Centre of Procurement Expertise of any shortages or discrepancies using established Trust procedures.

15.4 Goods supplied directly from Suppliers

15.4.1 For goods supplied directly from suppliers, the Chief Executive shall identify those authorised to requisition and accept goods. The authorised person shall check receipt against the delivery note and order and notify of any shortages or discrepancies using established Trust procedures.

16. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

KEY POINTS

- The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations and ensure these are notified to managers;
- Assets shall be sold for best price, taking into account the costs of sales. Generally assets will be sold by auction or competitive tender;
- **Heads of Service** are responsible for ensuring that all data held on assets for disposal are dealt with appropriately and securely;
- The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments in line with DHSSPS guidance;
- **Any employee** discovering or suspecting a loss of any kind must either immediately inform their Head of Department or inform the Trust's Fraud Liaison Officer.

16.1 Disposals and Condemnations

16.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

16.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate. Assets shall be sold for best price, taking into account any costs of sale, as advised by Land and Property Services Generally assets shall be sold by auction or competitive tender. All receipts derived from the sale of assets must be declared in accordance with DOH guidance by the Director of Finance.

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

(c) items to be disposed of with an estimated sale value of less than £20,000 (this figure to be reviewed on a periodic basis);

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DOH guidance has been issued but subject to compliance with such guidance.

16.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance;

(b) recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries

shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

16.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

16.1.5 Heads of Department will be responsible for ensuring that all data held on assets for disposal are dealt with appropriately and securely.

16.1.6. Other than at public auction, no article shall pass into the possession of any member of Trust staff or member of its Board without approval of the DoH.

16.2 Losses and Special Payments

16.2.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for losses, and special payments, in line DOH guidance.

16.2.2 The Director of Finance will consult with the DoH where proposed losses, irrespective of value:

- 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.

16.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Director of Finance.

16.2.3 Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud or corruption, the Director of Finance will determine when to inform the PSNI in accordance with the Trust's Anti -Fraud Policy and Response Plan.

16.2.4 The Director of Finance or other nominated Trust Officer must notify the BSO Counter Fraud and Probity Services on discovery of a loss or suspected loss to public funds or property as a result of fraud, misappropriation or malicious damage.

16.2.5 Within limits delegated to it by the DOH, the Board shall approve the writing-off of losses.

16.2.6 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

16.2.7 For any loss, the Director of Finance should consider whether any insurance claim can be made. Losses will not be written off until all reasonable attempts to make a recovery have been made and proved unsuccessful and there is no feasible alternative.

16.2.8 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

16.2.9 No special payments exceeding delegated limits shall be made without the prior approval of the DOH.

16.2.10 All losses and special payments must be reported to the Audit Committee at least once per annum .

17. INFORMATION TECHNOLOGY

KEY POINTS

- The Director of Finance is responsible for the accuracy and security of the computerised financial data of the Trust;
- The Director of Finance will ensure that contracts for computer services for financial applications with another health organization or other agency clearly define the responsibilities of all parties;
- The Director of Performance and Reform will ensure that risks to the Trust arising from the use of IT are effectively identified and considered;
- Where computer systems have an impact on corporate financial systems, the Director of Finance will need to be satisfied across a range of measures.

17.1 Responsibilities and duties of the Director of Finance

17.1.1 The Director of Finance who is responsible for the accuracy and security of the computerised financial data of the Trust, will delegate to the Director of Performance and Reform responsibility to:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the General Data Protection Regulations;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

17.1.2 The Director of Finance shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

17.2 Contracts for Computer Services with other health bodies or outside agencies

17.2.1 The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation (e.g. BSO) or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

17.2.2 Where another health organisation (e.g. BSO) or any other agency provides a computer service for financial applications, the Director of Finance shall at least annually seek assurances that adequate controls are in operation.

17.3 Risk Assessment

The Director of Performance and Reform shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

17.4 Requirements for Computer Systems which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems the Director of Finance shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Finance staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried out.

18. PATIENTS' AND CLIENTS' PRIVATE PROPERTY

KEY POINTS

- The Trust has responsibility to provide safe custody for money and other personal property in a number of circumstances;
- The Chief Executive is responsible for ensuring that patients/ or their next of kin are informed that the Trust will not accept responsibility or liability for property brought into the premises unless it is handed over and a receipt obtained;
- The Director of Finance will provide written instructions on the management of patients/clients property for all staff;
- **Line managers** must ensure that staff are appropriately informed of their responsibilities and duties for the administration of patients'/clients' property.

18.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") in the following circumstances:

- handed over by, or collected on behalf of, patients or clients;
- in the possession of unconscious or confused patients or clients;
- found in the possession of patients dying in Trust facilities or dead on arrival.

18.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets;
- admission documentation and property records;
- the oral advice of administrative, nursing and other professional staff responsible for admissions,

that the Trust will not accept responsibility or liability for property brought into Trust premises, unless it is handed over for safe custody and a copy of an official patients' property record is obtained as a receipt.

18.3 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' or clients' property (including instructions on the disposal of the property of deceased patients or clients and of patients or clients transferred to other premises) for all staff whose duty it is to administer, in any way, the property of patients or clients. Due care should be exercised in the management of a patient's/client's money in order to maximise the benefits to the patient.

18.4 Where DoH instructions require the opening of separate accounts for patients' or clients' monies, these shall be opened and operated under arrangements agreed by the Director of Finance.

18.5 The Trust shall take cognisance of the provisions of the Enduring Powers of Attorney (NI) Order 1987 to provide for a patient or client to choose for someone other than a member of Trust staff to deal with his/her property and affairs.

18.6 Where patients'/clients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient/client in writing.

18.7 A patient's / client's property record, in a form determined by the Director of Finance, shall be completed in respect of the following:

(a) property handed in for safe custody by any patient or client (or guardian or next-of-kin as appropriate)

(b) property taken into safe custody having been found in the possession of patients or clients who are:
- mentally disordered
- confused or disorientated
- unconscious
- dying in a Trust facility
- severely incapacitated for any reason

A record shall be completed in respect of all persons in category (b) above.

18.8 The record shall be completed by a member of staff in the hospital or facility concerned in the presence of a second member of staff and in the presence of the patient/client or his/her personal representative where practicable. It shall then be signed by both members of staff and the patient / client, except where the latter is restricted by physical or mental incapacity. Any alterations shall be validated by signatures as required for the original entry on the record.

18.9 Property handed over for safe custody shall be placed into the care of the officer responsible for the custody of patients' / clients' property, except where there are no administrative staff present, in which case the property shall be placed into the care of the most senior member of staff on duty.

18.10 Patients' and clients' income from pensions and associated allowances shall be dealt with in accordance with current DOH Regulations.

18.11 Refunds of cash handed in for safe custody shall be dealt with in accordance with the written instructions issued by the Director of Finance. Property other than cash which has been handed in for safe custody shall be returned to the patient or client by the officer who has responsibility for its security. The return shall be receipted by the patient or client (or guardian or next-of-kin if appropriate) and witnessed.

18.12 The disposal of property of deceased patients / clients shall be effected by the officer who has responsibility for its security. Such disposal shall be in accordance with the written instructions of the Director of Finance. Where cash or valuables have been deposited for safe custody, they shall only be released after written authority has been given by an officer delegated by the Director of Finance. Such authority shall include details of the lawful kin or other person entitled to the cash and valuables in question.

18.13 In all cases where property of a deceased patient is of a total value in excess of £10,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) (Increase of Limit) Order (NI) 2004), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £10,000 or less, forms of indemnity shall be obtained.

18.14 In respect of a deceased patient's or client's property, if there is no will and no identified lawful kin, the property vests in the Crown, and the details shall be notified to the Crown Solicitor for Northern Ireland.

18.15 Any funeral expenses necessarily borne by the Trust are a first charge on the deceased's estate. Where it is deemed necessary for the Trust to make appropriate arrangements for burial or cremation, any cash of the estate held by the Trust may be appropriated towards funeral expenses, upon the authorisation of the Director of Finance. No other expenses or debts shall be discharged out of the estate of a deceased patient or client.

18.16 The Director of Finance shall be responsible for investing patients' and clients' monies in accordance with DOH guidance so as to ensure a reasonable return associated with a minimum level of risk. Individual accounts shall be maintained within the Trust's Patients'/Clients Property System and interest earned shall be apportioned regularly to those accounts on an equitable basis.

18.17 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients/clients.

18.18 The Director of Finance will be responsible for seeking consent from RQIA to hold monies in excess of the limit set by the DOH (£20,000) on behalf of patients/clients who have been deemed incapable of managing their monies and property under Article 116(4) of the Mental Health Order (NI) 1986.

Southern Health and Social Care Trust

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19. CHARITABLE TRUST FUNDS

KEY POINTS

- The Director of Finance has primary responsibility to the Trust Board and E&G Committee for ensuring that Charitable Trust funds are managed appropriately with regard to their purpose and requirements.
- The Director of Finance will arrange for the administration of all new and existing funds;
- The Director of Finance will provide guidelines to **Trust officers** on how to proceed with donations, legacies and bequests;
- The Director of Finance will deal with all arrangements for fund raising; ensure that appropriate banking arrangements are in place and be responsible for all aspects of the investment of Charitable Trust funds;
- Donated assets will be maintained along with the general estate and inventory of assets;
- The Director of Finance will ensure regular reporting to the E&G Committee and preparation of annual Trustees' report and accounts.

19.1 Trust responsibilities for Charitable Trust funds are distinct from responsibilities for public funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. The Director of Finance should ensure that each fund is managed appropriately with regard to its purpose and requirements.

19.2 The Director of Finance has primary responsibility to the Trust Board, and E&G Committee for ensuring that these SFI's are applied and for compliance with the requirements of the Charity Commission for Northern Ireland (CCNI).

Existing Charitable Trust Funds

19.3 The Director of Finance should arrange for the administration of all existing Charitable Trust funds. They should ensure that a governing instrument exists for every trust fund and should produce detailed codes of procedure covering every aspect of the financial management of Charitable Trust funds, for the guidance of directors and employees. Such guidelines should identify the restricted or unrestricted nature of certain funds.

19.4 The Director of Finance should periodically review the Charitable Trust funds in existence and should make recommendations to the

E&G Committee regarding the potential for rationalisation of such funds within statutory guidelines.

New Charitable Trust Funds

19.5 The Director of Finance should arrange for the creation of a new Charitable Trust fund where funds and/or other assets, received in accordance with policies, cannot adequately be managed as part of an existing Charitable Trust fund.

19.6 The governing document for each new Charitable Trust fund should clearly identify, inter alia, the objectives of the new fund, the capacity to delegate powers to manage and the power to assign the residue of the Charitable Trust fund to another fund contingent upon certain conditions, e.g., discharge of original objects.

Sources of Charitable Trust Funds

Donations

19.7 In respect of donations, the Director of Finance should:

(a) provide guidelines to officers of the Trust as to how to proceed when offered funds. These include:

(i) the identification of the donor's intention in line with structure of Trust funds available;

(ii) the avoidance of new Charitable Trust funds;

(iii) the avoidance of impossible, undesirable or administratively difficult objects;

(iv) sources of immediate further advice;

(v) treatment of offers for personal gifts;

(vi) promotion of gift aid.

(b) provide secure and appropriate receipting arrangements which will indicate that funds have been accepted directly into Charitable Trust funds and that the donor's intentions have been noted and accepted.

Legacies and Bequests

19.8 In respect of legacies and bequests, the Director of Finance should:

(a) provide guidelines to officers covering any approach regarding:

(i) the wording of wills;

(ii) the receipt of funds/other assets from executors;

(b) where necessary, obtain grant of probate, or make application for grant of letters of administration, where the Charitable Trust fund is the beneficiary;

(c) be empowered to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty; and

(d) be directly responsible for the appropriate treatment of all legacies and bequests.

Fund Raising

19.9 In respect of fund-raising, the Director of Finance shall:

(a) deal with all arrangements for fund-raising by and/or on their behalf and ensure compliance with all statutes and regulations;

(b) be empowered to liaise with other organisations/persons raising funds and provide them with an adequate discharge. The Director of Finance shall be the only officer empowered to give approval for such fund-raising subject to the overriding direction of the Trust Board;

(c) be responsible for alerting the Trust Board to any irregularities regarding the use of the Trust or Charitable Trust fund's name or its registration numbers; and

(d) be responsible for the appropriate treatment of all funds received from this source.

Investment Income

19.10 In respect of investment income, the Director of Finance shall be responsible for the appropriate treatment of all dividends, interest and other receipts from this source (see below).

Investment Management

19.11 The Director of Finance shall be responsible for all aspects of the management of the investment of Charitable Trust funds. The issues on which he/she should be required to provide advice to the Trust Board should include:

(a) the formulation of investment policy within the powers of the Charitable Trust fund under statute and within governing instruments to meet its requirements with regard to income generation and the enhancement of capital value;

(b) the appointment of advisers, brokers, and where appropriate, fund managers. The Director of Finance should agree the terms of such appointments and for such appointments written agreements should be signed by the Chief Executive;

(c) pooling of investment resources and the preparation of a submission to the DOH for them to make a scheme;

(d) the participation in common investment funds and the agreement of terms of entry and withdrawal from such funds;

(e) that the use of Trust investments shall be appropriately authorised in writing and charges raised within policy guidelines;

(f) the review of the performance of brokers and fund managers;

(g) the reporting of investment performance.

Disposition Management

19.12 The exercise of dispositive discretion shall be managed by the Director of Finance in conjunction with the Board. In so doing he/she shall be aware of the following:

(a) the objects of various funds and the designated objectives;

(b) the availability of liquid funds within each trust fund;

(c) the powers of delegation available to commit resources;

(d) the avoidance of the use of Public funds to discharge Charitable Trust fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the

Exchequer shall be discharged by Charitable Trust funds at the earliest possible time:

(e) that Charitable Trust funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the Charitable Trust fund; and

(f) the definitions of "charitable purposes" as agreed by the DOH.

Banking Services

19.13 The Director of Finance should advise the Trust Board and, with its approval, should ensure that appropriate banking services are available to the Charitable Trust fund. These bank accounts should permit the separate identification of liquid funds to each fund where this is deemed necessary by the DOH.

Asset Management

19.14 Assets in the ownership of or used by the Charitable Trust fund, shall be maintained along with the general estate and inventory of assets. The Director of Finance shall ensure:

(a) in conjunction with the legal adviser, that appropriate records of all assets owned are maintained, and that all assets, at agreed valuations, are brought to account;

(b) that appropriate measures are taken to protect and/or to replace assets. These to include decisions regarding insurance, inventory control, and the reporting of losses;

(c) that donated assets received on trust rather than into the ownership of the Trust shall be accounted for appropriately;

(d) that all assets acquired from Charitable Trust funds which are intended to be retained within the Charitable Trust funds are appropriately accounted for, and that all other assets so acquired are brought to account in the name of the Trust.

Reporting

19.15 The Director of Finance shall ensure that regular reports are made to the E&G Committee with regard to, inter alia, the receipt of funds, investments, and the disposition of resources.

19.16 The Director of Finance shall prepare annual Trustees' report and Charitable Trust fund accounts in the required manner which shall be submitted to the Trust Board and DOH within agreed timescales.

Accounting and Audit

19.17 The Director of Finance shall maintain all financial records to enable the production of Charitable Trust fund reports as above and to the satisfaction of internal and external audit.

19.18 The Director of Finance shall ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year. He will liaise with external audit and provide them with all necessary information.

19.19 The Board shall be advised by the Director of Finance on the outcome of the annual audit. The Chief Executive shall submit the Report to those charged with Governance to the Trust Board.

Administration Costs

19.20 The Director of Finance shall identify all costs directly incurred in the administration of Charitable Trust funds and, in agreement with the Trust Board, shall charge such costs to the appropriate Charitable Trust accounts.

Taxation and Excise Duty

19.21 The Director of Finance shall ensure that any Charitable Trust fund liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

20. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT

KEY POINTS

- **Trust staff** are required to comply with the Gifts, Hospitality and Sponsorship Policy and Conflicts of Interest Policyand guidance

20.1 The Director of Finance shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits-in-kind by staff. This policy follows DOH guidance and is contained in the Gifts, Hospitality and Sponsorship Policy and Conflicts of Interest Policy.

20.2 The Chief Executive shall ensure a written record is maintained of any such gifts, bequests or donations and of their estimated value and whether they are disposed of or retained.

21. RETENTION OF RECORDS

KEY POINTS

- The Chief Executive is responsible for maintaining records in accordance with DHSSPS guidelines, Good Management and Good Records.

21.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with DOH guidelines, Good Management and Good Records.

21.2 The records held in archives shall be capable of retrieval by authorised persons.

21.3 Records held in accordance with latest DOH guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

22. RISK MANAGEMENT AND INSURANCE

KEY POINTS

- The Chief Executive shall ensure that the Trust has a programme of risk management which is approved and monitored by Trust Board.
- There are only three exceptions of when the Trust may enter into arrangements for commercial insurance.

22.1 Programme of Risk Management

The Chief Executive shall ensure that the Trust has a system 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 DoH/Treasury guidance and MPMNI.

The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) audit arrangements including; Internal Audit, clinical audit, health and safety review;

f) a clear indication of which risks shall be insured

g) arrangements to review the Risk Management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make a statement on the effectiveness of Internal Control within the Mid-Year Assurance statement and Governance Statement as required by current DoH guidance.

22.2 Insurance arrangements with commercial insurers

22.2.1 There is a general prohibition on entering into insurance arrangements with commercial insurers, other than insurance which is statutory obligation or which is permitted under MPMNI. There are, however, **three exceptions** when Trust's may enter into insurance arrangements with commercial insurers. The exceptions are:

(1) Trust's may enter commercial arrangements for **insuring motor vehicles** owned by the Trust including insuring third party liability arising from their use;

(2) where the Trust is involved with a consortium in a **Private Finance Initiative contract/Public Private Partnership** and the other consortium members require that commercial insurance arrangements are entered into; and

(3) where **income generation activities** take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for an HSC

purpose the activity may be covered in the risk pool. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Director of Finance should consult the DOH.

In the case of a major loss or third party claim, the DoH shall liaise with the Trust about the circumstances in which an appropriate addition to budget will be considered.

The Trust is listed in 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.

23. HSC TRUST FINANCIAL GUIDANCE

KEY POINTS

- The Director of Finance will ensure that members of the Trust Board are aware of extant finance guidance from the DoH.

23.1. The Director of Finance shall ensure that members of the Trust Board are aware of the extant finance guidance issued by DoH and that this direction and guidance is followed by the Trust.

Southern Health and Social Care Trust

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Integrated Governance Framework

2017/18 -2020/21

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Directorate responsible for this Document	All
Date	September 2017
Review Date	September 2021

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1.0 INTRODUCTION

This framework sets out the arrangements for integrated governance within the Southern Health and Social Care Trust for the four year period 2017/18 – 2020/21. It is based on the extant integrated governance strategy 2007 – 2009 which was approved by Trust Board in February 2008 and covers all domains of governance associated with the delivery of health and social care services i.e. corporate governance, clinical and social care governance, information governance, risk management, performance management and financial governance.

The Southern Health and Social Care Trust is committed to implementing the principles of good governance. 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 framework aligns the requirements placed upon the organisation by the Department of Health (DoH), incorporates the risk management policy statement, defines the governance structures and arrangements through which assurances can be provided to the Trust Board. It also further builds on the proposals emanating from the 'Review of Clinical and Social Care Governance' undertaken during 2010 and implemented in April 2011 and the subsequent revisit of the outcomes of the 2010 review undertaken in April 2015.

2.0 CONTEXT FOR INTEGRATED GOVERNANCE

Integrated Governance is defined as: ***"****The systems, processes and behaviours by which Trusts lead, direct and control their functions in order to achieve organisational objectives, safety and quality of services and in which they relate to patients and carers, the wider community and partner organisations." (Integrated Governance Handbook, Department of Health February 2006).*

Integrated Governance is therefore the means by which all the competing pressures on the Trust Board and its supporting structures are pulled together to enable good governance and the delivery of the organisation's objectives. The framework considers the principal strands of governance common to HSC organisations and describes how the Southern Trust's governance arrangements bring these together.

This framework should therefore be considered alongside other key documents, in particular the Trust's Risk Management Strategy which provides a framework for the management of risks to achieving the Trust's strategic aims and objectives. The strategy is designed to establish a consistent and integrated approach to the management of risk across the whole Trust.

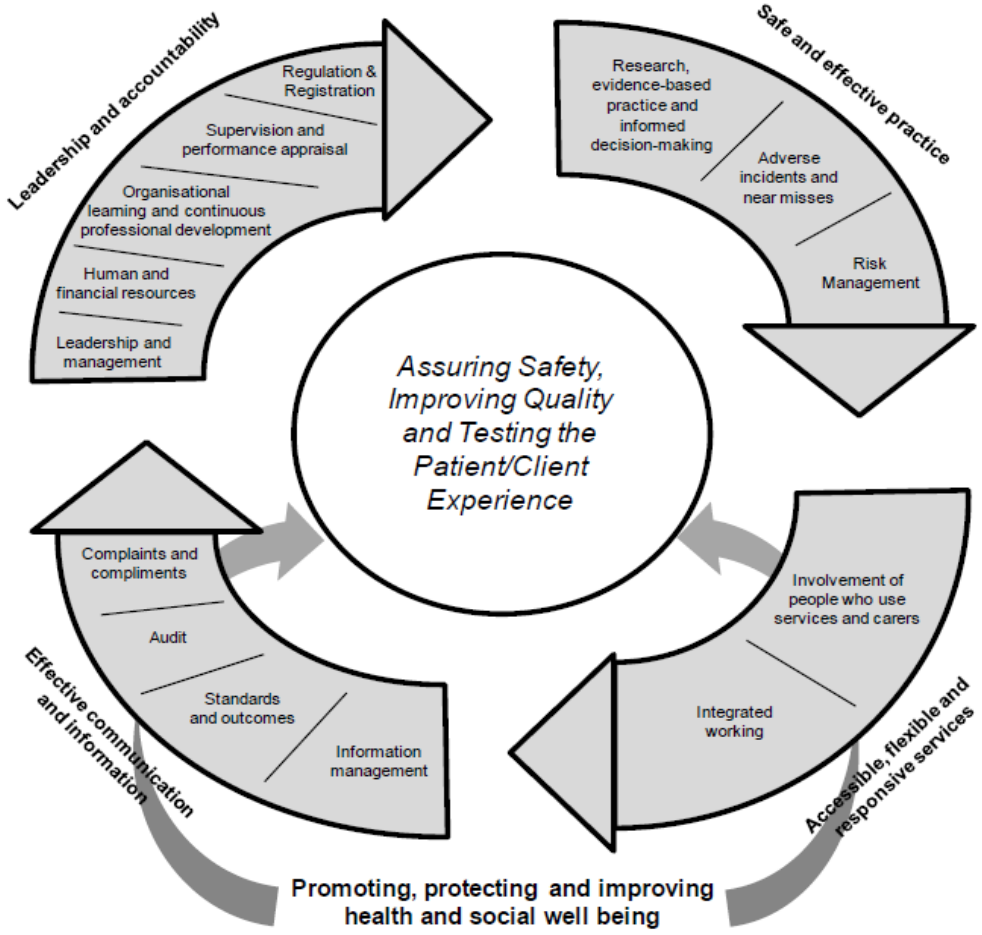
Corporate Governance is defined as: *"The system by which an organisation is directed and controlled, at its most senior levels, to achieve its objectives and meet the necessary standards of accountability, probity and openness. Corporate Governance is therefore about achieving objectives, including value for money, and upholding public service values"*

The Trust applies the principles of good practice as outlined in 'Corporate Governance in Central Government Departments: Code of Good Practice NI 2013'.

Clinical and Social Care Governance is defined as: *"A framework through which HPSS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish" (A First Class Service, DOH 1998).*

To support this framework, the Trust has also adopted the model of Integrated Governance as set out in Figure 1 below. This model is set within the HPSS Quality standards (2006) and illustrates in diagrammatic format how all areas of governance practice are linked together to positively influence the quality of service provided to our patients, clients and service users.

Figure 1 Model for Integrating Governance



3.0 AIMS AND OBJECTIVES OF THE FRAMEWORK

This framework aims to provide clear direction for all staff on the arrangements for Integrated Governance in the Southern Health and Social Care Trust. It seeks to integrate all the requirements placed on the Southern Trust and integrate and streamline the processes for managing, reporting and providing assurances of compliance.

The framework also outlines the responsibilities of all staff across the organisation and the overall corporate accountability of the Trust Board, standing committees of the Board and sub - committees.

As an organisation, the Trust has a statutory duty of quality to ensure the provision of quality services. All staff have a responsibility to ensure that good standards of care are maintained and the Trust has internal systems to monitor the provision and delivery of services. The framework has been developed in line with the Trust's Vision - *"to deliver safe, high quality health and social care services, respecting the dignity and individuality of all who use them".* The integration and utilisation of such processes will ensure that the Trust provides high quality, safe and effective care to patients, clients, carers, staff and the public.

The core objectives of this framework are therefore to ensure that:-

- Patients, clients and their carers receive high quality care and services and are protected from harm;

- Staff are competent in their role, suitably skilled and are meeting their requirements in relation to practice standards and professional development; and

- Teams and systems are developed and reviewed in order to ensure the delivery of effective, efficient and patient/client focused services. The Trust is accountable for the quality of services it provides and takes responsibility for maintaining and improving service provision and practice which promotes a positive user experience.

4.0 CORPORATE LEADERSHIP, ACCOUNTABILITY AND RESPONSIBILITY ARRANGEMENTS FOR GOVERNANCE WITHIN THE TRUST

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

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

This section of the framework defines how the Southern Trust is governed to ensure that it fulfils its overall purpose; achieves its intended outcomes for patients, clients and carers and operates in an effective, efficient and ethical manner.

4.1 The Role of the Trust Board

The Trust Board is responsible for ensuring that the Trust has effective systems in place for governance, essential for the achievement of its organisational objectives. It is also responsible for ensuring that the Trust consistently follows the principles of good governance applicable to HSC organisations and will work actively to promote and demonstrate the values and behaviours which underpin Integrated Governance.

The Trust Board operates in accordance with the Codes of Accountability and Conduct issued by the Department of Health in 2012 and, as members of the Trust Board, all have explicitly subscribed to these Codes.

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

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

4.2 Standing Orders and Standing Financial Instructions

The Trust's Standing Orders and Standing Financial Instructions provide the regulatory framework for the business conduct of the Trust.

4.3 Governance Statement

The Annual Governance Statement (GS) and the Mid-Year Assurance Statement outline the Trust's governance framework for directing and controlling its functions and is supported by the Board Assurance Framework and underpinning Trust Risk Management arrangements.

The content of the Governance Statement and Mid-Year Assurance Statement are informed by the Head of Internal Audit opinion on the efficacy of the Trust's internal control mechanisms.

The Governance Statement is subject to external scrutiny by the Trust's External Auditors on an annual basis.

Significant weaknesses in the Trust's internal control mechanisms will be explicitly highlighted in the Governance Statement, together with actions necessary to address the issues reported on.

Separately, the Trust's Audit and Governance Committees assess the adequacy and completeness of the Governance Statement to provide

assurance to Trust Board that it is comprehensive in its review of the system of internal control operational in the Trust.

4.4 Managing Principal Risks to Achieving Objectives - Board Assurance Framework and Risk Management Strategy

The Board Assurance Framework is an integral part of the governance arrangements for the Southern Trust and provides a comprehensive method for the effective and focused management of the principal risks to meeting its corporate objectives. It sets out the key controls through which these risks will be managed and identifies the sources of assurance on the effectiveness of these controls and actions to further reduce the risk or manage it to an acceptable level.

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. The Board Assurance Framework is reviewed by the Trust Board on a six-monthly basis.

The Trust is fully committed to the effective management of risks in all areas. It is the policy of the Trust that a proactive approach to risk management is taken in order to:

- Bring about the desired continual improvements in the care/services the Trust provides
- Ensure the Trust does its reasonable best to ensure the safety of staff and the security of Trust premises for those staff that visit, live or work in them
- Improve the way the Trust conducts its business
- Enhance the services, reputation and efficient management of resources of the Trust
- Comply with the statutory and public duties placed upon the Trust

- To ensure that there is a consistent approach to the assessment and recording of risk across the organisation

  The Risk Management Strategy provides the tools to make the risk management systems robust and systematic.

The Trust's internal business planning and performance monitoring process is linked to the Trust's principal objectives. This ensures a holistic approach to Board Assurance, Risk Management and Performance Management Frameworks throughout the Trust.

4.5 Financial Governance Framework

The Financial Governance Framework of the Trust is designed to fulfil the requirements for financial governance as outlined in the Trust's Management Statement/Financial Memorandum and Standing Orders.

The framework consists of four key elements:

- Standing Financial Instructions
- Detailed financial policies and procedures
- Authorisation and Approvals Framework
- Independent internal audit assurance

Standing Financial Instructions: the Standing Financial Instructions are the "business rules" that Directors and employees must follow when acting on behalf of the Trust. They outline the key financial responsibilities which apply to everyone working for the Trust and are mandatory.

Detailed financial policies and procedures: the Director of Finance carries responsibility to "ensure that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions." (SFIs section 1.2.5)

Authorisation and Approvals Framework: this document outlines the financial authority delegated from the Chief Executive.

The Chief Executive will set out (SFIs section 11.1.2):

- The list of managers who are authorised to place requisitions for the supply of goods and services and minor works;
- The maximum level of each requisition and the system for the authorisation above that level.

Audit Assurance: the Director of Finance ensures there are arrangements to review, evaluate and report on the effectiveness of internal financial control including an effective Internal Audit function. The Director of Finance also ensures that an internal strategic plan covering a three year period is produced from which an annual operational plan is derived and that an annual internal audit report is prepared for the consideration of the Audit Committee.

This framework is designed to assist the organisation in providing assurance to Trust Board that effective arrangements are in place regarding financial governance.

4.6 Performance Framework

The performance management framework focuses on those areas of the Trust's business where targets must be achieved and improvements can be made and is designed to:

Ensure that the Southern Health & Social Care Trust (SHSCT) has a clear accountability framework and approach to improving performance to deliver better outcomes for service users and families and to ensure as an organisation the SHSCT is able to:

- Assess and track performance against targets and goals with clear measures
- Identify and escalate early alerts and trends that may predict future performance/outturn
- Establish review and accountability mechanisms to identify key actions necessary to support improvement
- Enable the focus of key resources and improvement efforts in the required areas

Complement the existing Board Assurance Framework and not replicate or replace existing arrangement for controls assurance, risk management, clinical and social care governance or specialist performance reports but may draw on a range of key indicators to reflect a rounded performance position.

Seek to provide an integrated approach to performance management with development of integrated reporting at a corporate level to provide greater insight to interdependencies. This will reflect the Trusts Quality Improvement Framework and key outcomes of providing care that is **Safe, Personal and Effective**.

Within the framework the Director of Performance & Reform will seek to ensure foundations and context for effective performance via

- A clear organisational structure, objectives and accountabilities;
- A corporate strategic planning process, including the Corporate Plan and Trust Delivery Planning processes;
- Performance support for monitoring arrangements through a cycle of performance review meetings at Trust, Directorate, Service Line, Team and individual level;
- Provision of business intelligence and performance information - regular and timely performance information;
- Provision of performance management capacity supporting review and interpretation of performance information, action planning, improvement, recovery/turnaround and support to facilitate effective performance management developing insight and judgment for robust decision making, and
- Support for Continuous Improvement and building staff capability for improvement and innovation.

Operational directors will have in place arrangements for all staff to;

- Measure, monitor and manage performance, understanding how its translates to corporate performance of the Trust and to
- Contribute to performance improvement and management by being encouraged and supported to identify improvement opportunities and to take the required action.

4.7 Governance Reporting Framework

The governance reporting framework focuses on standards and obligations set for the Trust, the organisational, clinical and social care and the financial governance systems that are in place

The governance reporting framework provides assurance that:

- Minimum standards are met i.e. Controls Assurance Standards, HPSS Quality standards.
- Statutory obligations are met and statutory functions are delivered.
- Effective Risk Management is in place.

The governance reporting framework through the reporting of complaints, serious adverse incidents, findings of independent reviews/inquiries, case management reviews etc provides quality assurance of the performance reported.

4.8 Information Governance

Information governance is concerned with how data, both corporate and clinical is held, obtained, recorded, used and shared. It is vital that a robust framework is in place to support good data management practice.

A Senior Information Risk Owner (SIRO) along with the Medical Director and Director of Children and Young People's Service (Personal Data Guardians) are the Trust leads for ensuring compliance with the Data Protection Act 1998 and the Code of Practice on Protecting the Confidentiality of Service User Information.

Each Directorate with support from the Information Governance Department has developed an Information Asset Register and identified risks in accordance with the Risk Management Strategy and the Department of Health (NI) Information Governance Framework. A Register of Data Access Agreements is held to ensure that sharing of data with third parties complies with Trust policy. In addition, any new services which impact on the processing of personal data is subject to privacy impact assessment.

Compliance with the Freedom of Information Act 2000 and Data Protection Act 1998 is reported on a quarterly basis to the Senior Management Team. Additional legislation and standards which impacts on information governance and record keeping include the Access to Health Records Act 1990 and the Good Management, Good Records Guidance, DHSSPS, 2012.

Protecting personal information and confidentiality are important to ensure that information is appropriately communicated to those who need to know and effectively used to inform decision making. Information should be obtained fairly and efficiently, recorded accurately and reliably, used ethically, held securely and when no longer necessary – archived or destroyed in accordance with appropriated policies and procedures.

It is essential that the reporting frameworks referenced above provide the right information and data, in formats suitable for different users, at the appropriate time and avoid duplication of effort.

The Trust Board will require information that will help formulate strategy, benchmark existing services in terms of safety, quality, cost effectiveness etc, and set measurable objectives and targets. It will seek assurance that the organisation is using appropriate information to performance manage its processes and outcomes and to receive relevant reports on the successful implementation of its strategies and policies and those that comprise response to regulators, the HSC partner organisations and the public.

4.9 Validating the Systems

A systematic approach is needed to ensure that the systems upon which the Trust relies are challenged and tested. The sources of external assurance and system validation are identified in the Board Assurance framework and include for example, the Regulation and Quality Improvement Authority, Internal and External Auditors, Royal Colleges and Professional Councils.

4.10 Compliance with Legislation, Regulations and Standards.

The Trust complies with a number of statutory obligations including those under the Scheme of Delegation.

All Directorates are responsible for ensuring that systems and processes are in place to comply with all relevant regulations and standards relating to their areas of responsibility.

4.11 Statutory Duty of Quality

Quality is at the heart of the Integrated Governance agenda. The Quality Improvement Order in 2003 placed a statutory 'duty of quality' on those organisations responsible for the delivery of health and social care. With this legislation came the requirement to comply with HPSS standards e.g. HPSS Quality standards, Controls Assurance standards and Care Standards. This legislation also extended the range of services to be regulated by the Regulation and Quality Improvement Authority.

The Integrated Governance Framework will ensure that the Trust Board and its Sub Committees are structured effectively and properly constituted.

4.12 The Trust Board and Sub Committees
(see 4.1)

4.13 The Governance Committee is a strategic committee with responsibility to Trust Board for all matters pertaining to Integrated Governance. It is supported by SMT Governance which leads the strategic and operational agenda in relation to risk management and the delivery of safe and effective care.

The Committee is comprised of the Non-Executive Directors with the Chief Executive and other senior staff accountable for the themes identified in this framework in attendance. The remit of this Committee is to ensure that:

- There are effective and regularly reviewed structures in place to support the effective implementation and continued development of integrated governance across the Trust;

- Assessment of assurance systems for effective risk management which provide a planned and systematic approach to identifying, evaluating and responding to risks and providing assurance that responses are effective;

- Principal risks and significant gaps in controls and assurances are considered by the Committee and appropriately escalated to Trust Board;

- Timely reports are made to the Trust Board, including recommendations and remedial action taken or proposed, if there is an internal failing in systems or services;
- There is sufficient independent and objective assurance as to the robustness of key processes across all areas of governance;

- Recommendations considered appropriate by the Committee are made to the Trust Board recognising that financial governance is primarily dealt with by the Audit Committee.

4.14 The Audit Committee is comprised of 5 Non-Executive Directors. Its role is to provide the Trust Board with an independent and objective assurance on the adequacy and effectiveness of internal control systems and that all regulatory and statutory obligations are met. In carrying out its work, the Committee primarily utilises the work of Internal Audit, External Audit and other assurance functions and concentrates on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness

4.15 The Remuneration and Terms of Service Committee is comprised of 2 Non-Executive Directors. This Committee has delegated powers to advise the Trust Board about appropriate remuneration and terms of service for the Chief Executive and other Senior Executives including all aspects of salary, provisions for other benefits and arrangements for termination of employment and other contractual terms.

4.16 The Endowment and Gifts Committee is comprised of 3 Non-Executive Directors, the Director of Acute Services and the designated Director with responsibility for Estates. The role of the Committee is to oversee the administration of Endowment and Gift Funds, their investment and disbursement.

4.17 The Patient and Client Experience Committee is comprised of 4 Non-Executive Directors and 4 members of the Trust's PPI Panel. The role of the Committee is to provide assurance to the Trust Board that the Trust's services, systems and processes provide effective measures of patient/client and community experience and involvement; and to identify opportunities for development to deliver ongoing improvements.

4.18 SMT Governance

A dedicated governance agenda is incorporated into the Senior Management Team meeting schedule every six weeks.

4.19 Accountability and Responsibility arrangements for Governance

Good governance requires all staff to be clear about the functions of governance and their roles and responsibilities and that of others. Clarity of roles also helps all stakeholders to understand how the governance system works and who is accountable for what.

The undernoted section describes the role and responsibilities of the Trust Chair, Non-Executive Directors, Chief Executive, Directors, Operational Governance Leads, Managers, Professionals and Staff in respect of governance arrangements within the Trust.

Trust Chair

The Chair is responsible for leading the Board and for ensuring that it successfully discharges its overall responsibility for the organisation as a whole.

Non-Executive Directors

All Non-Executive Directors are members of the Governance Committee and are responsible for providing the Trust Board with an assurance of the effectiveness of the Trust's governance arrangements. As members of the Governance Committee, they will assure themselves and the Trust Board that the Committee is addressing key governance issues within the Trust and that key issues of concern are being brought to the attention of the Trust Board, as appropriate.

Chief Executive

The Chief Executive is the Accounting Officer of the Trust and has overall responsibility for the effective and efficient management of the Trust and for the quality of health and social care provided. This responsibility encompasses the financial arrangements within the Trust and for the statutory duty of quality, as well as the executive governance arrangements and the Corporate Risk Register. Whilst this overall responsibility is maintained, responsibilities for some aspects of governance have been delegated to executive directors as outlined below.

Lead Director for Clinical and Social Care Governance

The **Medical Director** is the Executive Director with responsibility for strategic leadership for risk management and clinical and social care governance. This role encompasses:

- The effective co-ordination of clinical and social care risk and governance – specifically this relates to the functional areas of patient/client safety, patient/client liaison, litigation, effectiveness and evaluation, risk management and multi-disciplinary research.
- The provision of risk management support to Trust Directors via the clinical and social care governance structures of the medical directorate.
- Clinical and social care governance support for clinicians, nursing staff, social workers and allied health professionals.
- Regional/national initiatives related to clinical and social care governance are addressed and brought to the attention of appropriate staff.
- Regular clinical and social care governance reports/information are brought to the Governance committee (in line with the Governance reporting framework) and the Trust Board.

The **Medical Director** is supported by **the Assistant Director, Medical Directorate and Assistant Director for Clinical and Social Care Governance** who is responsible for the development of systems and processes for risk management, clinical and social care governance. This includes the development of the strategic approach to patient client safety initiatives, patient client liaison (this includes management of complaints and users views), litigation, effectiveness and evaluation (this includes standards, guidelines and audit) and risk management.

Lead Director for Financial Governance

The **Director of Finance** is accountable to the Chief Executive for ensuring that effective processes and systems are in place to ensure good financial governance within the Trust.

Lead Director of Social Work/Social Care Governance

The **Director of Children and Young People's Services (Executive Director of Social Work) is** responsible to the Chief Executive for the

Trust's social work/social care governance arrangements and for the delegation of statutory social care functions and corporate parenting responsibilities.

Lead Director for Nursing and AHP Governance

The **Director of Older People and Primary Care Services** has assumed interim responsibility for ensuring effective governance within the nursing and Allied Health Professions across the Trust.

Assistant Directors of Governance, Workforce Development and Training - AHPs, Nursing and Social Work – are responsible for providing assurances that the respective professional managers for AHPs, Nursing and Social Work have robust arrangements in place to achieve high standards of governance for their respective professions. This will include monitoring, evaluating and reporting on the quality of practice and service; providing expert advice on rules, standards and legislation pertaining to their respective professional groups.

The role also incorporates driving education and workforce development to facilitate service modernisation and building a competent and flexible professional workforce. They are responsible for ensuring integration of professional governance across all relevant directorates.

Lead Director for Information Governance

The **Director of Performance and Reform** is the Trust's Senior Information Risk Owner (SIRO) who along with the Medical Director and Director of Children and Young People's Services (Personal Data Guardians), are the Trust leads for ensuring compliance with the Data Protection Act 1998 and the Code of Practice on Protecting the Confidentiality of Service User Information.

Operational Directors

The Director of Performance and Reform is accountable to the Chief Executive for ensuring that the Trust operates sound systems of operational performance. The Director has a lead role in ensuring organisational progress against the Trust's objectives, is responsible for the performance framework, the reform agenda, for ensuring that there are proper systems in place for the maintenance and safe management of information, records and information and communications technology.

The **Director of Primary Care and Older People** is the lead director responsible for the strategic development of patient/client, carer and community engagement, in order to ensure the voice of users informs strategic and local planning and implementation of services across all programmes of care.

The **Director of Acute Services** has responsibility for ensuring that systems and structures are in place to meet all professional and clinical obligations in relation to the acute hospital services workforce. The Director of Acute services is the Trust wide lead director responsible for environmental cleanliness standards in Trust facilities.

The Director of Mental Health and Disability is responsible for ensuring the strategic development and operational management of mental health and disability services throughout the Southern Trust.

The **Director of Human Resources and Organisational Development** is responsible for ensuring that proper systems are in place throughout the Southern Trust for managing human resources, in line with statutory requirements and reporting to the Trust Board on results of audit, quality control and assurance functions in relation to human resources. The Director is responsible for the Trust wide management of the Southern Trust Estate and Health and Safety.

The **Director of Pharmacy** is responsible for medicines governance within the Trust, by ensuring that systems are in place to appropriately address all aspects of the safe and secure handling of medicines and reports directly to the Director of Acute services for this purpose. The Director of Pharmacy, in the role of superintendent pharmacist, is responsible for ensuring that services provided by the pharmacy meet the relevant professional standards.

The Board Assurance Manager is responsible for managing the administrative arrangements for the Trust Board, standing committees of the Board and establishing procedures for sound governance of the Trust. This includes the development of the Board Assurance Framework, the Corporate Risk Register the annual cycle of reporting to the Board and ensuring the appropriate completion of the Controls Assurance Standards to support the embedding of organisation wide risk management.

5.0 OPERATIONAL ARRANGEMENTS FOR GOVERNANCE

As outlined in section 1.0, the Trust Board approved new structures for Clinical and Social Care Governance.

Operational Governance Arrangements

Operational Directorate Governance Foras are responsible for considering all aspects of the Trusts Model of Integrated Governance (figure 1)

Directorates are supported with this function by the Clinical and Social Care Governance (CSCG) Co-coordinators and Governance Officers aligned to each of the directorates. Directorate Governance Foras meet monthly and are reflective of all specialty interests/service areas across Directorates/Divisions.

Membership of Directorate Governance Foras should be drawn from (though not limited to) Associate Medical Directors, Clinical Directors, Assistant Directors, Heads of Service and the Clinical and Social Care Governance (CSCG) Coordinators and Governance Officers aligned to the Directorates of Acute, Children & Young People, Older People & Primary Care and Mental Health & Disability, as appropriate.

Professional Governance Leads (Assistant Directors of Professional Governance – Nursing, AHPs and Social Work) and the Assistant Director of Clinical and Social Care Governance feed organisational and directorate intelligence on the areas set out in figure 1 of this framework.

Within the context of this framework, the Directorate Governance Foras consider all aspects of the Trusts Model of Integrated Governance and formulate Directorate Governance plans using the organisational intelligence available to them via the following information flows:

- Clinical and Social Care Governance
- Professional Governance
- Performance and reform
- Information Governance
- Financial Governance
- Patient Experience

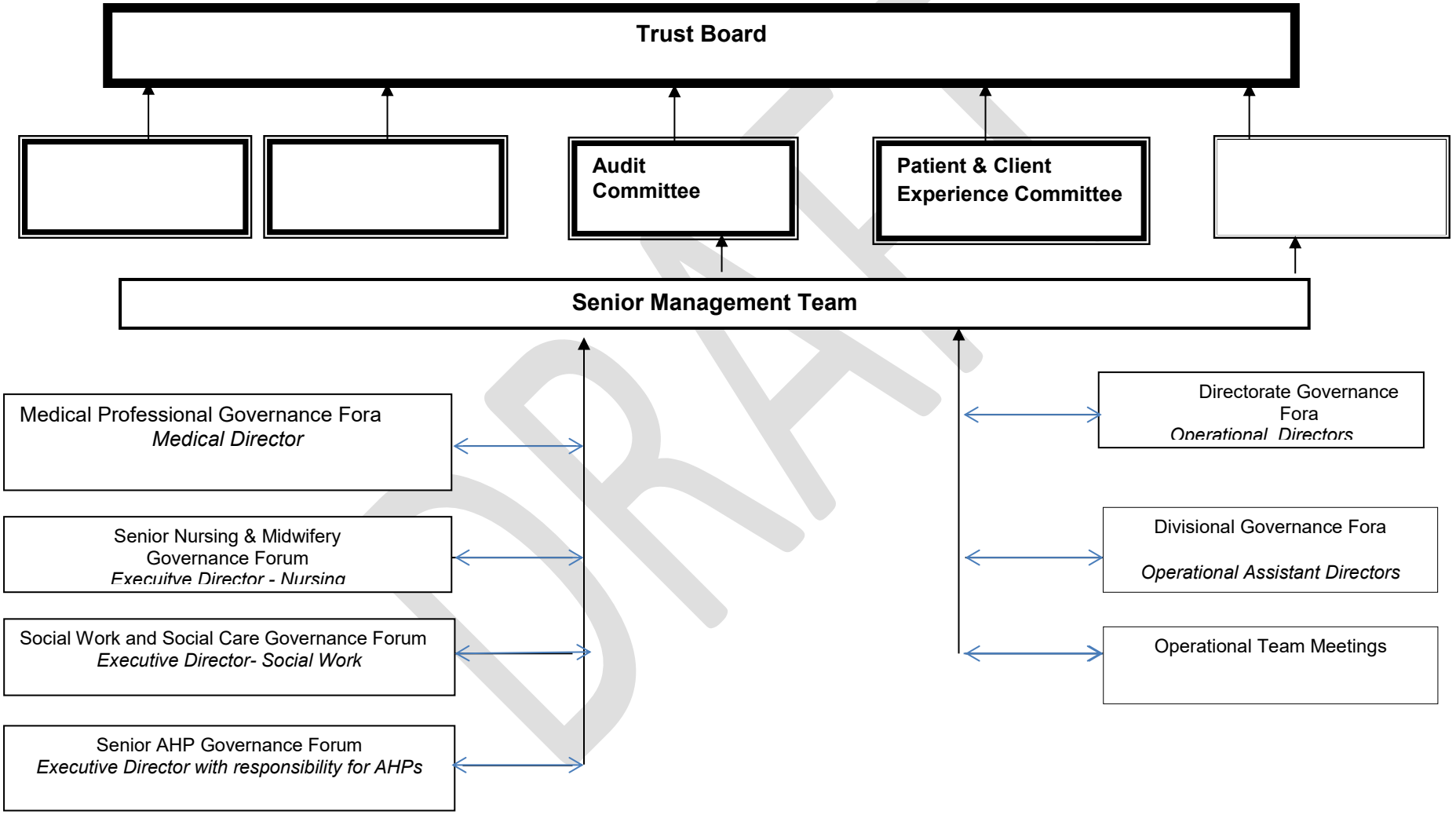
Any aspects of the Directorate Governance Plans that present risk in respect of Patient Safety or Quality which cannot be managed at Directorate level and/or may require consideration in respect of addition to the Corporate Risk Register to the Senior Management Team by the appropriate Director

All **Managers** must ensure that activities within their area of responsibility are assessed for risk and that any identified risk is eliminated or controlled. Where this is not possible, the manager must ensure that the assistant director to whom they are accountable is informed. They are also responsible for ensuring that staff are adequately inducted, informed and trained in order to undertake their duties effectively and safely. Managers are responsible for ensuring that procedures for adverse incident reporting are adhered to.

Each member of staff is responsible for providing each patient and client with the highest possible quality of service and for taking appropriate actions to promote patient and staff safety by minimizing risk. There is an onus on each staff member to comply with safe systems of working and to report any adverse incidents, including accidents and near misses. Everyone has a responsibility to continuously improve the quality of service that they provide to patients and clients throughout the Southern Trust.

Figure 2

High Level Governance Structure



1.0 INTRODUCTION

Throughout the modules on the Corporate Governance course, each of the perspectives on governance highlighted the importance of the collective role of the Board in ensuring high standards of good governance practice. This is particularly important in the context of the current economic climate and the increased focus on the effectiveness and safety of health and social care services. As the governing body of the organisation, Board members have a crucial role to play in ensuring that the organisation is run efficiently and effectively and that resources are invested in a way that delivers optimal outcomes and high quality services.

This project is based on a review of the Southern Health and Social Care Trust Board's effectiveness which covered a whole range of the Board's activities. Whilst recognising the importance of all of the Board's activities, the project focuses primarily on how the Board currently fulfils its function, what it does well and what challenges it. Quantitative research was undertaken in 2007 at the inception of the Trust and again in 2011 in the form of two questionnaires. The contributions of all Board members were sought both in terms of their own role and that of others. These included assessment questions around core business; strategy and leadership; trust and support; contribution and execution and engagement with stakeholders. The responses were analysed to determine how effective the Board is in practice and to identify areas for development and further improvement.

2.0 BACKGROUND

2.1 Establishment of the Trust

The Southern Health and Social Care Trust (the Trust) is a statutory body which came into existence on the 1st April 2007 under the Southern Health and Social Services Trust Establishment Order (Northern Ireland) 2006. It is responsible for providing health and social care services to a population of 358,647 million across the council areas of Armagh, Banbridge, Craigavon, Dungannon and South Tyrone and Newry and Mourne. The Trust employs approximately 13,300 staff and incurred expenditure of £543 million in 2011/12.

3.0 CONTEXT

The Trust spends nearly £1.43 million per day delivering services to local people. High standards of service delivery, governance and accountability are expected by the public and all aspects of Trust business are closely monitored. Trust Board members are collectively responsible for ensuring that the organisation has a secure financial position and meets its financial targets.

The health and social care needs of people living in the Southern area are changing – people are living longer, their expectations of services are rightly high, demand for services is increasing and the costs of care are rising. It is therefore a constant challenge for the Trust to balance the needs of its service users with the need to achieve financial balance within a difficult financial environment. Despite the challenges, the Trust Board remains committed to the corporate objectives of the Trust (Appendix I).

In the coming months and years, the scale and pace of transformation required in 'Transforming Your Care: A Review of Health and Social Care' (TYC) will demand leadership by a highly effective Board. This strategy will result in a significant shift in the way services are provided across hospitals and the community and for the Board will mean producing a clear strategic direction, ensuring accountability and driving a culture of quality, safety and high performance to ensure stakeholder confidence. These changes will take place within an environment of substantial political and public interest in the delivery of health and social care services and greater accountability for outcomes. Alongside this, there is the demand to do more with less with Boards having to take decisions in a context of uncertainty that good governance systems and effective risk management. Whilst this project aims to evaluate how effective the Board is in practice, it will also seek to establish if the Board is not only 'fit for purpose', but also 'fit for the future.'

4.0 COMPOSITION, ROLES AND RESPONSIBILITIES

4.1 Composition of the Membership of the Trust Board

The composition and membership of the Board is defined by the Membership, Procedure and Administration Arrangements Regulations and is as follows:

- Chairman (Appointed by the DHSSPS Public Appointments Unit)
- 7 Non-executive members (Appointed by the DHSSPS Public Appointments Unit)
- 5 Executive members – Chief Executive; Director of Finance; Medical Director; Director of Nursing and Director of Social Work

In addition to the members listed above, other members of the senior management team are in attendance and are as follows:-

- Director Acute Services
- Director of Human Resources and Organisational Development
- Director of Performance and Reform
- Director of Older People and Primary Care Services

With 17 Directors present at Board meetings, this enables efficient and effective communication, debate and decision-making.

4.2 Roles and Responsibilities of Members

The main purpose of a Board of a public body is to provide effective leadership, direction, support and guidance to the organisation and to ensure that the policies and priorities of the Minister are implemented. The Board's role is to function as a corporate decision-making body, with executive and non-executive members acting as full and equal members. As the governing body of the organisation, it has seven key objectives for which it is accountable to the Department of Health, Social Services and Public Safety (DHSSPS):-

1. Sets the strategic direction of the Trust
2. Monitors performance against objectives
3. Ensures effective financial stewardship
4. Ensures that high standards of corporate governance and personal behaviour are maintained
5. Appoints, appraises and remunerates Senior Executives

6. Ensures that there is effective dialogue on its plans and performance between the Trust and the local community
7. Ensures robust and effective arrangements are in place for clinical and social care governance and risk management

Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions and a Management Statement and Financial Memorandum are in place to enable the Board to discharge its responsibilities effectively.

4.3 Integrated Governance

Corporate governance is defined in the Cadbury Report as: 'the system by which organisations are directed and controlled'. The CIPFA Good Governance Standard for Public Services sets out six core principles of good governance for public bodies:

1. Focus on organisation's purpose and outcomes
2. Performing effectively in clearly defined functions and roles
3. Promoting values
4. Taking informed, transparent decisions and managing risk
5. Developing the capacity and capability of the governing body
6. Engaging stakeholders and making accountability real

The Trust Board has been committed to integrating governance from the inception of the Trust and by applying these principles is thereby able to effectively discharge all of its statutory duties and set strategic direction. The Integrated Governance Framework brings overall coherence to the Board's exercise of the various component parts of governance. A key component of Integrated Governance is whole board development.

5.0 REVIEW OF BOARD PERFORMANCE

Board evaluation provides valuable feedback for improving Board effectiveness and highlights areas for further development. Research undertaken by the NHS Federation 'Effective boards in the NHS' identified four main characteristics that interviewees believed made a board effective:

- Strategic decision-making
- Trust and cohesion
- Constructive challenge
- Effective board processes

The following aspects of Board performance have been used to develop a robust framework to help NHS chairs reflect upon how well they and their Boards as a whole are doing:-

- Clarity of Board purpose and activities
- Board members understanding their individual roles and responsibilities
- The quality and quantity of information presented to the Board, and the ability of Board members to understand this information
- Positive working relationship, especially between Non-Executive and Executive Directors
- Degree and nature of challenge at Board level, including Executives challenging Non-Executives and other Executives
- Clear lines of accountability
- Effective decision making processes

The Southern Health and Social Care Trust Board adapted the framework published by the NHS Clinical Governance Support Team and NHS Institute for Innovation and Improvement, adapting it to the context of the Southern Trust.

5.1 Board Review Tools and Review Process

Two questionnaires were used to review Board Effectiveness, these included:

5.2 Board Meeting Review

I designed and analysed this questionnaire (Appendix II) which was issued to all members attending the Board meetings held between April 2011 and September 2011. It focused on the following areas.

- Atmosphere
- Agenda
- Member engagement
- Challenging
- Balance of time on strategic/operational and governance matters
- What went well
- Chairmanship
- What would improve the meeting
- Expectations

This questionnaire also included assessment questions on the quality of Board agenda items.

Key points to note from the analysis were that the atmosphere at Board meetings was described by members as energetic, productive and honest. There was a good balance of strategic versus operational matters and a satisfactory balance of time spent between strategic, operational and governance agenda items. There were good levels of member engagement and the challenging was described as constructive, but was mainly from the Non Executive Directors. Meetings were well chaired with appropriate time allowed for questions/challenge.

5.3 Chair and Board Review Tool

This questionnaire (Appendix I) focused on 4 key areas (with 8 questions on each area) as follows:

- Focus on core business
- Trust and support
- Contribution and execution
- Engagement with stakeholders

When evaluating if a Board is fit for purpose, the contributions of all Board members need to be reviewed. This questionnaire was therefore completed by all members in attendance at the Board meetings in 2007 and 2011.

The analysis of some of the results of the questionnaires is outlined in section 5.4 below. Overall, the results demonstrated an improvement in the Board's performance from 2007 to 2011 across all domains. This provides assurance that the Board has evolved and became more effective since its inception in 2007.

5.4 Analysis

The following section presents some of the results of the questionnaires against the four key characteristics of an effective Board. The graphs present the comparisons between responses in 2007 compared with responses in 2011.

5.4.1 Core Business/Strategic decision-making

A key objective of the Trust Board is setting and overseeing the strategic direction of the Trust. The Trust Board has a vision for the key priority areas the Trust should focus on to deliver efficiencies and sustain safe, quality care. During 2011/12, the Board gave consideration as to how these objectives could be progressed and agreed some guiding priorities for 2011 – 2015. These will be subject to annual review.

Expectations of public services continue to rise and the Board needs to ensure this informs strategic choices. As part of ICSA's Mapping the Gap research into NHS governance best practice, respondents were asked what they believed contributed to an effective board. Nearly half of the respondents (49%) thought that the most important aspect for a board to govern effectively was to focus on strategic decision-making.

A5. Is at least one third of the Board's time is spent looking to the future of the organization?

Overall Comparisons 2007 – 2011

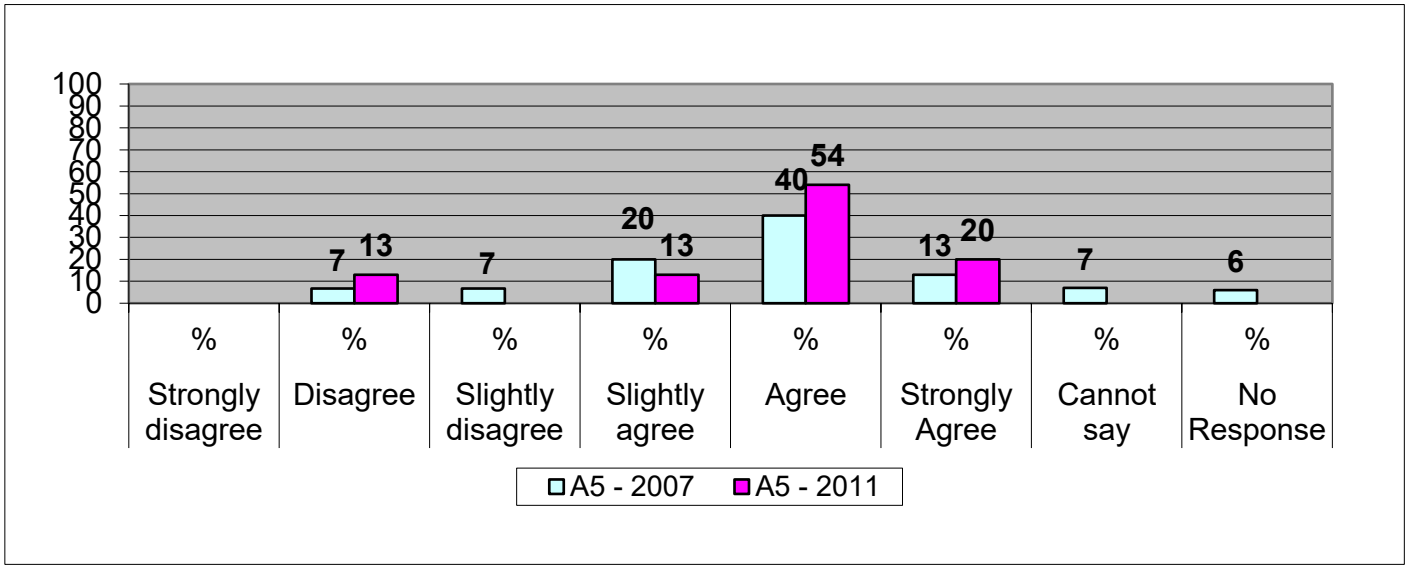


Fig 1.

The results in Figure 1 illustrate the range of views in relation to the Board's time spent looking to the future of the organisation. In 2007, 53% of Board members agreed/strongly agreed with the above statement. In 2011 this had increased to 74%.

During 2011/12, the Trust Board held a number of workshops to explore strategic issues and plan service development.

5.4.2 Trust and Support

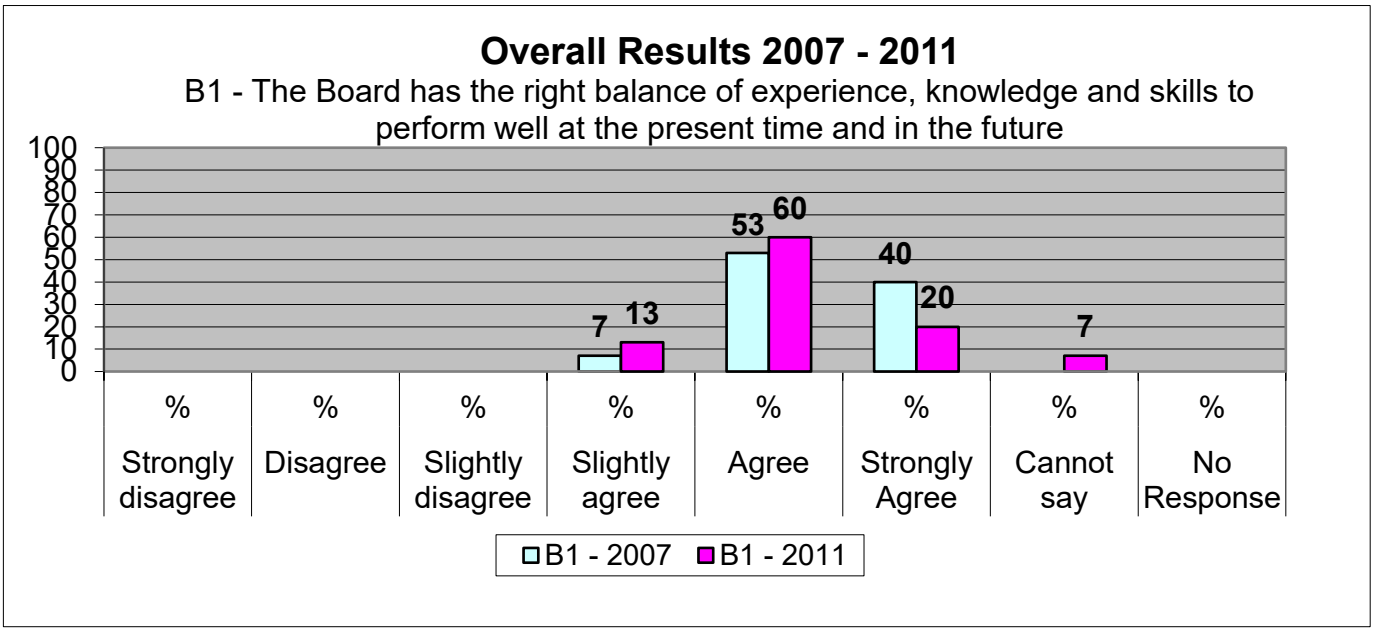


Fig 2

The results in Figure 2 illustrate that in 2007, 93% of the Directors agreed/ strongly agreed that the Board had the right balance of experience, knowledge and skills to perform well at that time and in the future. In June 2011, this had reduced to 80%. This may have been due to increased knowledge/experience and changed context e.g. the tougher financial challenge). However, also at that time in 2011, the full Board complement was not in place as the appointment of some new members was awaited. Following their appointments, new Board members undertook a comprehensive formal induction programme and this was also extended to other initiatives such as mentoring. On an ongoing basis, members are given access to training and development opportunities.

5.4.3. Constructive challenge

In the Financial Reporting Council's Guidance on Board Effectiveness (March 2011) it states: '*An effective Board should not necessarily be a comfortable place. Challenge, as well as teamwork, is an essential feature.'* Ensuring robust and appropriate challenge depends on a number of factors being in place, not least the right information in the right format in advance of the meeting; good chairmanship; appropriate boardroom behaviours and the encouragement of a culture where challenge is accepted.

Degree and nature of member engagement and challenge at Board level

Was the challenging, constructive, overdone, underdone, shared, left to a few or mostly NEDs?

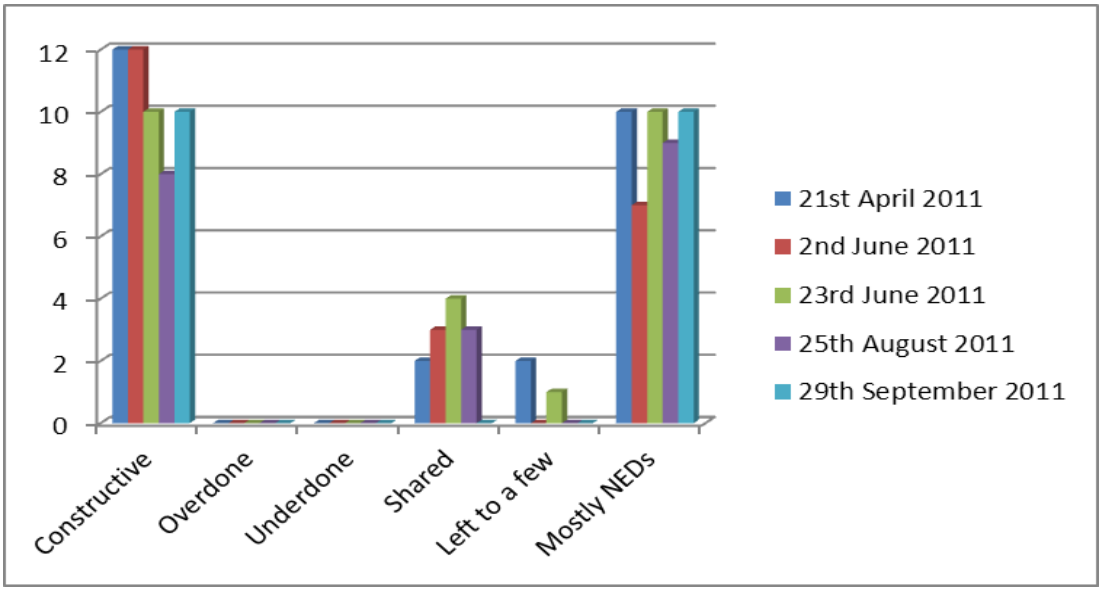


Fig 3.

This illustrates that the challenging at Board meetings was described as constructive and shared, but mainly from the non executive directors. Executive Directors robustly challenge each other at Senior Management Team meetings and achieve an agreed position on most issues which reduces the challenge at Board meetings. The Executive professional roles (Medical; Nursing and Social Work) ensure executive challenge as these posts are designed to give

independent professional assurance to Trust Board.

Through learning from the Corporate Governance course on the importance of debate and challenge, I developed a template to accompany reports to Trust Board. Directors are required to focus their presentation of the report under specific headings which helps focus the Board on meaningful discussion. This template also provides the opportunity for the challenge by the Senior Management Team to a particular proposal/report to be described.

5.4.3 Effective Board processes

The Board is accountable to the Minister, the DHSSPS, the public and stakeholders for the quality and safety of Trust services.

In order to ensure effective accountability, the Trust Board established 5 Standing Committees i.e. Audit, Remuneration, Governance, Endowments and Gifts and Patient and Client Experience Committee. Membership is comprised Non Executive Directors with Directors in attendance. All Board Committees are chaired by a Non Executive Director. Sufficient time is allowed at Trust Board meetings for Committee Chairs to report back to the Board. Chairs of the Standing Committees evaluate their respective Committees on an annual basis.

To assess performance and quality, Board members have adopted a more interactive style beyond the Board meeting. To ensure this insight is used in the Board process, I designed a proforma for walkabouts/ward visits which are a direct process of engagement where Board members step outside the Boardroom to gain firsthand experience of the staff and user experience. Any issues identified are escalated to the Chief Executive who in turn addresses them with the relevant Director and assurance is provided back to the Chair and the Non Executive that remedial action has been taken to address concerns. This process also enables Board member to offer appreciation and encouragement where performance is excellent.

i) How the Board conducts its business

The Trust Board holds its meetings in public, normally on the fourth Thursday of each month. Meetings are widely publicised through the press and the Trust website. Meetings are held in public to afford openness and transparency and the information

discussed and decisions taken are therefore in the public domain. Attendance by the public is encouraged and the meetings are held at various locations throughout the Trust to facilitate public attendance. Agenda and papers are accessible on the Trust website so that everyone can keep a close eye on how the Trust is performing. There are normally eight formal Trust Board meetings and four Board Workshops held per year.

ii) Effective Board Meetings

Effective forward planning for Board meetings enhances Board effectiveness and productivity. I developed an Annual Board calendar of meetings and agenda topics. Whilst this ensures a sufficient degree of forward planning, this is balanced with flexibility to accommodate changing priorities. I meet with the Chair prior to each meeting to agree the agenda, thus ensuring that all relevant items are brought to the Board's attention.

Quality is a core part of Board meetings and is a standing agenda item as well as being an integrated element of all major discussions and decisions. The agenda comprises strategic, operational, quality and performance items. Each agenda item has a time allocation to ensure that there is sufficient time for discussion and debate. Operational and patient safety and quality of care items are rotated to ensure equal priority. Time is also allowed for the Board to reflect on innovative practice in relation to quality improvement.

iii) Effective Chair

An effective Board requires the effective discharge of the Chair's responsibilities. The role of the Chair is of paramount importance and creates the conditions for the overall board and individual Director effectiveness. The Chair is responsible for leading the Board and for ensuring that it successfully discharges its overall responsibility for the organisation.

The Chair's relationship with the Chief Executive is a key relationship that will help the Board to be more effective. In the Southern Trust, there is clarity between their respective roles as defined in the Trust's Management Statement.

Feedback from the Board Meeting Review Questionnaire evidenced that the Chair demonstrates strong, consistent and effective leadership.

To be an effective Board, it is not only important to have the right structures and processes in place, but individual Board members have a responsibility to demonstrate the highest standards of behaviour. In the Report on Corporate Governance in Financial Institutions prepared by Sir David Walker, it states '*principle deficiencies in …… boards related much more to patterns of behaviour than the organisation*.' This highlights the importance of regular evaluation of a Board's performance. The Chair of the Southern Trust conducts an annual evaluation of Board performance and views it as a positive tool to encourage development and further improvement.

To ensure that public service values remain at the heart of the Health and Personal Social Services, Trust Directors are required to subscribe to Codes of Conduct and Accountability for HPSS Boards. At the outset, the Chair introduced a range of good practices including the way members should interact and work together to promote the organisation's vision, its culture and its values. The Chair also introduced a 'best approach' framework to ensure that the Board and its Standing Committees are conducted in a manner that accommodates and reflects a large and complex agenda and the increased scrutiny of decision making by public bodies.

iv) Effective Board Support

The Southern Trust has a Board Assurance Manager in place whose responsibilities include:-

- Developing and agreeing an agenda for Board meetings with the Chair
- Ensuring good communication flows within the Board and its Standing Committees and between the Senior Management Team and the Non Executive Directors
- Ensuring the Board follows due process
- Advising the Board, through the Chair, on governance matters
- Recording Board decisions accurately and ensuring action points are followed up
- Board Development
- Production of Board Assurance Framework

v) Engagement with Stakeholders

An effective Board gives priority to engaging with key stakeholders, both internal and external to the organisation. Engaging effectively is an important way for the Board to demonstrate its openness and transparency and ultimately its accountability. A Public Affairs Strategy is in place to ensure effective relationships with elected representatives.

The Trust recognises the importance of engagement with stakeholders and the Chair, Chief Executive and members of the senior team have arranged specific meetings with interested groups to consult/engage on topics where there are differences of opinion. These meetings are held separate to a formal Trust Board meeting.

The Trust Board established a sub Committee known as the Patient and Client Experience Committee. The information presented to the Committee provides assurance that the Trust's services, systems and processes provide effective measures of patient/client and community experience and involvement. The Committee is also responsible for identifying opportunities for development to deliver ongoing improvements in those areas impacting on the user experience of care.

6.0 CONCLUSIONS

The Board Effectiveness review provides assurance that the Southern Health and Social Care Trust Board is effective in fulfilling its role as a public body. Its vision for the organisation is clearly articulated through its strategic plan and corporate priorities and the Board takes appropriate steps to assure itself that the organisation can deliver on its strategic priorities. Despite Board members' desire to be more strategic, full and complex agendas, imposed by operational matters, can often prevent this. Following the Board meeting review analysis, agendas have since been reviewed to ensure strategic focus.

The Board is composed of motivated individuals who work collectively to help deliver its strategic intent. Members carry out their corporate responsibilities and work constructively together in a climate characterised by informed trust, involvement and robust dialogue.

The Board is led by a Chair who demonstrates strong, consistent and effective leadership.

The Board is clear about who its stakeholders are and proactively engages with all of them to ensure that their interests are taken into account in developing and delivering services.

7.0 RECOMMENDATIONS

i) New Board members to continue to develop their skills as Board members
ii) Chair to continue to encourage robust and appropriate challenge
iii) Board members to continue to meet with interested groups to consult/engage on contentious topics prior to Public Board meetings
iv) Frequency of meetings to be reviewed. Additional workshops to consider strategy and 'important matters of the day'
v) Interviews with a cross section of Board members to provide more contextual data to broaden understanding of what Board does well and what challenges it
vi) External evaluation of Board performance every 3 years as a means of adding value by introducing a fresh perspective and new ways of thinking.

The Chair and Chief Executive have considered the findings and recommendations of the Board review. An action plan will be developed summarising the issues/areas identified for development and/or improvement.

8.0 REFERENCES

Effective Boards in the NHS? – The NHS Confederation

Report on Corporate Governance in Financial Institutions – Sir David Walker

CIPFA Good Governance Standard for Public Services

ICSA's 'Mapping the Gap' Research

Financial Reporting Council's Guidance on Board Effectiveness (March 2011)

Judt, Sandra

From: Judt, Sandra [redacted]
Sent: 16 April 2015 12:17
To: Brownlee, Roberta; Mrs D Blakely; Graham, Edwin; Kelly, Hester; Mahood, Elizabeth; Mullan, Raymond; Rooney, SiobhanNED; Clarke, Paula
Cc: Comac, Jennifer; McLoughlin, Sandra E
Subject: MinutePad training

In order to improve the ability to work paperless at both Trust Board and Committee meetings, we are implementing a software product 'MinutePad'.

A training session on the system for both SMT and Non Executive Directors is being arranged for Wednesday, 22nd April 2015 at 1.30 p.m. – 2.30 p.m. in the Boardroom, Trust HQ.

I would be grateful if you would advise me of your availability to attend by return please.

Thanks

Sandra Judt
Board Assurance Manager
SH&SCT
Trust Headquarters
68 Lurgan Road
Portadown
Craigavon
BT63 5QQ
Tel: [redacted]
Email: [redacted]

You can follow us on Facebook and Twitter

Judt, Sandra

From: Judt, Sandra [redacted]
Sent: 03 December 2020 13:44
To: OKane, Maria; McClements, Melanie
Cc: Wallace, Stephen; Stinson, Emma M
Subject: Trust Board confidential agenda item on 10.12.2020
Attachments: Item 6. Confidential TB Update - Urology.docx

Grateful if you would arrange for attached paper to be updated and returned to myself by **lunchtime on Monday, 7th December 2020** please for inclusion in the Trust Board confidential papers.

Thanks

Sandra

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

Tel: [redacted]
Email: [redacted]

Southern Health and Social Care Trust

Quality Care - for you, with you

'YOUR RIGHT TO RAISE A CONCERN'

(WHISTLEBLOWING)

SOUTHERN HSC TRUST
POLICY ON RAISING CONCERNS

Lead Policy Author & Job Title:	Regional HSC Policy
Directorate responsible for document:	HR & Organisational Development
Issue Date:	01 April 2018
Review Date:	01 April 2021

Policy Checklist

Policy name:	'Your Right to Raise a Concern' (Whistleblowing)
Lead Policy Author & Job Title:	Head of Employee Relations
Director responsible for Policy:	Vivienne Toal
Directorate responsible for Policy:	HR & Organisational Development
Equality Screened by:	Lynda Gordon, Head of Equality, Sarah Moore, HR Manager and Lesley Dowey, HR Advisor on 03/01/2018
Trade Union consultation?	Yes ☒ No ☐
Policy Implementation Plan included?	Yes ☐ No ☒
Date approved by Policy Scrutiny Committee:	
Date approved by SMT:	
Policy circulated to:	Directors, Assistant Directors, Heads of Service for onward distribution to line managers/staff, Global email, Staff Newsletter
Policy uploaded to:	SharePoint and Trust Intranet

Version Control

Version:	**Version 1_0**		
Supersedes:	N/A		
Version History			
Version	**Notes on revisions/modifications and who document was circulated or presented to**	**Date**	**Lead Policy Author**
N/A	N/A	N/A	N/A

Contents

1. Introduction

All of us at one time or another may have concerns about what is happening at work. The Southern Health & Social Care Trust (the Trust) wants you to feel able to raise your concerns about any issue troubling you with your managers at any time. It expects its managers to listen to those concerns, take them seriously and take action to resolve the concern, either through providing information which gives assurance or taking action to resolve the concern. However, when the concern feels serious because it is about a possible danger, professional misconduct or financial malpractice that might affect patients, colleagues, or the Trust itself, it can be difficult to know what to do.

The Trust recognises that many issues are raised by staff and addressed immediately by line managers – this is very much encouraged. This policy and procedure is aimed at those issues and concerns which are **not resolved, require help to get resolved or are about serious underlying concerns.**

Whistleblowing refers to staff reporting suspected wrongdoing at work, for example, concerns about patient safety, health and safety at work, environmental damage or a criminal offence, such as, fraud.

You may be worried about raising such issues and may think it best to keep it to yourself, perhaps feeling it is none of your business or that it is only a suspicion. You may also feel that raising the matter would be disloyal to colleagues, to managers or to the organisation. It may also be the case that you have said something but found that you have spoken to the wrong person or raised the issue in the wrong way and are not sure what to do next.

Remember that if you are a healthcare professional you may have a professional duty to report a concern. **If in doubt, please raise it.**

2. Aims and Objectives

The Trust is committed to running the organisation in the best way possible. The aim of the policy is to promote a culture of openness, transparency and dialogue which at the same time:

- reassures you that it is safe and acceptable to speak up;
- upholds patient confidentiality;
- contributes towards improving services provided by the Trust;
- assists in the prevention of fraud and mismanagement;
- demonstrates to all staff and the public that the Trust is ensuring its affairs are carried out ethically, honestly and to high standards;
- provides an effective and confidential process by which you can raise genuine concerns so that patients, clients and the public can be safeguarded.

The Trust's roles and responsibilities in the implementation of this policy are set out at **Appendix A.**

3. Scope

The Trust recognises that existing policies and procedures which deal with conduct and behaviour at work (Disciplinary Procedure, Grievance Procedure, Maintaining High Professional Standards Framework, Conflict, Bullying & Harassment Policy, Complaints Procedure and the Accident/Incident Reporting Procedure) may not always be appropriate to extremely sensitive issues which may need to be handled in a different way.

This policy provides a procedure for all staff of the Trust, including permanent, temporary and bank staff, staff in training working within the Trust, independent contractors engaged to provide services, volunteers and agency staff who have concerns where the interests of others or of the organisation itself are at risk. **If in doubt - raise it!**

Examples may include:

- malpractice or ill treatment of a patient or client by a member of staff;

- where a potential criminal offence has been committed, is being committed or is likely to be committed;
- suspected fraud;
- breach of Standing Financial Instructions;
- disregard for legislation, particularly in relation to Health and Safety at Work;
- the environment has been, or is likely to be, damaged;
- a miscarriage of justice has occurred, is occurring, or is likely to occur;
- showing undue favour over a contractual matter or to a job applicant;
- research misconduct; or
- information on any of the above has been, is being, or is likely to be concealed.

If you feel that something is of concern, and that it is something which you think the Trust should know about or look into, you should use this procedure. If, however, you wish to make a complaint about your employment or how you have been treated, you should follow the Trust's Grievance procedure, Harassment at Work procedure or Working Well Together procedure which can be obtained from your manager. This policy complements professional and ethical rules, guidelines and codes of conduct and freedom of speech. It is not intended to replace professional codes and mechanisms which allow questions about professional competence to be raised. (However such issues can be raised under this process if no other more appropriate avenue is apparent).

4. Suspected Fraud

If your concern is about possible fraud or bribery the Trust has a number of avenues available to report your concern. These are included in more detail in the Trust's Anti-Fraud Policy & Fraud Response Plan and Anti-Bribery Policy and are summarised below.

Suspicions of fraud or bribery should initially be raised with the appropriate line manager but where you do not feel this is not appropriate the following officers may be contacted:

- Director of Finance, Procurement & Estates
  Ms Helen O'Neill

- Fraud Liaison Officer (FLO)
  Mrs Fiona Jones

Employees can also contact the regional HSC fraud reporting hotline on Personal Information redacted by the USI or report their suspicions online to Personal Information redacted by the USI These avenues are managed by Counter Fraud and Probity Services (CFPS) on behalf of the HSC and reports can be made on a confidential basis.

The Trust's Fraud Response Plan will be instigated immediately on receipt of any reports of a suspicion of fraud or bribery.

The prevention, detection and reporting of fraud and 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 and third parties to perform their duties impartially, honestly, and with the highest integrity.

5. Our Commitment to You

5.1 Your safety

The Trust Board and Senior Management Team, the Chief Executive, managers and the trade unions/professional organisations are committed to this policy. If you raise a genuine concern under this policy, you will not be at risk of losing your job or suffering any detriment (such as a reprisal or victimisation). The Trust will not tolerate the harassment or victimisation of anyone who raises a genuine concern.

The Trust expects you to raise concerns about malpractices. If any action is taken that deters anyone from raising a genuine concern or victimises them, this will be viewed as a disciplinary matter.

Provided you are acting in good faith, it does not matter if you are mistaken or if there is an innocent explanation for your concerns, you will be protected under the

law. However, it is not uncommon for some staff to maliciously raise a matter they know to be untrue. In cases where staff maliciously raise a matter they know to be untrue, protection under the law cannot be guaranteed and the Trust reserves the right to take disciplinary action if appropriate.

5.2 Confidentiality

With these assurances, the Trust hopes that you will raise concerns openly. However, we recognise that there may be circumstances when you would prefer to speak to someone in confidence first. If this is the case, you should say so at the outset to a member of staff in Human Resources.

The Trust is committed to maintaining confidentiality for everyone involved in a concern. This includes the person raising the concern and the person(s) whom the concern is about. Confidentiality will be maintained throughout the process and after the issue has been resolved.

If you ask for your identity not to be disclosed, we will not do so without your consent unless required by law. You should however understand that there may be times when we will be unable to resolve a concern without revealing your identity, for example, where personal evidence is essential. In such cases, we will discuss with you whether and how the matter can best proceed.

5.3. Anonymity

Remember that if you do not disclose your identity, it will be much more difficult for us to look into the matter. It will also not be possible to protect your position or give you feedback. So, while we will consider anonymous reports in the exact same manner as those which are not anonymised, these arrangements are not best suited to deal with concerns raised anonymously.

If you are unsure about raising a concern you can get independent advice from Protect (see contact details under Independent Advice).

6. Raising a concern

If you are unsure about raising a concern, you can get independent advice at any stage from your trade union/professional organisation, or from one of the organisations listed in Section 7. You should also remember that you do not need to have firm evidence before raising a concern. However, you should explain as fully as possible the information or circumstances that gave rise to the concern.

6.1 Who should I raise a concern with?

Option 1: In many circumstances the easiest way to get your concern resolved will be to raise it with your line manager (or lead clinician or tutor). But where you do not think it is appropriate to do this, you can use any of the other options set out below.

Option 2: If raising it with your line manager (or lead clinician or tutor) does not resolve matters, or you do not feel able to raise it with them, please raise the matter with another senior person you can trust. This might be another manager / professional lead or a Senior HR representative and again you may wish to involve a Trade Union representative or colleague.

The Deputy Director of HR Services, Mrs Siobhan Hynds is the designated HR representative for Raising Concerns

If exceptionally, the concern is about the Chief Executive, then it should be made (in the first instance) to the Chair, who will decide on how the investigation will proceed.

Option 3: If you still remain concerned after this, you can contact:

- Mrs Vivienne Toal - Director of Human Resources & Organisational Development who is the lead director for Raising Concerns
- Dr Maria O'Kane - Executive Medical Director
- Mrs Heather Trouton – Interim Executive Director of Nursing, Midwifery & AHPs
- Mr Paul Morgan – Executive Director of Social Work
- Mrs Helen O'Neill – Executive Director of Finance, Procurement & Estates

- Mr John Wilkinson – Lead Non-Executive Director for Raising Concerns on Trust Board – contactable through the Office of the Chair, Trust HQ.

All these people are required to receive training in dealing with concerns and will give you information about where you can go for more support.

Option 4: If for any reason you do not feel comfortable raising your concern internally, you can raise concerns with external bodies (see paragraph 7 below).

6.2 Independent advice

If you are unsure whether to use this policy, or if you require confidential advice at any stage, you may contact your trade union/professional organisation.

Advice is also available through the independent charity, Protect (formerly Public Concern at Work (PCaW)) on 020 3117 2520.

6.3 How should I raise my concern?

You can raise your concerns with any of the people listed above, in person, by phone or in writing. A dedicated email address is also available: Personal Information redacted by the USI .

Whichever route you choose, please be ready to explain as fully as you can the information and circumstances that gave rise to your concerns.

If in writing or email, you should set out the background and history of the concerns, giving where possible:

- names,
- dates,
- places, and
- the reasons why you are particularly concerned about the situation.

If you do not feel able to put the concern in writing, you can of course raise your concern via telephone or in person. A statement can be taken of your concern which can be recorded for you to verify and sign.

6.4 Supporting you

It is recognised that raising concerns can be difficult and stressful. Advice and support is available from the Deputy Director of HR Services or a nominated deputy throughout any investigation process. The Deputy Director of HR Services will not undertake an investigation role in the whistleblowing case but will provide support throughout the process, ensuring that feedback is provided at appropriate stages of the investigation. The Trust also provides independent support services to all employees through its Employee Assistance Programme - Inspire; this service is free to all employees and is available 24/7. Contact details are: 0808 800 0002.

The Trust will take steps to minimise any difficulties which you may experience as a result of raising a concern. For example if you are required to give evidence at disciplinary proceedings, the Deputy Director of HR Services will arrange for you to receive advice and support throughout the process. If you are dissatisfied with the resolution of the concern you have raised or you consider you have suffered a detriment for having raised a concern, this should be raised initially with the Deputy Director of HR Services.

7. Raising a concern externally

The Trust hopes this policy reassures you of its commitment to have concerns raised under it taken seriously and fully investigated, and to protect an individual who brings such concerns to light.

Whilst there may be occasions where individuals will wish to report their concerns to external agencies or the PSNI, the Trust would hope that the robust implementation of this policy will reassure staff that they can raise such concerns internally in the first instance.

However, the Trust recognises that there may be circumstances where you can raise a concern with an outside body including those listed below:

- Department of Health;
- A prescribed person, such as:

- General Chiropractic Council, General Dental Council, General Medical Council, General Osteopathic Council, Health & Care Professional Council, Northern Ireland Social Care Council, Nursing and Midwifery Council, Pharmaceutical Society Northern Ireland, General Optical Council
- The Regulation and Quality Improvement Authority;
- The Health and Safety Executive;
- Serious Fraud Office,
- Her Majesty's Revenue and Customs,
- Comptroller and Auditor General;
- Information Commissioner
- Northern Ireland Commissioner for Children and Young People
- Northern Ireland Human Rights Commission

Disclosure to these organisations/persons will be protected provided you honestly and reasonably believe the information and associated allegations are substantially true.

We would wish you to raise a matter with the external agencies listed above than not at all. Protect (formerly PCaW) or your Trade Union representative will be able to advise you on such an option and on the circumstances in which you may be able to contact an outside body safely.

8. The Media

You may consider going to the media in respect of concerns if you have done all you can by raising them with the Trust or an external body and you feel they have not been properly addressed. Your professional regulatory body, if applicable, will be able to provide guidance / advice in this situation. You should carefully consider any information you choose to put into the public domain to ensure that patient/client confidentiality is maintained at all times. The Trust reserves the right to take disciplinary action if patient/client confidentiality is breached.

Communications with the media are coordinated by the Communications Department on behalf of the Trust. Any member of staff approached by the media should direct the media to our Communications Department in the first instance.

9. Conclusion

While we cannot guarantee that we will respond to all matters in the way that you might wish, we will strive to handle the matter fairly, impartially and properly. By using these whistleblowing arrangements you will help us to achieve this.

Please note, this document has been developed to meet best practice and comply with the Public Interest Disclosure (NI) Order 1998 (the Order) which provides employment protection for whistleblowing.

The Order gives significant statutory protection to staff who disclose information reasonably in the public interest. To be protected under the law an employee must act with an honest and reasonable belief that a malpractice has occurred, is occurring or is likely to occur. Disclosures may be made to certain prescribed persons or bodies external to the Trust listed in the Order. The Order does not normally protect employees making rash disclosures for example to the media, when the subject could have been raised internally.

10. Equality, Human Rights & DDA

The Southern Health & Social Care Trust confirm this policy has been drawn up and reviewed in the light of Section 75 of the Northern Ireland Act (1998) which requires the Trust to have due regard to the need to promote equality of opportunity.

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.

11. Alternative Formats

This document can be made available on request on disc, larger font, Braille, audio-cassette and in other minority languages to meet the needs of those who are not fluent in English.

12. Sources of advice in relation to this document

The Director of Human Resources & Organisational Development should be contacted with regard to any queries on the content of this policy.

APPENDIX A

Roles and Responsibilities

The Trust Board and Senior Management Team of the Southern Health & Social Care Trust

- To listen to our staff, learn lessons and strive to improve patient care;
- To ensure that this policy enables genuine issues that are raised to be dealt with effectively
- To promote a culture of openness and honesty and ensure that issues are dealt with responsibly and taken seriously
- To ensure that employees who raise any issues are not penalised for doing so unless other circumstances come to light which require this, e.g. where a member of staff knowingly raises an issue regarding another member of staff which they know to be untrue.
- To share learning, as appropriate, via the Trust's lessons learned arrangements

Lead Non-Executive Director (NED)

- To provide assurance to Trust Board that there are robust arrangements in place in relation to raising and handling concerns
- To have responsibility for oversight of the culture of raising concerns within the Trust.

Director of Human Resources & Organisational Development

- To take responsibility for ensuring the implementation of the whistleblowing arrangements
- To ensure that any safety issue about which a concern has been raised is dealt with properly and promptly and escalated appropriately through appropriate management levels / professional lines
- To ensure that all awareness and training requirements arising from this policy are delivered
- To establish a network of advocates, to support the implementation of this policy

All Directors & Managers

- To ensure staff are familiar with and have access to the Raising Concerns Policy and Procedure
- To recognise that raising a concern can be a difficult experience for some staff and to treat the matter in a sensitive and confidential manner
- To respond quickly to concerns and take all concerns seriously and in confidence, wherever possible
- To seek immediate advice from HR on the handling of any concern raised, and other professionals within the Southern Health & Social Care Trust where appropriate
- To ensure that staff are supported following the raising of a concern so as not to suffer detriment
- To foster an environment in which their teams are engaged in the delivery of high quality and safe services and feel secure to raise concerns as a matter of good practice
- To create an open and safe atmosphere (in team meetings, appraisals etc.) where staff feel their views, regarding the effective and safe delivery of care and services to our service users, will be welcomed and be seen as an opportunity to learn and to consider how services can be improved
- To ensure feedback/ learning at individual, team and organisational level on concerns and how they were resolved.

Deputy Director of HR Services

- To ensure Medical Director, Director of Nursing & AHPs, or Director of Social Work is informed, if the concern raised deems this to be appropriate in order to ensure the safety of patients and clients.
- To oversee any investigation undertaken and provide support to the individual raising the concern throughout the process, ensuring that feedback is provided at appropriate stages of the investigation.
- To intervene if there are any indications that the person who raised a concern is suffering any recriminations.
- To work with Directors and Managers to address the culture and tackle the obstacles to raising concerns.

All Members of Staff

- To recognise that it is your duty to draw to the Trust's attention any matter of concern
- To adhere to the procedures set out in this policy
- To maintain the duty of confidentiality to patients and the Trust and consequently, where any disclosure of confidential information is to be justified, you should first, where appropriate, seek specialist advice for example from a representative of a regulating organisation such as the Nursing & Midwifery Council or the General Medical / Dental Council.

Role of Trade Unions and other Organisations

- All staff have the right to consult and seek guidance and support from their Professional Organisations, Trade Union or from statutory bodies such as the Nursing & Midwifery Council, the General Medical Council, Health & Care Professions Council and the Northern Ireland Social Care Council.

APPENDIX B

SOUTHERN HSC TRUST PROCEDURE FOR RESPONDING TO CONCERNS

HOW WE WILL DEAL WITH THE CONCERN

Stage 1

1) Any manager / Director to whom a concern is raised must arrange to meet with the employee to discuss the detail of the concern **without delay**.

2) The manager / Director should be clear on the range of other Trust policies and procedures in the event that the concern raised might be more appropriately dealt with under another policy / procedure e.g. Grievance Procedure, Working Well Together Procedure, Maintaining High Professional Standards (Medical & Dental staff).

3) The manager / Director should establish the background and history of the concerns, including names, dates, places, where possible, along with any other relevant information. The manager should also explore the reason why the employee is particularly concerned about the matter. The manager should document a summary of the discussion.

4) The manager should explain that they will need to seek advice from their Assistant Director / Director, providing there are no specific objections raised by the employee regarding protection of their confidentiality in this regard. If there are concerns expressed as to who should be made aware, then the manager / Director should seek advice immediately from the Director of HR or Deputy Director of HR Services.

5) ALL whistleblowing concerns must be notified by the Assistant Director / Director to the HR Director's office for logging and decision on best course of action to address the concern.

6) If the concern is raised with the Director of HR, s/he will refer the concern to the Deputy Director of HR Services to arrange to meet with the employee to discuss the detail of the concern.

It may be necessary with anonymous allegations to consider whether it is possible, based on limited information provided in the complaint, to take any further action. Where it is decided that further action cannot be justified, the reasons for this decision should be documented and retained by the HR Director's Office.

Stage 2

Once the issue(s) of concern has been established, the approach to independently investigating the concern will be discussed and agreed by an Oversight Group, chaired by the Director of HR and an Executive Director, depending on the nature of the concern. The Director of HR will advise the relevant operational Director that a concern has been raised and the nature of it. The Director of HR will withhold the identity of the individual raising the concern, if requested.

A record should be made of the decisions and/or agreed actions which should be signed and dated. Agreed Terms of Reference for any investigation should be established.

The Director of HR will ensure that the Deputy Director of HR Services is aware of the concern (if not previously aware) to ensure any necessary support can be provided to the employee raising the concern.

Stage 3

Within a prompt and reasonable timescale of the concern being received, the Deputy Director of HR Services must meet with the employee to:

- Acknowledge that the concern has been received
- Discuss if confidentiality is to be / can be maintained throughout investigation, and ensure this is documented using the ***Record of Discussion Regarding Confidentiality***
- Discuss how the matter will be dealt with and by whom
- Outline the support available
- Provide an estimate as to how long it will take to provide a final response.

A summary of the discussions will be followed up in writing.

Stage 4

A proportionate investigation – using someone suitably independent (usually from a different part of the organisation), will be undertaken and conclusion reached within a reasonable timescale. The investigation will be objective and evidence-based, and a report of the findings will be produced.

Stage 5

The Oversight Group will consider the report and determine any action required, based on the findings, including any lessons to be learned to prevent problems recurring.

Stage 6

The HR Director will ensure that feedback to the individual raising the concern is provided.

If You Remain Dissatisfied

If you are unhappy with the response you receive when you use this procedure, remember you can go to the other levels and bodies detailed in the Trust's Policy. While we cannot guarantee that we will always respond to all matters in the manner you might wish, we will do our best to handle the matter fairly and properly.

RECORD OF DISCUSSION REGARDING CONFIDENTIALITY

Name of individual raising concern

SUMMARY OF DISCUSSION REGARDING CONFIDENTIALITY

Please record a summary of the discussion with the individual raising a concern regarding maintaining their confidentiality under the Trust's Raising Concerns (Whistleblowing) Policy

CONSENT TO REVEAL IDENTITY

Does the individual wish to their identity to remain confidential during any whistleblowing investigation? **YES / NO** **Who has the individual given consent for their name to be revealed to as part of the whistleblowing investigation?** **Is the individual aware that should further action be required following a whistleblowing investigation in the form of disciplinary action for example, that their identity may have to be revealed following discussion with them and that they may have to provide a witness statement?**

YES / NO

INFORMATION STORAGE

Summary of discussion regarding how information will be held and investigation undertaken to ensure identity is protected.

Signed by individual raising concern(s): **Date:**

Signed by Trust representative : **Date:**

Trust Risk Assessment Form for Risk Register

SOUTHERN HEALTH & SOCIAL CARE TRUST		
RISK ASSESSMENT FORM	**Risk ID No**	
Directorate: Chief Executive's Office	**Facility/Department/Team** Public Inquiry Team	**Date:** 02/02/2022
Where is this being carried out? **(e.g. Trust premises/home of client/staff/ private nursing home etc)** Trust-wide impact Primarily Acute Directorate	**Objective(s)** 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; and 6. Working in partnership.	

Risk Title: (Threat to achievement of objective)
Response to Statutory Public Inquiry into Urology Services in the Southern Health and Social Care Trust (USI):

There is a 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;

The further risk will be issues identified through the discovery process which may impact on the reputation and function of the Trust

Description of Risk:

This assessment details the risk to the Trust and to individual members of staff, current and former, from the Urology Services Inquiry (USI).

Health Minister Robin Swann, in a statement to the Assembly, on 24 November 2020, advised Members of his intention to establish a Public Inquiry, under the Inquiries Act 2005, into the circumstances surrounding Urology Services in the Southern Health and Social Care Trust.
The Urology Services Inquiry began on 6 September 2021.

The Inquiry is being chaired by Christine Smith QC. A Public Inquiry is a major investigation – set up by a government minister - that can be gifted special powers to compel testimony and the release of other forms of evidence. The only justification required for a public inquiry is the existence of "public concern" about a particular event or set of events. In announcing the Urology Services Inquiry on November 24, 2020, the Health Minister said: 'The remaining issues to be addressed relate to the management of all past, present and future cases that would meet the threshold for an SAI review; as well as establishing why this happened, and whether action could have been taken earlier by the Southern Trust to identify and address the apparent deficiencies in the consultant's clinical practice. Given the large number of cases already identified as meeting the threshold for an SAI review and my concerns that

there may be more to come, a different and specific approach is required ….. therefore, I intend to establish a statutory public inquiry, under the Inquiries Act 2005.'

The initial stage of the Inquiry involves evidence gathering by the Inquiry team.

Section 21 of the 2005 Act provides the Chair of the Inquiry with various powers, requiring a person to:

- Attend to give evidence
- Produce any *document or documents in his/her custody or under his/her control that relate to a matter in question at the Inquiry:
- Produce any other thing in his/her custody or under his/her control for inspection, examination or testing by, or on behalf of, the Inquiry Panel,:
- or Provide evidence to the Inquiry in the form of a written statement.

*document in this context includes information recorded in any form including, for instance, correspondence, notes, emails, memoranda and text communications.

The USI will hold a series of hearings in public at a date yet to be determined.

Outline the potential for harm: (Consider injury to client, staff, litigation, etc.)

Provision of information to USI
Over 30,000 pieces of information – emails, correspondence, minutes etc - have so far been transferred to the USI. The timeframes for compliance have been challenging and there is a wide scope of discovery. This has been a huge undertaking, and involved trawling through archive emails, personal accounts, etc. There is a risk of not achieving full compliance with the S21 notices. This maybe be due to incomplete historical information being available; the Trust's IT storage and retrieval systems capacity; the Trust's network capacity and the process for transfer of large amounts of data across to the USI. The Trust has also had to comply with requests for information to be provided in a specific format for the USI, which is time-consuming and has required use of a document transfer system which has capacity limitations. Acting on instructions from the USI in relation to timeframes for response, the information that has already been released has not been fully assessed or reviewed due to time constraints and the high volume of information requested.

Human Resource impact – staff
Staff are required to provide high volumes of historical information in response to Section 21 (S21) notices received from the USI. This primarily relates to staff in the Acute Directorate who must also manage services during the on-going pandemic. Timeframes for return of information have to date been four weeks which is extremely

challenging. The Trust has provided around 30,000 documents as part of initial discovery process.

The USI teams are currently collating the documentation provided by the Trust and it is anticipated that this will generate further queries which the Trust will be expected to respond to within short timeframes.

In the next stage of the USI, any staff deemed of interest to the Inquiry will receive individual S21 notices. These will detail specific questions and will require a witness statement along with supporting evidence. The Trust must ensure these staff have capacity and support to fulfil their S21 obligations. This has the potential to have a detrimental impact on staff and is likely to have an adverse impact on the delivery of normal services.

Reputational risk
Reputational risk to the Trust exists with the production of information in the Public Inquiry which relates to Urology Services. This will include witness statements, evidence from staff, patients and families, and other external bodies. As the hearing will be held in open session, this is likely to attract high and sustained levels of media interest.

Organisational risk
There is a high level of organisational risk. Staff who are involved in providing evidence to the USI are likely to have to be relieved of normal duties. This presents a risk to service delivery, with potential service retraction if it is not possible to backfill key posts. Given the public attention on Trust urology services, it may be difficult to attract and retain staff.

The challenging timeframes to supply S21 responses, and the likely extent of required disclosures, will add significant personal stress on staff who have managed services through the pandemic and may result in staff absences with the potential resulting impact on patient care.

Staff diversion to comply with S21 notices may impact on Trust's pandemic rebuilding process adding further stress into an already stressed system.

Capacity of Trust to support multiple S21s simultaneously. This will be in addition to on-going risk posed by Covid-related staff absence which is impacting on staffing levels across the Trust.

Individual risk and responsibility of staff
Individual staff will be responsible for their own witness statements and may be required to give evidence in open hearings. It is essential that all staff complete their own statements and are fully aware of all information released to the USI. It is estimated that between 20-30 staff will be issued with S21 notices. It is likely that staff will have to provide responses to more than one S21 notice, as the USI gathers and assesses evidence. Non-compliance with any S21 notice carries a risk of sanction. The Trust will need to provide significant support for individual staff to complete their S21 responses which may impact on the maintenance of services. There is a reputational risk to individuals who are part of the USI process, to their professional reputation and their personal wellbeing.

Staff engagement/communication
In an already busy and pressured environment, staff will need to make time to understand the requirements of the USI and the legal standing of the PI. There is a risk of staff being unaware of their obligations, or potential consequences of non-compliance. As this is likely to be the first exposure to a Public Inquiry for staff, lack of acknowledgement or understanding of the process will be a risk.

Finance
There is no funding currently earmarked to support the Public Inquiry. The costs of supporting the PI response are likely to be considerable, including direct staff costs, backfill, staff support, legal representation, etc.

Governance
Operational governance arrangements to support the Trust response will need to be developed and resourced to ensure robust oversight and assurance to manage the risks.

Information Governance is also a risk as the high volumes of information which are being provided have not been risk assessed, and may contain confidential information.

Patients – risk of increased litigation/rise in complaints

Lookback exercise
The Urology clinical and operational teams have worked to identify, assess and see the first cohort of patients reviewed as part of the Public Inquiry. The Trust is currently waiting for the Royal College of Surgeons report on 100 patients, and if this report signals the need for a further lookback, this will likely have an impact on already very long waiting lists due to capacity within the clinical teams. This has the potential to cause further stress and anxiety to patients.

Quality assurance agenda
Due to capacity and resource issues the Trust may be unable to implement the full raft of recommendations contained in the Urology SAIs.

Summary of current control measures: (Consider equipment, staffing, environment, policy/procedure, training, documentation, information – this list is not exhaustive).

Human resource mitigation measures

- Resource Public Inquiry Team are co-ordinating responses to USI, liaise with DLS and the USI team and provide repository for organisational information.
- Directorate teams providing backfill where possible to release staff to comply with S21 notices
- Public Inquiry team working to ensure good communication with impacted staff and wider organisation
- Work ongoing to identify resources for staff psychological support

- Work ongoing to identify former staff who may be impacted, explain and engage with offer of full support

Provision of information to USI

- Public Inquiry Team alert DLS as required to any issues/concern re: discovery and ensure that USI are kept fully informed.
- IT enhanced support regarding retrieval of information through email system, and access to Kofax for data transfer to facilitate USI data transfer requirements.
- DLS support to review information provided by Trust as part of the discovery process
- To analyse, collate and assess information which has so far been retrieved, the Trust will seek to employ paralegal support. This will facilitate access to information for individual staff members, alert to any data protection issues and validate completeness of archive.

Reputational risk

- To ensure that all discovery is delivered on time, is complete and there is full co-operation with the USI team the Trust Public Inquiry team has recruited additional staff
- To ensure that the Trust has knowledge of information shared with the USI and the likely consequence of its release the Trust Public Inquiry team has recruited additional staff
- To ensure that all participants in the Inquiry are fully supported for full disclosure of all relevant information the Trust Public Inquiry team has recruited additional staff
- To ensure that all learning is incorporated and shared as appropriate in a continuous and timely way the Trust Public Inquiry team has recruited additional staff
- To ensure that any patients/families identified as impacted through the Lookback process are supported by the Trust a dedicated clinical assurance manager has been appointed to oversee the task.

Organisational risk

- The Public Inquiry team are working to support the earlier identification of staff required to complete S21s, review impact and provide backfill where possible
- The Public Inquiry team are alerting DLS/USI where there are patient implications in complying with S21 deadlines and seek to find an agreed way forward.
- The Public Inquiry team / DLS are working to anticipate S21 requests and collate relevant information to assist with full disclosure
- Ongoing work by the Public Inquiry Team to identify a cohort of experienced staff, likely recently retired, who can provide assistance to individuals responding to S21s. This may help alleviate pressure on other staff and minimise impact of service disruption
- Public Inquiry team will issue early alert to HSCB/Dpt in the event of service disruption due to demands of USI. This concern has been flagged to HSCB.

Individual risk and responsibility for staff

- The Public Inquiry team will provide targeted support for staff receiving individual S21 notices.
- The Public Inquiry team will create time for S21s to be completed – through backfill, work deferment/retraction, or other appropriate means
- The Public Inquiry team will ensure psychological support available to staff
- DLS will provide expert legal advice for staff, to ensure they are aware of obligations, and potential for sanctions in the case of non-compliance.
- All services will work to identify former staff likely to be impacted, and ensure they are fully supported by the Trust, if that is their wish.

Staff engagement / communication

- The Public Inquiry team will develop a pro-active communication strategy developed
- The Public Inquiry team will develop a suite of information assets to support staff
- The Public Inquiry team will develop a targeted communication for those staff most impacted
- The Public Inquiry team will develop support systems for discovery phase and preparation for open hearings to be developed in conjunction with staff.
- The Public Inquiry team will work to make available psychology support – informal support networks

Finance

- The Trust did bid for funding to cover expenditure in 2021-22 at the October monitoring and this wasn't accepted. However it was funded from "general pressures" non-recurrent funding. The Trust has informed the HSCB and DOH that the cost of the Inquiry will give rise to pressures in future years and the Trust will seek funding from the DOH each year when they arise.

Governance

- Programme Board established chaired by Chief Executive to oversee Trust response, provide assurance to Trust Board and ensure learning is shared
- Establishment of three sub-groups of Programme Board to manage Trust response:
    - Public Inquiry Steering Group
    - Lookback Group
    - Quality Assurance group
- Mechanisms developed to ensure timely response to patient/family complaints arising from Urology concerns
- Development of effective support processes in place for patients/family impacted by PI
- Escalation to HSCB/commissioner identifying funding requirements to implement recommendations of Urology SAIs.

Are these controls: (b) Require Further Action **Please list control measures considered but discounted and why (where appropriate):**

Assessment of Risk	**Likelihood** **e.g. Likely**	**Consequence/ Impact** **e.g. Moderate**	**Risk Rating** **L and C = RR e.g. Likely and Moderate = YELLOW**
	Likely	**Major**	**High (4x4)**

Southern Health and Social Care Trust

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BOARD REPORT SUMMARY SHEET

Meeting: Date:	Trust Board 12th November 2020
Title:	Urology Update
Lead Director:	Dr Maria O'Kane, Medical Director Melanie McClements, Director of Acute Services
Purpose:	Information

Overview:

The purpose of this paper to provide an update to Trust Board (November 2020) on the ongoing review of urology services relating to Consultant A

Key areas for SMT / Committee consideration:

- Update on review progress to date (10th November 2020)
- Formation of Department of Health Oversight group and details of planned ministerial statement to the NI Assembly
- Update on the progress of identified Serious Adverse Incidents and Public Health Agency advice regarding a proposed 'Clinical Investigation' model for future identified urology incidents
- Update on engagement with the Independent Sector Provided engagement to provide review appointments for 236 oncology backlog patients
- Update on review of prescribing of the medication Bicalutamide, an Anti-androgen drug, to date there have been 26 patients out of 300 identified as needing an urgent appointment.

Human Rights/Equality:

None to declare

Background to Review

A review of clinical processes has been undertaken, the background and current status of the ongoing review is provided below. The necessity of a further review of clinical care is being discussed with the Royal College of Surgeons.

Elective Care	The review has identified that Consultant A had operated on 334 patients, and out of these 120 patients were found to have undergone delays in dictation of their discharge with a further 36 patients having no record of their discharge on the Trust's electronic care record (NIECR). **Of the 36 patients, there have been 2 incidents identified that meet the threshold for SAI reviews.**
Management of Pathology and Cytology Results	The review has identified 50 out of 168 patients that require review as a result of un-actioned Pathology or Cytology results. **Of the 50 patients requiring review there have been 3 incidents identified that meet the threshold for SAI reviews with a further 5 requiring a review follow-up to determine if these patients have come to harm.**
Management of Radiology Results	The review has identified 1536 radiology results which require review to ascertain if appropriate action was taken. A review of the 1536 cases is ongoing.
Actions required as a result of Multidisciplinary Team Meetings	There were 271 patients under Consultant A's care whose cases were discussed at Multidisciplinary Team Meetings. A review of these patient records is being undertaken. To date there are currently **3 confirmed SAI's and a further 1 needing a review follow-up** to determine if these patients have come to harm. This exercise is ongoing.
Oncology Review Backlog	236 review oncology outpatients will be seen face to face by an Urologist in the independent sector for review. To date there has been **one SAI confirmed** from this backlog as the patient presented to Emergency Department and he has been followed up as a result of this attendance.
Patients on Drug "Bicalutamide"	There are concerns regarding Consultant A's prescribing of androgen deprivation therapy outside of established NICE guidance regarding the diagnosis and management of prostate cancer[1]. *Bicalutamide is an Anti-androgen that has a number of recognised short term uses in the management of prostate cancer. In men with metastatic prostate cancer NICE Guidance states;* *'1.5.9 For people with metastatic prostate cancer who are willing to*

[1] Prostate cancer: diagnosis and management. National Institute for Health and Care Excellence. NICE guideline 131. May 2019.

	accept the adverse impact on overall survival and gynaecomastia with the aim of retaining sexual function, offer anti-androgen monotherapy with bicalutamide[6] (150 mg). ***[2008]*** *1.5.10 Begin androgen deprivation therapy and stop bicalutamide treatment in people with metastatic prostate cancer who are taking bicalutamide monotherapy and who do not maintain satisfactory sexual function.* ***[2008]'*** All patients currently receiving this treatment are being identified by a number of parallel processes utilising Trust and HSC / Primary Care systems in order to facilitate a review to ascertain if the ongoing treatment with this agent is indicated or if an alternative treatment / management plan should be offered.

Department of Health Oversight Group

The Permanent Secretary has established a Department of Health level of external oversight and assurance group to review progress and guide the way forward in terms of the Trust's management plan. Currently the Urology Assurance Group has begun to meet weekly. Michael O'Neill, Acting Director of General Healthcare Policy, is leading on this in the Department and providing secretariat for the group.

Ministerial Statement

The Minister for Health issued a written statement to the NI Assembly on the 26th October. The Trust has been advised a further statement from the Minister to the NI Assembly will be made on 17th November 2020 which will provide additional details. The Trust is preparing proactive communication arrangements in anticipation of this announcement.

Serious Adverse Incidents (SAI) Update

The SAI panel membership has been agreed Terms of Reference have been internally agreed and have been forwarded to the HSCB. All 9 patients/families identified through the SAI process have been spoken to this week with some of them being offered a further appointment with a Consultant Urologist, taking place this week. During the initial consultations with one family there appears to be some discrepancies in what the families understanding of what had been said by the consultant and what the expert reviewer has indicated.

Four out of the five patients/ families, along with the index patient of the previous SAI's, have also been spoken to. The family of the fifth patient's family (RIP) is still outstanding as this is being

clinically considered due to the recent death of the patient. The Chair of the SAI panel is also going to meet with these patients and this is currently being organised.

Given the number of patient cases from this review period (January 2019 to June 2020), this review exercise continues to be ongoing, and the above information is the current position at this point in the review.

The Health and Social Care Board / PHA have advised that any additional incidents that are identified as meeting the threshold for an SAI review should be paused will be managed via a separate 'clinical investigation' process. The Public Health Agency has indicated that this process will be independent of the Trust and will be guided by and have parameters set by the HSCB/PHA/Department of Health.

Consultants Private Practice

It was requested at the Department of Health Oversight Group meeting on 6th November 2020 that the Trust write to the Consultant to gain assurances surrounding their private practice for the last 5 years. Either of the options below are to be offered:

- A written assurance from the Consultant to the Trust that they will make arrangements for their private patients to be reviewed by an independent urologist; or
- The Consultant provides details of their private practice and the Trust will make arrangements for the review of these patients and recharge the cost to them / their medical insurer

Summary of Activity for Patient Facing Information Line

The Trust established since 26th October 2020 a patient information line available for patients who may have questions or concerns regarding their care. The details of contacts made to date:

- **Total calls – 153 (up to and including Tuesday 10 November)**
- **2** patients are being seen as part of the oncology review backlog in Independent Sector
- **1** patient was on Bicalutamide and was seen at clinic on Monday 2 November
- **1** patient was picked up as not having been added to any system for a Red Flag Flexible Cystoscopy and has an appointment for Monday 9 November 2020

The Trust has also set up an accompanying GP information line for GP's who may wish to find out more information regarding patients who have been referred to Trust urology services. The details of contacts made to date:

- **1** GP has called the **GP Information line** - communication has been sent by HSCB

Independent Sector Clinics

A total of **236** oncology patients were deemed to be part of a backlog relating to Oncology Reviews. These patients will be seen for review by an Urologist in the Independent Sector. There have been **191** oncology review patients transferred to the Independent Sector and clinics are fully booked for the month of November for these patients. To date one case has been identified as meeting the threshold for an SAI review from this backlog.

- **131** patients have been offered and accepted an appointment over the next four weeks.
- **39** patients still to be contacted (not answering phone) so a letter has been sent asking them to ring to arrange an appointment
- **21** patients have been returned to Trust
    - 8 patients have advised that they no longer require an appointment and happy to be discharged
    - 1 patient has moved to Scotland
    - 12 patients not willing to travel so will be offered an appointment in the Southern Trust by end of November 2020.

Bicalutamide Audit

There are concerns regarding Consultant A's prescribing of a particular drug, which appears to be outside of established NICE guidance, regarding the diagnosis and management of prostate cancer. The drug is Bicalutamide, an Anti-androgen drug, which has a number of recognised short term uses in the management of prostate cancer. All patients currently receiving this treatment are currently being identified by the Trust, in order to facilitate a review to ascertain if their ongoing treatment with this drug is indicated or if an alternative treatment management plan should be offered. To date there have been 26 patients out of 300 identified as needing an urgent appointment.

- **26** patients identified from the first review of the patients:
- Two all-day clinics (Monday 2nd & Tuesday 3rd November) were held in Craigavon Hospital clinical team (1 x Consultant, 2 x Specialist Nurses and 1 x Pharmacist in attendance)
- **26** patients were contacted and offered an appointment:
- **9** patients attended the hospital
- **2** patients cancelled on the day
- **1** patient did not attend

- **14** patients (or their main carer) declined face to face appointment and these patients will be followed up by a telephone consultation

General Medical Council

The Trust is continuing to liaise with the General Medical Council regarding professional issues.

Royal College of Surgeons Invited Review Service

The Trust has approached the Royal College of Surgeons (RCS) Invited Review service to request a review of Trust urology services in relation to consultant A's practice. This engagement is at an initial stage and a meeting with a clinical lead from the RCS is being scheduled for this week / beginning of next week.

Grievance Hearing

The outcome of the formal grievance hearing was communicated to Consultant A on 26th October 2020 by report.

The panel was constituted by an external HR professional and a senior medic not previously involved in the case from within the Trust.

Overall, the panel did not find Consultant A's grievance upheld. Consultant A has subsequently lodged an appeal.

Additional Subject Matter Expertise / Consultant Reviews

The Trust via the Royal College of Surgeons has engaged with the British Association of Urological Surgeons (BAUS) who have provided two subject matter expert Consultant Urologists to assist with the ongoing work. One subject matter expert is providing independent expertise for the SAI process with the second expert engaged to assist with the review of electronic patient records.

Investment Proposal Template (IPT) HSCB

The HSCB have advised that the Trust develop and submit an IPT to cover additional costs associated with current and projected future work relating to the Urology review. This work will include clinical, managerial and governance oversight costs.

Southern Health and Social Care Trust

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BOARD REPORT SUMMARY SHEET

Meeting: Date:	Trust Board 25th March 2021
Title:	Urology Update
Lead Director:	Dr Maria O'Kane, Medical Director Melanie McClements, Director of Acute Services
Purpose:	Information

Overview:

The purpose of this paper to provide an update to Trust Board (March 2021) on the ongoing review of urology services relating to Consultant A

Key areas for SMT / Committee consideration:

- Update on review progress to date (16th March 2021)
- Update on the progress of identified Serious Adverse Incidents and creation of a Structured Clinical Record Review model for future identified urology incidents
- Update on engagement with the Independent Sector Provided engagement to provide review appointments for 236 oncology backlog patients
- Update on GMC and Private Practices process

Human Rights/Equality:

None to declare

Summary of reviews of clients under Consultant A since July 2020 by SHSCT

- Review of stent removals Jan 2019 - June 2020 - 160 pts
- Review of elective activity Jan 2019 - June 2020 - 352 pts – **2 SAI's identified** –
- Review of pathology results Jan 2019 August 2020 - 168 pts – **3 SAI's**
- Review of Radiology requests Jan 2019 - August 2020 - 1536 results/1028 pts episodes. 511 completed and no delays/concerns raised. 1025 still to be reviewed by Subject Matter Experts.
- Review of MDM episodes Jan 2019 - July 2020 – 271 episodes/186 pts - **3 SAI's**. (Urology Subject Matter Expert is currently undertaking this review)
- Oncology Review Backlog – 236 patients to be reviewed by Independent Urologist. – **1 SAI** identified in backlog review – This exercise is now complete with 200 patients having been seen by 22 December 2020

  200 management plans have been received back from Independent Sector
  - **124** of these have been referred back to the care of their GP
  - **34** have been sent back to Trust for further care/follow-up.
  - **39** to be reviewed at Trust's Urology MDT (Professor Sethia has agreed to be the independent Consultant on these MDT's and these are commencing on 14 January and will be every fortnight.
  - **3** referral to Oncologist for Urgent reassessment of treatment

Public Inquiry

The Minister for Health has announced the chairperson of the Public Inquiry will be Ms Christina Smyth QC. The Minister has also indicated the aim of the inquiry being fully underway by summer 2021. The next steps for the Chairperson will be to finalise the terms of reference for the inquiry, following engagement with the Assembly's Health Committee and the patients affected by the lookback, and to finalise the members of the Inquiry Panel.

Ms Smith is an experienced Queen's Counsel with a background in public inquiry work. She is Senior Counsel to the Independent Neurology Patients Recall Inquiry and was Senior Counsel for the Historical Institutional Abuse Inquiry. She also appeared for the Department of Finance in the RHI Inquiry.

Engagement with the HSCB / DoH

The Trust continues to attend separate fortnightly meetings with both the Department of Health and Health and Social Care Board. The Department of Health meeting, chaired by Richard

Pengelly, Permanent Secretary is responsible for ensuring a coordinated approach to with regard to all strands of the Urology review work across all domains of practice. The next meeting is due to take place 19th March 2021.

Serious Adverse Incidents Update

The SAI process chaired by Dr Dermot Hughes has concluded. A total of 10 reports (9 patient specific and 1 overarching report) have been completed in draft form. Each patient / family received a copy of the report relating to their / their family members care and copies of all of the reports have been shared with the Urology and Cancer services teams for factual accuracy checking, this process will conclude on the 2nd April 2021. Prior to finalising the draft reports Dr Hughes met individually with each family to discuss the format and progress of each SAI review.

- Families received a copy of their SAI report and also a copy of the overarching SAI report on 18th March 2021.
- The Urology Consultants and Clinical Nurse Specialists received a copy of the SAI reports and also a copy of the overarching SAI report on 16th March 2021.
- Mr O'Brien's solicitor received copies of all the draft SAI reports and the overarching report on Friday 5th March 2021.

Dr Hughes will meet with the families following sharing of the reports and the Trust will continue to offer support to those patients / families who feel they require this. There is also been a meeting organised for Tuesday 23rd March with Chief Executive, Medical Director, Acute Director and the urology team to afford them the opportunity to share their thoughts on this.

The Trust is prioritising the learning and recommendations for service improvement, this work will be led by the Trust Urology Oversight Group chaired by Melanie McClements and Dr Maria O'Kane.

The Family Liaison Officer has continued to support 8 out of the 9 families (9th family declined this support on their own wishes) and has advised all families that she will continue to be available for them once they have received and read through the reports.

Structured Clinical Record Reviews

RCP are conducting two train the trainer sessions for using Structured Judgement Review (SJR) methodology for Trust medical staff on 18th and 25th March. SJR principles are what underpin the SCRR process. The Trust has shared the SCRR draft form with the RCP and has received positive feedback in its design and structure. To support the SCRR process the Trust has identified an additional Consultant Urology subject matter expert via the Royal College of Surgeons to support reviews as required.

Summary of Activity for Patient Facing Information Line (16/03/21)

The Trust has established a patient information line since 26th October 2020 for patients who may have questions or concerns regarding their care.

- 154 calls/emails up to 16 March 2021

From Saturday 6th March one of the core consultant urologists has commenced weekly telephone clinics and will chronologically review patients from Mr O'Brien's review backlog list. The consultant is completely the Patient Review form for each of these patients. As of this report he has reviewed 20 patients.

The Subject Matter Expert has commenced reviewing the case notes of previous MDM patients that were under the care of Consultant A from January 2019- June 2020, and will complete a Patient Review form for each of these patients and will also escalate any patients he has concerns in respect of their care.

Admin & Clerical Review

A review of processes including triage, communications, patient information and private patient management has been completed. This has considered issues, gaps, policies/processes and risks. An external opinion was sought and they have cross referenced with other Trust processes to ascertain any learning, the report is due completion at end of March 2021.

General Medical Council

Further to Mr O'Brien's interim suspension from the Medical Register on 15th December 2020 the Trust is continuing to liaise with the General Medical Council regarding professional issues.

Grievance Hearing

Following receipt of the grievance outcome Mr O'Brien subsequently lodged an appeal. As a result an appeal panel had been organised with dates offered to Mr O'Brien. Mr O'Brien has indicated on 4th March 2021, through his representative, that he will not be attending any further meetings with the Trust with regards this process and intends to address the matters via Public Inquiry. His representative has stated that with regards to the appeal itself, they raise no objection to the Trust proceeding with the Appeal Panel. His representative's response has been forwarded to DLS for advice.

Consultant's Private Practice

Private Practice - Internal Audit

An Internal Audit review of Mr O'Brien's patients transferring into SHSCT as HSC patients is ongoing. Currently internal audit are scoping all diagnostics that were carried out under Mr O'Brien's name, along with auditing laboratory and pharmacy systems. At time of writing there has been one private patient anomaly identified.

Private Practice – External to the Trust

The Trust continues to liaise with the Department of Health regarding Mr O'Brien's private practice work outside of the HSC. The Trust held a meeting with the GMC and DoH on 16th March to discuss the Trust and DoH roles in consideration of Mr O'Brien's private practice. This issue is to be discussed further with at the fortnightly DoH UAG meeting 19th March 2021.

Royal College of Surgeons Invited Review Service

The Trust has approached the Royal College of Surgeons (RCS) Invited Review Service to request a review of Trust urology services in relation to Consultant A's practice. The following actions have been taken to advance this:

- Terms of reference for the review have been agreed with HSCB / DoH and shared with the Royal College of Surgeons
- The Royal College of Surgeons has identified a review team to undertake this project.
- A stratified approach to sampling of cases from calendar year 2015 has been agreed with the HSCB / DoH. Where required, an electronically driven random sampling method was used to select cases.

The Trust held a meeting on 11 March 2021 with the Royal College of Surgeons on how best to transfer the data for the review, so it was agreed that this would be done using the Egress secure platform. It is anticipated the review will commence in May 2022.

Additional Subject Matter Expertise / Consultant Reviews

The Trust has identified via the Royal College of Surgeons a Consultant Urology Subject Matter Expert to support the review of Mr O'Brien's clinical activity between 1st January 2019 and 30th June 2020. The Subject Matter Expert will review the patients in the following order:

- Cancer MDM (187)
- Triage of patients contacting the information line (154)
- Radiology results (1028)

Staff Engagement

Regular Team meetings are continuing with the Clinical Teams and the Chief Executive, Medical Director and Director of Acute Services, next one scheduled for 23 March 2021. Conversations are taking place with the Clinical Teams to offer a range of support options on an individual basis or as a team going forward. Professional Nursing support has been planned as requested and being organised for the Cancer Nurse Specialists.

Investment Proposal Template (IPT)

IPT prepared associated with current and projected future work relating to the Urology review. This work will include clinical, managerial and governance oversight costs and patient related support services including SAI Review costs, information/help lines, counselling, psychological support and family liaison.

- Conversations underway with Trust Psychology, HR and Inspire, regarding model of 6 sessions per person who require support. Role of GP referral to be further explored.
- 2 locum Urologists have also been recently appointed by the Trust. (= 6 WTE of 7 funded urology posts) which will increase capacity to progress clinical assessments and reviews.
- Discussion with HSCB - Urologist (7) underspend can be repurposed towards IPT costings.

Communication Plan

Liaison across HSCB, DOH, Trust Communications Teams and operational /clinical staff. Trust website information updated regarding information line and FAQ's has been revised.

Southern Health and Social Care Trust

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GOVERNANCE COMMITTEE COVER SHEET

Meeting Date	16th November 2021	
Agenda item	Bi-Annual – 'Raising Concerns – Whistleblowing'	
Accountable Director	Vivienne Toal Director of Human Resources & Organisational Development	
Report Author	Name	Siobhan Hynds Deputy Director, HR Services
	Contact details	Personal Information redacted by the USI

This paper is presented for: Information

Links to Trust Corporate Objectives		
	√	Promoting Safe, High Quality Care
	☐	Supporting people to live long, healthy active lives
	☐	Improving our services
	☐	Making best use of our resources
	√	Being a great place to work – supporting, developing and valuing our staff
	☐	Working in partnership

This report cover sheet has been prepared by the Accountable Director.

Its purpose is to provide the Trust Committee with a clear summary of the paper being presented, with the key matters for attention and the ask of the Committee.

It details how it impacts on the people we serve.

1. Summary of paper contents:

This report is provided to the Trust's Governance Committee, in line with the HROD Directorate Governance Structure, to enable robust and formal independent oversight of 'Whistleblowing' cases activity within the Trust.

1. **Cases – Themes and Trends (April 2021 to September 2021)**

This report outlines the cases and trends of Trust Whistleblowing cases from April 2021 to September 2021.

2. **Lessons learned from cases**

The report outlines the work underway to share the lessons from our cases across the Trust.

3. **Case Review** (Microbiology / Court LAC)

Freedom to Speak Up Guardian
Appendix 1a and b contain sample template Job Descriptions from NHS England for National Freedom to Speak Up Guardians. This is a model which the Trust would like to introduce, and discussion at Governance Committee on this type of role would be welcome.

2. Areas of improvement/achievement:

Case timescales remain a concern. Each case will require a different investigation timescale depending on the scale and complexity of the case. Some cases are also delayed due to third party involvement.

3. Areas of concern/risk/challenge:

There remains a risk in respect of the ability to manage the case activity and complexity of cases due to resources. An additional resource at Band 7 level has been appointed however unfortunately this is no longer on a full time basis due to another vacancy at this level in the team.

4. Impact: Indicate if this impacts with any of the following and how:

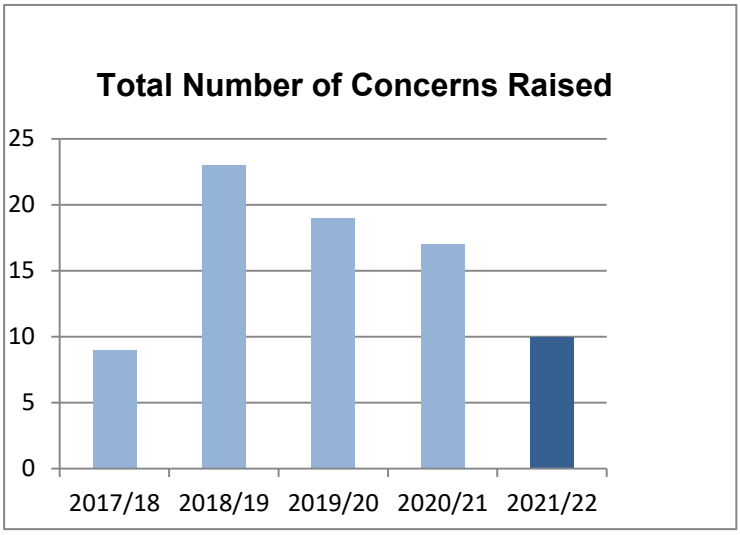
Corporate Risk Register	Links to People Risk
Board Assurance Framework	
Equality and Human Rights	

Raising Concerns (Whistleblowing)

1.0 Case Review (April 2021 to September 2021)

1.1 The data below sets out the key statistics in respect of concerns raised and logged from 1 April 2021 to 30 September 2021. The mid-year update indicates that the number of concerns raised so far is consistent with the previous two years.

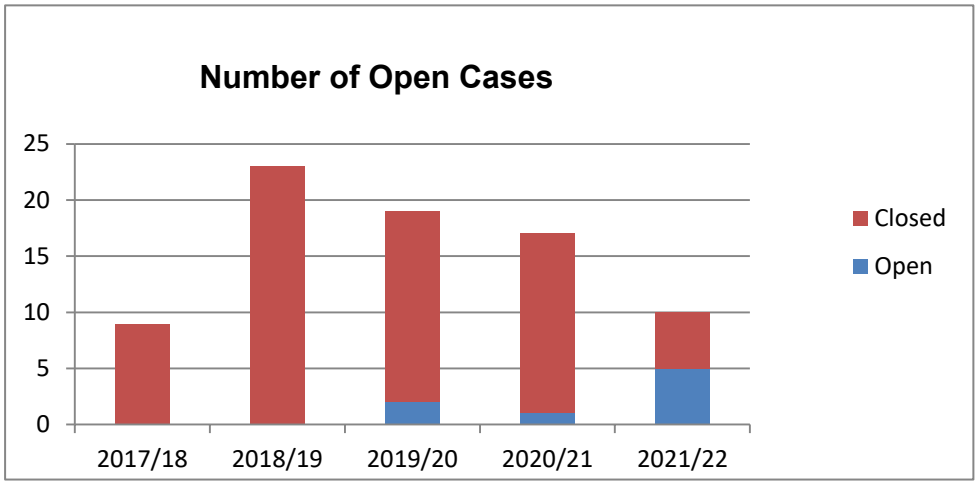
YEAR	2017/18	2018/19	2019/20	2020/21	2021/22
Total number concerns raised	9	23	19	17	10



1.2 In total, 8 cases remain open. The two cases from 2018/19 which remain open are within the Estates Services Area. One of these cases has been reported multiple times and we continue to liaise with the DoH Counter Fraud and Probity Services in respect of same. It is expected that DoH CFPS will close this case. An analysis of the relevant evidence is ongoing for the second open case from 2018/19, an update in relation to the progress of this is being provided to the Whistleblowing Oversight Committee on 26/11/21.

1.3 One case from 2019/20 remains open; this case is within the Directorate of Mental Health & Learning Disability. We have not yet been able to commence an investigation into these issues of concern due to a separate ongoing PSNI investigation involving the same members of staff.

1.4 Out of the 10 concerns raised so far this year, 5 have concluded and 5 are ongoing.



1.5 Current trends indicate that the number of concerns raised related to the Covid-19 pandemic are decreasing. In 2020/21 there were 9/17 concerns raised related to the Covid-19 pandemic. So far in 2021/22 2/10 concerns relate to Covid-19 pandemic. These are that;

- In the middle of a pandemic some staff were making plans to go to a B&B for a party
- Fraud on a Covid-19 rota arrangement (this concern was raised for a second time in respect of a staff member working within Microbiology and fraudulently claiming pay for unworked hours on a Covid-19 rota. We were already investigating this issue within Microbiology which was raised as a concern in 2020/21)

1.6 The remaining 8 cases raised so far in 2021/22 are as follows;

- **Patient Safety Issue** - Unthickened drinks being routinely left in front of patients with swallowing issues. Patients toileting needs not being met. Patients being left unattended/unsupervised.
- **Financial Abuse** of a Service User
- **Workforce Stability / Pressures** - High staff turnover on Acute Hospital Ward / Nurses extremely unhappy being moved to other wards
- favouritism, unfair allocation of workload, **perceived bullying**, lack of confidence in line manager
- **Inappropriate and unprofessional behaviour** from newly appointed line manager, increased staff turnover/sickness absence/reduced morale due to appointment of new line manager
- Concerns around **mistreatment of staff and service users** and favouritism from line managers
- Concerns related to poor treatment, **bullying and undermining of staff**
- **Fraud** - Staff member working in undeclared job while in receipt of Statutory Maternity Pay

1.7 Out of the 10 concerns raised in 2021/22; 4 of these concerns are related to individuals/services within Directorate of Acute Services, 4 concerns are related to individuals/services within Directorate of OPPC and the remaining 2 concerns are related to individuals/services within Directorate of MHLD.

1.8 The trend continues that majority of concerns are raised anonymously.

YEAR	2017/18	2018/19	2019/20	2020/21	2021/22
Anonymous	5	15	13	10	8
Confidential	2	3	4	1	1
Open	2	5	2	6	1
TOTAL	**9**	**23**	**19**	**17**	**10**

1.9 The trends continue to highlight that concerns are raised in good faith even where they are not upheld following investigation.

YEAR	2017/18	2018/19	2019/20	2020/21	2021/22
Upheld	1	7	4	7	2
Partially Upheld	1	6	1	4	1
Not Upheld	7	8	8	5	1
Cases On-going	0	0	2	1	5
No Action Required	0	2	2	0	1
TOTAL	**9**	**23**	**19**	**17**	**10**

1.10 Concerns related to patient services / patient safety significantly increased in 2020/21 with majority of the concerns relating to the Covid-19 pandemic. Current trends indicate that the number of patient safety concerns have reduced in 2021/22.

Type of concern raised each year	2017/18	2018/19	2019/20	2020/21	2021/22
Fraud	0	7	11	5	1
Financial concerns	2	3	0	1	2
Theft	1	1	0	1	0
Patient Services / Safety	3	8	4	9	3
Bullying / Poor treatment	0	3	2	1	4
Other	3	1	2	0	0
TOTAL	**9**	**23**	**19**	**17**	**10**

1.11 It is a concern that the number of cases reported related to perceived bullying/poor treatment of staff has more than doubled in the first 6 months of this year than in previous two years.

1.12 Case timescales remain a concern. Each case will require a different investigation timescale depending on the scale and complexity of the case. Some cases are also delayed due to third party involvement.

1.13 2 out of 10 concerns raised in 2021/22 have required a formal investigation. One of these Investigations commenced on 09 July 2021 and is expected to conclude with an action plan at the end of October 2021, this case coincided with a safeguarding investigation. The second case commenced on 07 May 2021 with a fact finding investigation and following this a formal investigation was initiated on 19 September 2021. it is anticipated that this case will conclude in November 2021.

1.14 Effective from 01 April 2021, all Whistleblowing cases are recorded on a new tracking system; Selenity ER Tracker. This new system will allow us to monitor, track case progress and report on average investigation timescales going forward. As well as this, quarterly ER case activity reports will be available via our new Case Management Dashboard.

2.0 How we are sharing the lessons from cases.

Staff Newsletter

2.1 Our first Whistleblowing staff newsletter has been published and shared across the Trust. The newsletter is a tool for reminding managers and staff about the importance of raising concerns and to share some of the lessons we have from our cases over the past number of years.

2.2 A further newsletter will be published in 2022 and we fully expect that continued publication of this newsletter will further highlight the raising concerns campaign.

Manager On-line Clinics

2.3 Coinciding with the publication of the staff newsletter, we held 4 zoom clinics for managers; these clinics ran throughout the month of June 2021. A separate clinic was also held for managers in Trasna House and newly appointed Nurse managers in Non-Acute Hospitals.

2.4 The aim of these clinics is to provide a forum for managers to hear the lessons arising from whistleblowing cases in the Trust and to provide an opportunity for discussion on what managers can do if they have concerns raised them in their teams or service. Each session was 1 hour long and attended by approximately 15 managers per session.

2.5 A further 4 awareness clinics are scheduled to take place in November and December 2021.

2.6 These clinics are also used as an opportunity to promote to managers the need to support us with the whistleblowing agenda and the need for investigators for cases.

Band 7 Resource

2.9 A Band 7 HR Manager has been appointed to manage the raising concerns campaign / Whistleblowing case load under the direction of the Deputy Director of HR Services. This is a pilot post initially for 1 year with the possibility of extension while we evaluate the appropriateness of this resource longer term.

2.10 Work has commenced on streamlining processes, developing standard operating procedures, developing/following up action plan logs and researching the role of the WB Advocate.

Freedom to Speak Up Guardian role

2.11 The Director of HR & OD along with the Deputy Director – HR Services joined the team meeting of the 'Freedom to Speak Up' Guardians at Merseycare NHS Trust to discuss their role and the set-up of the Guardian team. The role of the Guardian is something that requires further more detailed discussion within the Trust and consideration of the business case for implementing same. It is a role which could greatly enhance the confidence of staff seeking to raise concerns and give assurance to the Trust that concerns are being properly and effectively addressed.

2.12 Attached at Appendix 1a and b are the National Guardian template Job Descriptions, and a discussion at Governance Committee would be welcomed on the content of this role, and how this might assist in furthering work around raising concerns and our openness culture.

3.0 Case Review - update

Microbiology

The whistleblowing investigation and subsequent disciplinary investigations following fraud concerns within the Microbiology service have concluded with the exception of one disciplinary appeal hearing following dismissal of a staff member. This was scheduled to be heard on 22 October but has been delayed due to an individual positive covid case. An action plan is being developed on the back of a range of issues identified as part of the investigations. The action plan will continue to be subject to Oversight.

In total 16 individual staff were the subject of disciplinary proceedings with a range of outcomes from those hearings.

- 1 staff member - No Sanction
- 1 staff member - Informal Warning
- 3 staff members - Formal Warnings
- 10 staff members - Final Warnings
- 1 staff member summarily dismissed (currently being appealed)

Work is undergoing with Payroll Shared Services to begin the recoupment of fraudulent over claims resulting in overpayment of salary; this is estimated at the value of; £90,288.40 gross.

LAC whistleblowing case - 2015

In November 2015 issues were raised by a number staff under the Trust's Whistleblowing Policy regarding concerns in relation to the Court LAC Team.

The following is a summary of the main concerns raised by the Whistleblowers and have been themed as follows:

- Culture within the Team
- Use of inappropriate/derogatory/sexualised language regarding service users
- Quality of service provided to some families
- Culture of disrespect toward some service users.

The whistleblowing concerns were upheld.

There has been recent media report relating to the removal from the NISCC register of a Senior Practitioner who was referred to NISCC in respect of this case.

Extracts from the NISCC report from the hearing in September 2021 are below:

Particulars of the Allegation:

That, being registered under the Health and Personal Social Services Act (Northern Ireland) 2001 (as amended), and whilst employed as a social worker:
1. On dates unknown between 06 July 2009 and 16 March 2016, you used inappropriate and / or derogatory language in relation to service user(s).
2. On dates unknown between 06 July 2009 and 16 March 2016, you used inappropriate and / or derogatory language in relation to a colleague [name redacted].
3. In respect of some or all of the dates set out in Appendix A, you over-claimed mileage for reimbursement of travel by submitting claims with inflated distances for journeys.
4. In respect of some or all of the dates set out in Appendix B, you over-claimed mileage for reimbursement of mileage which was not allowable under Section 17 of the NHS Terms and Conditions of Service Handbook. 5. Your actions set out in 3 and 4 above were dishonest. And that by reason of the matters set out above, your fitness to practise is impaired by reason of your misconduct.

The Committee concluded that given the seriousness of the Registrant's misconduct and her lack of insight and remediation of her failings, a Removal Order was the only sufficient sanction. The Committee determined that the Registrant's behaviour was fundamentally incompatible with being a registered social worker. The Registrant's misconduct was persistent, repetitive and took place in her work place. The Registrant failed to attend the hearing, demonstrate insight and remorse or assure the Committee that there would be no repetition of her misconduct. The Committee found the Registrant's dishonest behaviour to be serious and at the higher end of the spectrum. The Committee considered that the Registrant abused her position as a social worker and used derogatory and inappropriate language about service users, for whom she was entrusted with personal information. Although no harm was caused to service users, the Registrant failed to refer to service users with dignity and respect. In all of the circumstances, the Committee concluded that a Removal Order was the only sanction available to it to protect the public and to meet the public interest, and to mark the seriousness and unacceptability of the Registrant's misconduct. The Committee considered the potential impact of a Removal Order on the Registrant, but concluded that the protection of service users and wider public interest in the system of regulation outweighed the impact on the Registrant. The Committee concluded

that a Removal Order was a suitable, appropriate, and proportionate sanction which will be imposed on the Registrant's registration with immediate effect.

Learning from this case will be shared in the first 2022 newsletter.

Southern Health and Social Care Trust

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GOVERNANCE COMMITTEE COVER SHEET

Meeting Date	12th May 2022		
Agenda item	Learning from Experience Update		
Accountable Director	Dr Maria O'Kane, Medical Director		
Report Author	Name	Caroline Doyle	
	Contact details	Personal Information redacted by the USI	
This paper is presented for: **Assurance**			
Links to Trust Corporate Objectives	√	Promoting Safe, High Quality Care	
	☐	Supporting people to live long, healthy active lives	
	√	Improving our services	
	√	Making best use of our resources	
	☐	Being a great place to work – supporting, developing and valuing our staff	
	☐	Working in partnership	

	This report cover sheet has been prepared by the Accountable Director. *Its purpose is to provide the Trust Committee with a clear summary of the paper being presented, with the key matters for attention and the ask of the Committee.* *It details how it impacts on the people we serve.*

1. Detailed summary of paper contents:

The purpose of this paper is to update the Governance Committee on Trust Learning from Experience ongoing progress and identified challenges. This paper should be considered as supplementary to the Trust Clinical and Social Care Governance Report. The key elements that are addressed are listed below:

- Pathways for Sharing Learning from Experience
- Improvements to date
- Focus for 2022 2023 – Quality and Safety Group; 3 specific areas targeted for improvement

2. Areas of improvement/achievement:

- Expansion of Weekly Governance meetings
- Echo Network
- Clinical Audit

3. **Areas of concern/risk/challenge:**

- Culture
- Scale of dissemination

4. Impact: Indicate if this impacts with any of the following and how:

Corporate Risk Register	Not Applicable
Board Assurance Framework	Not Applicable
Equality and Human Rights	Not Applicable

Learning from Experience Update 12th May 2022

Introduction

Within the Terms of Reference of the Learning from Experience Forum (LEF) is the requirement to provide assurance and updates in the form of 6 monthly reports to Trust Governance Committee on the work of the forum. The last update was provided to the 16th November 2021 meeting of the Governance Committee. Since then the LEF has met on two occasions – November 2021 and January 2022.

There are multiple pathways for sharing learning from experience in the Trust as previously reported to the Governance Committee:

- Weekly Governance Meetings
- Litigation Outcomes and Patient Safety (M&M) meetings
- Litigation Report for Trust Governance Committee
- Standardisation of SAI Template/Process
- Strengthening response to SAIs
- Standards & Guidelines and Learning Letters
- Learning from Patient Feedback at ward level
- Learning from cross Directorate Oversight Groups
- Learning from Whistleblowing (Raising Concerns)
- Nursing and Midwifery Learning from Practice Bulletin

These pathways are at varying stages of maturity.

Development Plans for 2022/23

As we move towards embedded collective governance & accountability to further improve the safety and quality of services, there will be a continued focus on improvements in systems for sharing learning. This will include:

- Quarterly presentations of summarised data and learning, including examples of good practice, in each division to the Learning from Experience Forum
- A process for feeding the above into the Quality and Safety Group where the data can be triangulated so that intelligence may be provided to the Governance Committee
- Closer involvement of Divisional Medical Directors in weekly governance meetings to strengthen the link between governance and wider sharing of learning
- Targeting areas for improvement. The specific areas for improvement in the coming year will be:

    - Improving Insulin administration
    - Reducing violence & aggression

- Reducing waiting times : GIRFT

Work will now commence to engage the support of QI, identify the measures which will be used to evaluate if there has been any change and complete these three projects between June 2022 and June 2023.

Further ways to enhance learning:

ECHO Network

A common theme at many forums, both within the Trust and regionally, is the challenge to disseminate learning from experience. In recognition of this, the Strategic Planning and Performance Group (SPPG), previously HSCB, has launched a series of ECHO Knowledge Network sessions, open to all Trusts and at which SHSCT is well represented. The objective is that topics, chosen by Trusts, will be presented via Case Study and the learning will be drawn out through group engagement i.e. the Trust representatives working together, facilitated by ECHO staff. The first programme for 2022 includes 5 sessions on the Deteriorating Patient. The final session, scheduled for October, is "**Learning: How we Apply and Disseminate the Key Learning from SAIs – are we succeeding?"**

The Objective is to "Discuss how learning from SAIs is currently disseminated across NI healthcare and explore ways in which this process could be enhanced."

Clinical Audit

Following recent agreement to establish a Clinical Audit team in SHSCT, the team is in the early stages of recruitment. The development of this pathway will also help to pull out learning and actions required to address.

Expansion of Weekly Governance Meeting

This is a very timely and practical way for many staff to share, with other operational teams, incidents and learning therefrom which have taken place in the previous week. As the experience has been positive, attendees at the weekly meeting and the areas discussed have expanded. It now covers:

- SAIs
- Catastrophic incidents
- Early alerts
- Never Events
- Director Oversight groups
- Litigation
- Medication incidents
- Safeguarding
- Information Governance
- Standards & Guidelines

- Clinical & Regional PIVFAIT audits
- Infection Prevention & Control
- Falls, Pressure Ulcers, Violence & Aggression, Datix incident numbers

It has been agreed that the following will also be included:

- Results Sign-off (monthly)
- Complaints data to enable triangulation of complaints, claims and incidents
- MRSA, CDiff and MSSA
- Waiting List/Waiting Times data

Quarterly Reporting to SMT on RQIA Recommendations and BSO Internal Audit Recommendations

In 2022-2023, quarterly summaries of recommendations made in:

- RQIA reports and
- Internal Audit reports

will be provided to SMT. This will facilitate Directors' oversight of recommendations and the action taken to implement them. It is anticipated that this will ensure a greater focus on learning from the findings in these RQIA and Internal Audit reports.

Conclusion

Some progress has already been made in providing opportunities for sharing learning. It is anticipated that a collective leadership culture, the incorporation of a Quality and Safety Group into the governance structure (with associated feeds into this group), and targeting specific areas for improvement in a defined timescale, will enhance learning and its dissemination. Work is underway to specify what the expectation is from operational teams and to begin to effect the changes from June 2022.

Southern HSC Trust
Fraud Report 2022-23
Audit Committee October 2022

Reported Fraud Cases 2022-23

Case Ref	Date Reported to CFPS	Case Outline	Directorate	Estimated Impact £	Action/Update	Case Status	Learning Outcome
3405	18.05.2022	A co worker off duty reported seeing a colleague (on duty) in a local pub. The manager followed up and the subject was not on the allocated ward.	MHD	Not yet known	Disciplinary investigation underway	Open	
3407	19.05.2022	Allegation that a staff member has been working elsewhere while in receipt of sick pay.	OPPC	Not yet known	Disciplinary investigation underway	Open	
3410	23.05.2022	Suspected theft of drugs by a member of staff within an GP Out of Hours setting	OPPC	<£5	Disciplinary investigation was initiated but the employee resigned. The matter has been reported to the PSNI due to the nature of the drugs stolen	Open	

Southern HSC Trust
Fraud Report 2022-23
Audit Committee October 2022

3465	25.07.2022	Concerns re fraudulent activity on a procurement purchase card	FPE	£247.99, was reimburse by Barclaycard	A transaction was identified to Currys which was not recognised by the Estates team. The retailer was unable to provide the detail on this transaction but internal investigation confirmed the cardholder did not usually make online transactions. Reported to Action Fraud and refund sought from Barclaycard. Card cancelled	Open	
3466	26.07.2022	Manager alerted to worker on sick/covid paid leave who has a second employment within the Trust, worked a shift on the second job.	OPPC	Not yet known	Disciplinary investigation underway, initial review identified another shift worked during sick leave in previous months	Open	
3467	27.07.2022	An anonymous phone caller reported allegations to the dom care manager that a worker has been working shifts for an independent sector agency while on long term (long covid) sick leave from her post in the SHSCT.	OPPC	Not yet known	Counter Fraud Service carrying out investigation, in conjunction with internal investigation	Open	

Southern HSC Trust
Fraud Report 2022-23
Audit Committee October 2022

3477	08.08.2022	Concerns around a nurse on long term sick leave (initially covid risk assessed, then long covid certified as covid anxiety), declined options to work from home, now evidence she has set up private business from home.	Acute	Not yet known	Disciplinary investigation underway	Open	
3487	05.09.2022	Allegation re suspected theft of staff personal property/money	Acute	Approx. £120 employee's money	Disciplinary investigation underway. Has been reported to the PSNI	Open	
3502	26.09.2022	Trust was informed by PSNI that a member of nursing staff was issued with a caution in respect of an allegation of theft from a service user.	OPPC	Allegation up to £500-£600 of service user's money	Employee placed on precautionary suspension pending more information and then disciplinary investigation will be initiated	Open	

Southern HSC Trust
Fraud Report 2022-23
Audit Committee October 2022

Updates on previous cases

Case Ref	Date Reported to CFPS	Case Outline	Directorate	Estimated Impact £	Action/Update	Case Status	Learning Outcome
3243	12 Oct 2021	Concerns raised that retired staff has removed/stolen patient records	CYPS	£nil	Review of case files raised concerns that former employee had not been carrying out duties. PSNI has been informed that the records are missing, to explore liaising with Garda **Oct22 Update**: *The case files have been returned to SHSCT*	Closed	Community staff to be reminded at supervision on Records Management and Info Governance
3334	10 Feb 2022	Routine checking identified excessive mileage claims from domcare worker	OPPC	£1927.52 recovered from former employee	Investigation in conjunction with Counter Fraud identified excessive mileage claims including claims for days when not working totalling 1542 miles over 6 months, review confirmed that overclaiming not present before this period. Disciplinary action underway, worker resigned from post. Overclaimed amount recovered from final pay **Oct22 Update**: *The worker resigned from domcare post but retained bank post. Disciplinary hearing outcome to reaffirm that would have been dismissed. Reported to NISCC. Former employee has sent in cheque for £1927.52 from estimated amount in disciplinary report*	Closed	Checking controls operating satisfactorily

Southern Health and Social Care Trust

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BOARD REPORT SUMMARY SHEET

Meeting: Date:	Trust Board 24th September 2020
Title:	Clinical concerns within Urology
Lead Director:	Dr Maria O'Kane Medical Director
Purpose:	Confidential – For Information

Key strategic aims:

Delivery of safe, high quality effective care

Key issues/risks for discussion:

This report outlines 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.

There is likely to be significant media interest in this case.

Plans need to be put in place to respond to primary care colleagues and to establish a targeted help line for patient concerns.

There is likely to be impact on other patients who are awaiting urological appointments/follow up.

Consultant A is no longer employed as of 17th July 2020, having given his notice of his intention to retire from his substantive post as at 30th June 2020. The Trust declined his request to return given outstanding employment matters relating to a previous MHPS case commenced on 30th December 2016. Although Consultant A initially challenged this matter, following correspondence exchange between his solicitor (Tughan's) and DLS, he is no longer employed as of 17th July 2020. There has been no legal challenge in respect of this matter, to date.

Introduction

On 7th June 2020, Consultant A sent an email to the Scheduling administrative staff for Urology, which was copied to the Associate Medical Director (AMD) – Surgery, in which Consultant A explained that he had added 10 patients to the Trust's list for urgent admission. On the AMD's initial review of the list of patients in his capacity as AMD, he noted that 2 of the patients were stated to have been listed on 11th September 2019 and 11th February 2020, both requiring *"Removal/Replacement of Stent and Right Flexible Ureteroscopic Laser Lithotripsy".*

It appeared to the AMD that these patients had been assessed on the dates given by Consultant A (11th Sept 2019 and 11th Feb 2020), but the outcomes of these assessments did not appear to have been actioned by him as required i.e. to add the patients to the inpatient waiting list on the Trust's Patient Administration System at that time. These patients therefore appeared on the face of it to fall outside the Trust's systems with all the potentially very serious clinical risks attendant on that.

As a result of these potential patient safety concerns a review of Consultant A's work was conducted to ascertain if there were wider service impacts. The internal reviews, which considered cases over a 17 month period (period 1st January 2019 - 31st May 2020), identified the following:

- The first internal review concentrated on whether the patients who had been admitted as an emergency had had a stent inserted during procedure and if this had been removed. There were 147 emergency patients under the care of Consultant A listed as being taken to theatre. Of these, information was not available on NIECR for 46 patients. Following further review of inpatient notes, it was identified that 3 patients had not had their stent management plans enacted. Management has been subsequently arranged for these 3 patients.

- The second internal review was for 334 elective-in patients admitted under Consultant A's name during the same period. Out of the 334 patients reviewed there were 120 of cases who were found to have experienced a delay in dictation ranging from 2 weeks to 41 weeks, a further 36 patients who had no record of care noted on the regional NIECR system.

- To date five patient cases have been identified through screening for Serious Adverse Incident review - this screening has indicated potential deficiencies in the care provided by Consultant A. A further two cases, managed by Consultant A, have been identified and these are being screened as Serious Adverse Incidents. These seven patients' care is now being followed up by the Urology Team.

Immediate actions following discovery of concerns in June 2020

- Advice sought from NHS Resolutions (formerly NCAS) who recommended restrictions of clinical practice.
- Referral of these concerns in respect of Consultant A was made to the GMC.
- Up until the date of termination, restrictions were placed by the Trust that Consultant A was to no longer undertake clinical work and that he did not access or process patient information either in person or through others either in hard copy or electronically. A request was also made that he voluntarily undertake to refrain from seeing any private patients at his home or any other setting and same was confirmed in writing via Consultant A's solicitor.
- Given that Consultant A is no longer employed, the handling of this case is now through the GMC, relevant solicitors and Trust.
- The Trust has set up a panel for the Serious Adverse Incident Reviews and this is being chaired by an independent Chair, with a Urology Consultant recommended by the Royal College of Surgeons as a Urology Subject Expert (from England).
- An Early Alert has been sent to the Department of Health advising them of the issues.
- Two separate weekly meetings have been established:
    - Internal oversight meeting - chaired jointly by Director of Acute Services and Medical Director;
    - External – Chaired jointly by Medical Director and Director of HSCB with representatives from Trust, PHA, HSCB and Department of Health.

The following are the areas that have been identified that immediately need to be concentrated on and actions being taken on these patients to mitigate against potentially preventable harm:

1. A concern identified in the SAIs is that a Cancer MDM treatment recommendation for a patient was not enacted. As a result, all notes for post MDM follow-up patients for Consultant A are being reviewed to ensure MDM treatment recommendations have been actioned. (This data is currently being collected as this is a manual exercise)
2. A further concern identified is patients have had diagnostic tests and the results have not been actioned or communicated to the patients, including results with significant findings. The diagnostic tests identified are Pathology and Radiology results. A total of 1711 results are currently being looked at by two of the Trust's Clinical Nurse Specialists. Where they identify that follow-up may not have been actioned, this is escalated for a Consultant Urologist to review and provide input.

Where the reviewing consultant feels that there is a possible issue with care provided, a Datix will be completed by the Consultant Urologist.

3. A further review of inpatients who had stent procedures performed by Consultant A from January 2018 to December 2018 is being carried out to ascertain if any further patients require stent management plans.

In addition, a significant number of patients who are overdue follow up on Consultant A's Oncology Outpatient Review Waiting List (patients who are past their review date) are having their outpatient assessment provided by a recently retired Urologist who has been engaged by the Trust - 235 patients.

A preliminary discussion has been undertaken with the Royal College of Surgeons Invited Review Service regarding Consultant A's practice and potential scope and scale of any independent external review, if required.

Timescales

The above reviews and scoping exercises are either completed or under way so timescales still need to be clarified. The Department of Health is keen to manage the oversight of the review process. The Minister will be required to share details of this with the Assembly and this is likely to be mid- October, subject to the outcomes of the review exercises. A resource plan is in development to identify clinical capacity for communication, patient information and clinical assessment and management plans. This will present significant challenge given the current workforce issues within the Urology speciality.

Previous concerns relating to Consultant A

Previous concerns relating to Consultant A were being addressed since March 2016, and under Maintaining High Professional Standards from December 2016. The timeline for these previous concerns is detailed below:

March 2016

On 23 March 2016, Mr EM, the then Associate Medical Director (Consultant A's clinical manager) and Mrs HT, Assistant Director (Consultant A's operational manager) met with Consultant A to outline their concerns in respect of his clinical practice. In particular, they highlighted governance and patient safety concerns which they wished to address with him.

Consultant A was provided with a letter dated 23 March 2016 detailing their concerns and asking him to respond with an immediate plan to address the concerns. Four broad concerns were identified:

- **Un-triaged outpatient referral letter**
  It was identified at that time that there were 253 un-triaged referrals dating back to December 2014.

- **Current Review Backlog up to 29 February 2016**
  It was identified at that time that there were 679 patient's on Consultant A's review backlog dating back to 2013, with a separate oncology waiting list of 286 patients.

- **Patient Centre letters and recorded outcomes from clinics**
  The letter noted reports of frustrated Consultant colleagues concerned that there was often no record of consultations / discharges made by Consultant A on Patient Centre or on patient notes.

- **Patient's hospital charts at Consultant A's home**
  The letter indicated the issue of concern dated back many years. No numbers were identified within the letter.

April to October 2016
During the period April to October 2016, discussions were on-going between Acute Directorate and Medical Director about how best to manage the concerns raised with Consultant A in the letter of 23 March 2016. It was determined that formal action would not be considered as it was anticipated that the concerns could be resolved informally. Consultant A advised the review team he did not reply to the letter but did respond to the concerns raised in the letter by making changes to his practice.

November 2016
Consultant A was off work on Personal Information redacted by the USI from 16 November 2016 Personal Information redacted by the USI and was due to return to work on 2 January 2017.

An on-going Serious Adverse Incident (SAI) investigation within the Trust identified a Urology patient Patient 10 who may have a poor clinical outcome because the GP referral was not triaged by Consultant A.

An SAI investigation was commenced in Autumn 2016. Through the SAI it was identified that the referral for patient Patient 10 had not been triaged by Consultant A. An initial look back exercise was undertaken and a number of other patients were identified as not having been triaged by Consultant A. Further assessment of the

issue identified a significant number of patients who had not been triaged by Consultant A.

The issues of concern relating to patient Patient 10 were wider than the referral delay. There were issues of concerns in respect of the radiology reporting on diagnostic images however from a urology perspective, it was felt that the symptoms recorded by the patient's GP on the initial referral should have resulted in the referral being upgraded to a 'red-flag' referral and prioritised as such.

December 2016

The concerns arising from the SAI were notified to the Trust's Medical Director, Dr RW in late December 2016. As a result of the concerns raised with Consultant A on 23 March 2016 and the serious concern arising from the SAI investigation by late December 2016, the Trust's Medical Director determined that it was necessary to take formal action to address the concerns.

Information initially collated from the on-going SAI of Consultant A's administrative practices identified the following:

- from June 2015, 318 GP referrals had not been triaged in line with the agreed / known process for such referrals. Further tracking and review was required to ascertain the status of all referrals.
- there was a backlog of 60+ undictated clinics dating back over 18 months amounting to approximately 600 patients, who may not have had their clinic outcomes dictated. It was unclear what the clinical management plan was for these patients, and if the plan had been actioned
- some of the patients seen by Consultant A may have had their clinical notes taken back to his home, and are therefore not available within the hospital. The clinical management plan for these patients was unclear, and may be delayed.

As a result of these concerns, work was undertaken to scope the full extent of the issues and to put a management plan in place to review the status of each patient. The management plan put in place was to provide the necessary assurances in respect of the safety of patients involved.

28 December 2016

Advice was sought from the National Clinical Assessment Service (NCAS) on 28 December 2016 and it was indicated that a formal process under the Maintaining High Professional Standards Framework was warranted.

30 December 2016
Consultant A was requested to attend a meeting on 30 December 2016 with Dr RW, Medical Director and Ms LH, HR Manager during which he was advised of a decision by the Trust to place him on a 4 week immediate exclusion in line with the Maintaining High Professional Standards (MHPS) Framework to allow for further preliminary enquiries to be undertaken.

A letter was issued to Consultant A in follow up to the meeting detailing the decision of immediate exclusion and a request for the return of all case notes and dictation from his home. The letter also advised Consultant A that Dr AK had been appointed as Case Manager for the case and Mr CW was identified as the Case Investigator.

03 January 2017
Consultant A met with Mrs MC, Head of Service for Urology to return all case notes which he had at home and all undictated outcomes from clinics in line with the request made to him by Dr RW on 30 December 2017.

20 January 2017
During the period of the 4 week immediate exclusion period notified to Consultant A on 30 December 2016, Mr CW wrote to Consultant A to request a meeting with him on 24 January 2017 to discuss the concerns identified and to provide an opportunity for Consultant A to state his case and propose alternatives to formal exclusion.

23 January 2017
On 23 January 2017, Mr CW wrote to Consultant A seeking information from him in respect of 13 sets of case-notes that were traced out on PAS to him but could not be located in his office and which had not been returned to the Trust with the other case-notes on 3 January 2017.

24 January 2017
The meeting between Mr CW and Consultant A took place on 24 January 2017 with Mrs SH, Head of Employee Relations present.

26 January 2017
In line with the MHPS Framework, prior to the end of the 4 week immediate exclusion period, a case conference meeting was held within the Trust to review Consultant A's immediate exclusion and to determine if, from the initial preliminary enquiries, Consultant A had a case to answer in respect of the concerns identified.

A preliminary report was provided for the purposes of this meeting.

At the case conference meeting, it was determined by the Case Manager, Dr AK that Consultant A had a case to answer in respect of the 4 concerns previously notified to him and that a formal investigation would be undertaken into the concerns.

The matter of his immediate exclusion was also considered and a decision taken to lift the immediate exclusion with effect from 27 January 2017 as formal exclusion was not deemed to be required. Instead, Consultant A's return to work would be managed in line with a clear management plan for supervision and monitoring of key aspects of his work.

These decisions were communicated to Consultant A verbally by telephone following the case conference meeting on 26 January 2017.

6 February 2017
A letter was sent to Consultant A on 6 February 2017 confirming the decisions from the case conference meeting on 26 January 2017 and notifying him of a meeting on 9 February 2017 to discuss the detail of the management plan and monitoring arrangements to be put in place on his return to work.

9 February 2017
Consultant A attended a meeting with the Case Manager, Dr AK on 9 February to discuss the management arrangements that were to be put in place on his return to work following the immediate exclusion period. Mrs SH and Consultant A's son were in attendance at the meeting. The action plan was accepted and agreed with Consultant A at the meeting.

20 February 2017
Between 27 January 2017 when the immediate exclusion was lifted and 17 February 2017, Consultant A was unable to return to work due to ill health. He returned to work on 20 February 2017 in line with action plan agreed at the meeting on 9 February 2017.

As part of the action plan agreed, monitoring mechanisms were put in place to continuously assess his administrative processes to safeguard against a recurrence of the concerns raised with regards to his outpatient work. This monitoring arrangement was in place up until Consultant A's date of leaving. There were 3 occasions when there were deviations from the agreed actions, and on two occasions Consultant A offered acceptable explanations. On the third occasion, Consultant A had no acceptable explanation for the delay in dictation, however all dictation was completed at the point of retirement.

January and February 2017
During January and February 2017, Consultant A made a number of representations to Dr RW, Medical Director and Mr JW, Non-Executive Director in respect of process and timescale. In considering the representations made, it was decided that Mr CW should step down as Case Investigator prior to the commencement of the formal investigation. Dr NC, Associate Medical Director and Consultant Psychiatrist was appointed as Case Investigator.

16 March 2017
The terms of reference for the formal investigation were shared with Consultant A along with an initial witness list.

April, May and June 2017
During April, May and June 2017 the Case investigator met with all witnesses relevant to the investigation. Witness statements were prepared and issued for agreement.

14 June 2017
Dr NC, Case Investigator wrote to Consultant A requesting to meet with him on 28 June 2017 for the purpose of taking a full response in respect of the concerns identified.

19 June 2017
Consultant A requested to reschedule the meeting to secure his preferred accompaniment to the meeting. This was facilitated. A meeting on 29 June, 30 June and 1st July was offered. Consultant A requested to defer the meeting until later in July until after a period of planned annual leave, and a meeting was confirmed for 31 July 2017.

05 July 2017
Consultant A advised the date of 31 July was not suitable and a date of 3 August 2017 was agreed.

03 August 2017
A first investigation meeting was held with Consultant A in order to seek his response to the issues of concern.

At the meeting on 3 August 2017 it was agreed that a response would not be taken in respect of term of reference number 4 in respect of private patients until patient information requested by Consultant A had been furnished to him. It was agreed that

a further meeting date would be arranged for this purpose once all information had been provided. Consultant A's responses to the remaining terms of reference were gathered.

16 October 2017
A meeting date for the second investigation meeting was agreed for 06 November 2017.

06 November 2017
A second investigation meeting was held with Consultant A in order to seek his response to the issues of concern in respect of term of reference 4. At the meeting of 6 November 2017, Consultant A advised Dr NC that he wished to make comment on both his first statement and also the witness statements provided to him. He further advised that his priority for November and December was completion of his appraisal and that he would not be able to provide his comments during this period. It was agreed his timescales would be facilitated.

15 February 2018
By 15 February 2018, Consultant A had not provided the comments he had previously advised he wished to make and therefore this was queried with Consultant A and an update sought.

22 February 2018
No response was received and a further email reminder was sent to Consultant A on 22 February 2018. On the same day, Consultant A responded to advise that he had not had time to attend to the process since the meeting in November 2017. He requested a copy of the statement from the November meeting and indicated he would provide commentary on all documents by 31 March 2018.

Consultant A was asked to provide comments by 9 March 2018 rather than 31 March 2018.

16 March 2018
Comments on the documents were not received on 9 March 2018 and a further reminder was sent to Consultant A requesting his comments no later than 26 March 2018. It was advised that the investigation report would be concluded thereafter if comments were not provided by 26 March 2018.

26 March 2018
No comments were received from Consultant A.

29 March 2018
A final opportunity was provided to Consultant A to provide comments by 12 noon on 30 March 2018. It was advised that the investigation report would be thereafter drafted.

30 March 2018
No comments were received from Consultant A.

2 April 2018
Comments on the statements from the meetings of 3 August and 6 November were received from Consultant A. Consultant A also queried requested amendments to notes of meeting on 30 December 2016 and 24 January 2017.

21 June 2018
In the interests of concluding the investigation report without further delay, all comments from Consultant A were considered and a finalised report was provided to Consultant A on 21 June 2018 for comment.

14 August 2018
The Case Manager, Dr AK wrote to Consultant A acknowledging receipt of his comments and advising he would consider these along with the final report and reach his determination in terms of next steps.

1 October 2018
Dr AK, Case Manager met with Consultant A to outline outcome of his determination that the case should be forwarded to a Conduct Panel under MHPS.

The Findings from the investigation

There were 783 un-triaged referrals by Consultant A of which 24 were subsequently deemed to need upgraded and a further 4 with confirmed diagnoses of cancer (plus the original SAI patient.) There was therefore potential for harm of 783 patients.

Consultant A stored excessive numbers of case notes at his home for lengthy periods. 288 charts were brought by him from his home and returned in January 2017. This is outside normal acceptable practice. There were 13 case notes missing

but the review team is satisfied with Consultant A's account that he does not have these.

There were 66 clinics (668 patients) undictated and 68 with no outcome sheets, some going back a few years. Consultant A gave an explanation of doing a summary account of each episode at the end. He indicated patients were added to waiting lists at the point they should have been in any event.

Some of Consultant A's private patients were added to the HSC waiting list ahead of HSC patients without greater clinical need by these private patients.

27 November 2018
Consultant A submitted a lengthy and detailed grievance of 40 pages, with 49 Appendices. It was lodged along with a request for information. The grievance was held in abeyance pending completion of the information requests.

9 April 2019
Consultant A was advised by Dr AK, Case Manager that a GMC referral was to be submitted following a discussion regarding the case with the GMC Liaison Officer.

Timeline for grievance process – November 2018 to June 2020:

The requested information relating to the information request was provided to Consultant A in 2 returns – one on 21 December 2018 and one on 11 January 2019.

Consultant A wrote to the Trust again on 12 March 2019, and advised that he had sought the advice of the Medical Protection Society and also Legal Counsel, and that he was therefore submitting a request for further information. Consultant A advised that following its receipt, the Trust would be advised whether any further information was to be requested, and /or whether the Formal Grievance was to be amended.

HR Director wrote to Consultant A on 3 June 2019, seeking further clarity on information requested in his 12 March 2019 letter. The Trust advised him that the information request was extensive in nature and would require significant time and resources within the Trust to compile. The Trust advised him that all reasonable efforts were being made to gather the requested information, however within his request there were elements which were much too wide and not properly defined.

Consultant A was therefore asked to refine and clarify the specifics of his request in respect of a number of points.

Consultant A responded on 24th June 2019, clarifying the information plus seeking 2 additional items. The request for information was still significant in nature, and took significant time and resources for the Trust to compile. The requested information was delivered to Consultant A's Secretary for his attention on 30th October 2019.

Since Consultant A had indicated that, following receipt of the requested information, he would advise whether or not his formal grievance was to be amended, the Trust awaited hearing from him in this regard. However, no further correspondence was received from Consultant A in respect of his grievance, or any amendments to it.

At this stage, from November 2019 through to end of January 2020, the Trust suffered significant disruption to its services and its HR function by reason of widespread Industrial Action by health service trade unions.

Furthermore, work was ongoing to finalise the SAI (Serious Adverse Incident) processes in respect of the patients affected by the original concerns in respect of Consultant A's practise.

In recent months the Trust's services and normal HR processes has been very severely impacted by the Covid – 19 pandemic. This prevented any employee relations work, including the hearing of grievances, being taken forward for a 3 month period from March to start of June.

On 26th April 2020, Consultant A wrote to the Trust's HR Director again, highlighting that a number of pieces of information from original requests had not been provided, and he requested these by 15th May 2020. On 15th, 22nd May and also on 8th June the Director of HR wrote to Consultant A with responses to these requests. The Trust believes that all substantial and detailed information requests have now been responded to.

June 2020 – September 2020

Grievance process ongoing. The grievance panel is due to conclude by mid October 2020.

As Consultant A is no longer employed, the Conduct Hearing under MHPS cannot be concluded. The GMC processes will continue regarding Consultant A's fitness to practise in light of both the previous concerns and the most recent concerns.

Summary of previous Serious Adverse Incidents – from 2016 onwards

Following the SAI Index Case Patient 10 which triggered the first MHPS case, the Trust identified a number of GP Urology referrals who were not triaged by Consultant A. 30 patients should have been red-flag referrals and of these 4 had cancer. A fifth patient, discovered during an outpatient clinic, was included as he was also not triaged and subsequently had a cancer confirmed. These five cases were subject to a further SAI review process.

Lessons Learned from the 5 SAI's

1. The clinical urgency category allocated by GPs to 30 patients referred to Urology were incorrect. The referrals using NICaN guidance should have been referred as a Red Flag. Four (plus 1) of these patients were subsequently shown to have cancer.

2. The process of triaging Urology cancer referrals from Primary Care to Secondary Care, under the direction of the HSCB, appears to be less efficient than it could be, bearing in mind that NICE NG12 guidance has not been adopted and electronic referral using CCG is not being used as efficiently as it could.

3. GP's are not mandated to provide HSCB with an assurance that they comply with the most up to date NICE or other guidelines. Therefore, HSCB are unaware of any risks consequent upon the non-compliance with NICE and other guidance within GP practices.

4. GP's are not mandated to refer patients using CCG clinical criteria banners; this can lead to error and delay.

5. There is no Regional or Trust guidance or policy on what is expected of clinicians when triaging referral letters. Triage of patient referrals is obviously viewed as extremely important but does not seem to be at an equivalent level of importance when ranked alongside other clinical governance issues. Despite being an evident problem for decades and requiring considerable time and effort to find a solution, it only really surfaced within the Trust after an Index case forced the situation out into the open.

6. Despite it being absolutely clear to Consultant A (based upon his close proximity to the development and signing off of regional guidance) of the consequences of non-triage, he did not routinely triage referral letters. The

Review Team consider that Consultant A's refusal to triage to a level similar to other clinicians, led to patients not being triaged, and this resulted in delays in assessment and treatment. This may have harmed one patient.

7. Consultant A confirmed that despite the Trust reminding him of the requirement to triage, he did not consistently triage referrals. He argued that, due to time pressures, he felt he was unable to perform the duties of the Consultant of the Week and his triaging duties. He has highlighted those views to Trust operational and management teams over a number of years.

8. The Trust made efforts to address Consultant A's non-triage over time. However, the Trust failed to put systems, processes and fail safes in place to ensure Consultant A consistently triaged patient referrals until 2017. However, this safeguarding process is heavily dependent on the Head of Service checking triage is completed when Consultant A is Consultant of the Week.

9. The Informal Default Triage process allows patients who should be red flagged to remain on a waiting list of routine or urgent cases.

HSC Business Services Organisation

Southern Health & Social Care Trust

Review of Mr A's Compliance with Relevant Authorities/Guidance in terms of his Private Work 2020/21

nqa ISO 9001 Registered Quality Management

Contents

Acknowledgement

Internal Audit wishes to thank management and staff at the Southern Health and Social Care Trust for their assistance and co-operation during the course of the assignment.

Control Log

Working Draft Issued to Inform Exit Meeting:	28 April 2021
Exit Meeting Held On:	29 April 2021
First Draft Issued On:	30 April 2021
Management Actions Received:	13 July 2021
Final Report Issued On:	31 August 2021

Distribution List

Shane Devlin	Chief Executive
Helen O'Neill	Director of Finance, Procurement & Estates
Dr Maria O'Kane	Medical Director
Melanie McClements	Director of Acute Services
Heather Trouton	Director of Nursing

Introduction

In November 2020, at the request of the Urology Assurance Group, the SHSCT Chief Executive requested a review of Mr A's patients transferring into SHSCT as HSC patients. In addition, the review will consider any Trust involvement with the Craigavon Urological Research & Education organisation.

Terms of Reference

The audit focused primarily on Mr A's change of status private patient's work during the period 1 January 2019 to 30 June 2020 in order to:

1. Establish the extent of SHSCT awareness of Mr A's private work, through the job plan process and their private patient identification and management processes.
2. Establish the extent to which Mr A's private work interacted with HSC services and facilities.
3. To identify all of Mr A's patients that changed status (private/NHS) and check that there is evidence that relevant guidance/authorities have been adhered to. This will include providing assurance that:
    - The appropriate Change of Status paperwork has been completed and authorised and that this is supported by an assessment, by the consultant, of the patient's clinical priority for treatment as a Health Service patient.
    - For all private work identified above, the patient joined the HSC waiting list at the same point as if their consultation had taken place as an NHS patient.
    - The Consultant fulfilled all obligations with regard to recording and identifying private activity.
    - Where private work was conducted on HSC premises, ensure the patient has been invoiced for relevant costs.

Internal Audit also considered whether the Trust has any involvement with CURE - Craigavon Urological Research & Education, to understand if there was a flow of money into the Trust and to check, as much as is possible from review of Trust records and engagement with Trust staff, whether any Directors/staff benefited from the operation of the company.

Limitation of Scope: Internal Audit would caution that the analysis conducted is largely based on the data provided by the Trust. Internal Audit did not walk through each individual patient's journey on their patient file and therefore the analysis may not be fully complete.

Executive Summary

Internal Audit has identified issues with Mr A's compliance with relevant guidance around private practice. Significant issues with the timing, completion and approval of change of status paperwork were identified when patients transferred from private to NHS care. Occasions were also found when patients that had been seen privately, were treated more quickly that than the Trust standard waiting times.

Significant issues were also found around the Trust's management and monitoring of compliance with private patient guidance in particular the change of status process and their ability to monitor that patients transferring from private to NHS care, are treated in an equitable manner. The findings in this report indicate issues around patients being able to pay to see a Consultant privately and then receiving preferential treatment in the NHS. The Trust should consider whether these issues are isolated to this one Consultant or indicative of a wider cultural issue.

In total in the review period, 5 of Mr A's private patients were identified as having been treated at the Trust without/prior to receipt of a change of status form. A further 8 patients were potentially private when they were seen in the Trust (excluding those cases that the Trust believe are poor administration rather than private work). 5 patients switched status more than once (from NHS-private-NHS). 6 change of status patients were seen ahead of Trust waiting times. A further 2 patients were added to PAS retrospectively effectively being placed on the waiting list ahead of where they should have been placed.

In addition to private practice issues, there are also patient safety matters identified in the report primarily around performance of Pre Operative Assessments.

The findings of the review are summarised as:

Trust Processes and Awareness of Mr A's Private Work

Trust Knowledge of Mr A's Private Work

1. The Trust were aware that Mr A holds a private outpatient clinic at his home. It is unclear what happened these private outpatients if they required diagnostics and/or inpatient/daycase procedures. The Trust does not appear to have explored or challenged the potential interaction with the Trust in the scenario where private outpatients may require diagnostics/procedures etc. There is learning for the Trust in this matter in terms of considering circumstances when a Consultant conducts private outpatients work only.

Job Planning & Payment

2. In line with job planning guidance and Consultant terms and conditions, a job plan review should take place annually. The most recent job plan available for Mr A is an unsigned job plan, dated 1 April 2018.
3. There is a query over the accuracy of APA payments to Mr A. As per HRPTS during the period January 2014 to July 2020, Mr A was paid for 2 Additional PAs. This does not agree to the various unsigned job plans available which show a range of APAs (from 1.275 to 2.5) for this period.

The Trust's Change of Status Process

4. The Trust's Change of Status form for when a private patient transfers to NHS treatment, has limited monitoring or control value. The Change of Status activity is not effectively approved by the Medical Director or reviewed by the Trust Clinical/Directorate Management. The Change of Status form itself and the Change of Status process require strengthening.
5. The Trust is not compliant with the regional guidance issued in 2018 which requires all Change of Status patients to be identified with a 'PTN' code on PAS.
6. The Trust does not have a process in place to ensure all change of status patients have been identified for monitoring purposes and to ensure that the process for changing status is effectively controlled and documented, as an assurance that the delivery of service is equitable.

Identification of Private Work

7. Laboratories, Radiology and Pharmacy are reliant on Consultants highlighting any private activity. There is a risk therefore that private activity in these departments may not be identified.
8. There is insufficient control over prescriptions pads to prevent the use of Trust prescription pads for private work.

Mr A's Change of Status Patient Activity

Approved Effective Change of Status Date

9. Contrary to Trust written procedure, the date the patient is added to PAS as an NHS patient is the effective date as per the Change of Status form, not the date the Change of Status form was approved by Medical Director.

Change of Status Patients who had Diagnostic (Radiology) Tests

10. In 10 out of the 21 Change of Status cases during the period from January 2019 to June 2020, the patient was referred for 1 or more imaging tests. In 3 of these 10 cases, the patient had the imaging tests in the Trust prior to changing status to NHS ie whilst still private patients. A further 5 out of the 10 patients had diagnostic requests made on the same date as the effective change of status date and the same date the patient was last seen privately. Given that these 5 Change of Status forms are unlikely to have been submitted and approved by the Medical Director on the same day as the patients' private appointments, these patients should potentially have been treated by the Trust as private patients.
11. 3 (including 1 of the 3 patients found to be private) out of the 10 patients were seen sooner than the Trust waiting time for the diagnostic/imaging test.

Patients who changed Status and had Inpatient/Daycase Procedure

12. Out of the 13 Change of Status cases transferred into the NHS for an inpatient/day procedure, 5 had their procedure during the review period (ie up to June 2020). The Trust Consultant Urologist assisting Internal Audit in this review considered that 2 of the 5 patients were not seen in line with the Trust waiting list time. These cases were not Urgent/red flag procedures (as categorised on PAS) and were seen significantly sooner than other patients on the waiting lists.

Retrospective Entry to PAS

13. Two change of status forms had been added retrospectively to PAS. Most significantly, one of these patients was added to the waiting list from September 2018 but this was not actually added to PAS in May 2020. At December 2020 this Change of Status had not been approved by Medical Director.

Protected Reviews

14. The Trust does not monitor the use of protected review appointments and there is a risk that private patients or Change of Status patients could potentially be seen quicker in a protected review appointment slot.
15. Internal Audit identified 1 case where a routine outpatient was seen in a protected review slot, 15 days after being added to the waiting list and therefore seen ahead of NHS patients with the same clinical priority.

Multiple Switches in Status

16. Contrary to guidance, in 5 of the 21 cases where a change of status form had been completed, the patient moved between NHS to Private to NHS for the same referral.

Analysis of Mr A Activity Data

Pre-Operative Assessments (POAs)

17. In 86 (25%) of the 351 procedures conducted by Mr A during the period January 2019 to June 2020 which required a Pre-Operative Assessment, a POA was not completed.
18. Upon further analysis, 1 of these 86 cases related to a private patient who was subsequently treated in the NHS. No Change of Status form had been completed.
19. 95% of the POAs completed on Mr A patients during the review period were completed less than 3 weeks before admission for surgery. The Trust requires POAs to be competed at least 3 weeks before (and up to 13 weeks before) admission for surgery,
20. The lack of POA or the short time scales between the completion of a POA and the date of admission for surgery is a potential indicator that a patient may have been seen privately and then had their procedure in the NHS.

Elective Surgery With No Outpatient Appointment

21. Out of a sample of records where a patient had surgery but there was no evidence on PAS of an outpatient appointment, we found:
    - 1 patient changed from NHS to private and back to NHS status in one day, with no Change of Status forms. This is a blatant breach of proper process and is an example whereby a significant advantage has been gained in terms of speed of treatment, by paying privately for an outpatient appointment. In the absence of an approved Change of Status form, this is arguably a private patient having a procedure using trust facilities and staffing.
    - In 2 cases, there was no outcome letter completed for the procedure potentially indicating that the patient may have transferred back to the private sector for review. *It should be noted that the Trust believe that these are poor administration issues rather than private patients.*

Elective Surgery with an Outpatient Appointment

22. Out of a sample of 29 patients who had an elective procedure and an outpatient appointment in the period under review, 4 occasions were found where the patient may potentially have been a private patient. In one case the patient was a retired Consultant and in another case the patient was a close relative of a GP. *It should be noted that the Trust believe that one of these cases associated with non completion of an outcome letter is poor administration rather than a private patient.*

Other Observations

23. Other issues have been noted by Internal Audit around the audit trail when ordering scans on NIPACS (Sectra); changes being made to the referral date on PAS (which should not be changed); registrations for episodes of care on PAS that remain open rather than being closed; and use and monitoring of electronic sign off on NIECR.

Extent of Trust Involvement with CURE

24. CURE - Craigavon Urological Research & Education – is an independent entity, separate from the Trust. Whilst a number of Trust staff sit on the CURE Committee, these roles are independent from their role in the Trust. From discussion with Trust Management and Trust staff involved with CURE, there is no indication of any flow of money into the Trust or Trust involvement in fund raising in recent years. Internal Audit understands from the Committee members that Trust staff may apply to CURE for funding and if granted, a cheque will be written from CURE to the applicant. Trust procedures do not provide guidance in respect of staff involvement in independent organisations with a potentially perceived affiliation to the Trust by their nature.
    Internal Audit did not have access to CURE financial records as part of this review and therefore do not have visibility over any payments made by CURE to Trust staff.

Detailed Findings Of The Review

1. TRUST'S AWARENESS OF MR A'S PRIVATE WORK AND MANAGEMENT OF COMPLIANCE WITH PRIVATE PATIENT GUIDANCE

1.1 Job Plan Document

The Consultant Job Planning - Standards of Best Practice (November 2003) and Consultant Terms and Conditions of Service (Northern Ireland) 2004 states that a job plan review should take place annually. A similar requirement is contained in the Medical and Dental terms and conditions 2008.

Internal Audit requested a copy of Mr A's job plan for the period 1 January 2019 to 30 June 2020. In line with the annual job plan review schedule, there should be 2 job plans to cover this period. There is no signed off job plan held by the Trust for the period 1 April 2011 to 30 June 2020. The most recent job plan available for Mr A is an unsigned job plan, dated 1 April 2018 and there is no end date recorded. This document is not signed by Mr A or his Clinical Director.

The most recent job planning meeting appears to have been held in November 2018. Regular, annual job plan meetings have not been held.

1.2 Trust Knowledge of Mr A's Private Practice

"A Code Of Conduct For Private Practice - Recommended Standards Of Practice For HPSS Consultants (An Agreement between the BMA(NI) Northern Ireland Consultants and Specialists Committee and the Department of Health, Social Services and Public Safety for consultants in Northern Ireland) (November 2003)" requires that Consultants declare any private practice and as part of the annual job planning process, consultants should disclose details of regular private practice commitments, including the timing, location and broad type of activity, to facilitate effective planning of NHS work.

Trust procedures "Trust Guidance on Paying/Private Patients – 2018 states:
In section 2.2 "Under the appraisal guidelines agreed in 2001, NHS consultants should be appraised on all aspects of their medical practice, including private practice. In line with the requirements of revalidation, consultants should submit evidence of private practice to their appraiser"
In Section 5.1 "While Medical Consultant staff have the right to undertake Private Practice within the Terms and Conditions of the Consultant Contract (2004) as agreed within their annual job plan review, it is the responsibility of Consultants, prior to the provision of any diagnostic tests or treatment to:

- *ensure that their private patients are identified and notified to the Paying Patients Officer.*
- *ensure full compliance with the Code of Conduct for Private Practice (see Appendix 2) in relation to referral to NHS Waiting Lists.*
- *ensure that patients are aware of and understand the range of costs associated with private treatment including hospital costs and the range of professional fees which the patient is likely to incur, to include Surgeon/Physician, Anaesthetist, Radiologist, hospital charges.*
- *Ensure that information pertaining to their private patient work is included in their annual whole practice appraisal.*

Although there is no private work identified in Mr A's most recent job plan, the Trust were aware that Mr A conducted private work outside the Trust:

- Mr A submitted a Trust "Declaration of Private Practice" in February 2018. In this declaration form, Mr A advised that he did not complete private practice within the Trust, however he did

treat private patients outside of the Trust. The declaration form is not sufficiently clear to clarify the type of private practice undertaken (ie outpatient/daycases/inpatients). On the Declaration Mr A did not confirm that he had read and understood the Trusts Guidance on Paying/Private patients. He did declare that he understood that any private patient work whether undertaken inside or outside of the Trust must be included in his job plan. *The Trust Declaration of Private Practice process should be conducted every year. A declaration therefore should have been made by Mr A in 2019 however this was not submitted to the Trust and the annual declaration process was not conducted in 2020 due to COVID-19.*

- The most recent appraisal completed for Mr A was in 2018. Internal Audit do not require access to this appraisal document, however the Trust have confirmed that Mr A declared that he conducted a private outpatient clinic at his home.

In the event that a private outpatient seen at Mr A's home clinic required diagnostics including blood tests or a daycase/inpatient procedure, it is unclear how this private activity was administered and whether or not such work entered the Trust either as private or NHS work. This issue is considered further in sections 2 and 3 of this report.

The Trust does not appear to have explored or challenged the potential interaction with the Trust in the scenario where private outpatients may require diagnostics/procedures etc. There is learning for the Trust in this matter in terms of considering circumstances when a Consultant conducts private outpatient work only.

1.3 Reconciliation of Job Plan to Payroll

Internal Audit reviewed HRPTS to ascertain what Mr A was paid. From 1 January 2014 to 17 July 2020 payment details were as follows:-

- 10 PAs – (full time contract – *agrees to most recent job plan*)
- 2 Additional PAs (APAs)
- 5% Category A on call from 12/05/2014 to 17/07/2020 *(agrees to operational rota)*
- Step 2 clinical excellence award *(awarded for the remainder of consultants career by the Trust's Local Clinical Excellence Award Committee in April 2009, with effective date from April 2008.)*

There is a query over the accuracy of APA payments to Mr A. As per HRPTS during the period January 2014 to July 2020, Mr A was paid for 2 Additional PAs (additional to full time PAs). This does not agree to the various unsigned job plans available for this period which record a range of APAs (2.5, 1.275 and 1.733) throughout this period.

1.4 Change of Status Process

The "Management of Private Practice in Health Service Hospitals in Northern Ireland: A Handbook – November 2007" requires that patients changing status from Private to NHS must have a Change of Status form completed by the consultant. The form must also detail the clinical priority for treatment as a health service patient. The Trust should be able to clearly identify these patients for monitoring purposes. It is important that the process of changing patient status is effectively controlled and documented as an assurance that the delivery of service is equitable.

The Trust Guidance on Paying/Private Patients procedures require Consultants to complete a Change of Status form when a private patient transfers to NHS treatment. However, effectively this form has limited monitoring or control value because:

1. The form is signed by the Consultant and stamped as approved by the Medical Directors office. It is not possible to establish who applied this stamp or the date it was applied. The change of status forms are filed in the cash offices at Craigavon Area Hospital/Daisy Hill Hospital and no

action or reporting takes place within the Trust. The Change of Status activity is not effectively approved by the Medical Director or reviewed by the Trust Clinical/Directorate Management.

2. The form contains no detail of the reason for the change of status.
3. The date the patient changes status to NHS is recorded on PAS as the effective date as per the Change of Status form, not the date the Change of Status form was approved by the Medical Director. This appears contrary to Trust Guidance on Paying/Private Patients procedures which state *"It is important to note that until the change of status form has been approved by the Medical Director, the patient's status will remain private and they may well be liable for charges."* The Change of Status form is confusing this matter, by including an effective date of change of status rather than, an approved date. The form does not clearly state that the approval date will be the date of transfer to NHS from private status.
4. There are no dates applied to the change of status form by either the Paying Patient Officer on receipt of the form or by the Medical Director's Office on approval of the form. Therefore Internal Audit were unable to establish whether the Change of Status forms were approved prior to the patient receiving an appointment/treatment, potentially impacting on income that may have been due to the Trust.

Prior to 11 September 2018 when the regional PAS Technical Guidance approved a code (PTN) to identify private patients transferring to NHS status, the Patient Administration System (PAS) did not require a change of status to be recorded on the system. The change of status may have been entered in a free text field which is not a mandatory field. The Southern HSC Trust has not yet implemented the regional code 'PTN' for patients transferring from private practice to NHS. A PAS report cannot therefore be run showing all change of status patients.

The Trust does not have a process in place to ensure all change of status patients have been identified for monitoring purposes and to ensure that the process for changing status is effectively controlled and documented, as an assurance that the delivery of service is equitable.

1.5 Private Patient Identification Processes

In line with the "Management of Private Practice in Health Service Hospitals In Northern Ireland: A Handbook (November 2007)" Consultants have a contractual obligation to cooperate in recording all private outpatient and day patient attendances, treatments and procedures. The patient's records and referral forms etc should always be suitably marked. Records kept in departments away from the main outpatient area (e.g. x-ray, pathology and physiotherapy) should identify private patients.

Internal Audit met with senior staff in Laboratories, Radiology and Pharmacy to discuss the processes in these departments for the identification and management of private patients. All three departments are reliant on Consultants highlighting any private activity. There is a risk therefore that private activity in these departments may not be identified.

Pharmacy:

When a consultant prescribes medication to a private/NHS patient at an outpatient clinic, there are 2 different prescription pads used:-

- Prescription which can be written and given to the patient to take to the hospital pharmacy for dispensing. These are numbered but there is no control over the issue of the prescription pads. These are in quadruplicate – White copy –to GP, yellow copy to Pharmacy, Blue copy community nursing and pink copy patient notes.
- Prescription letter which the patient must take to their GP and the GP writes a prescription for dispensing at the community pharmacist.

There are inadequate controls surrounding the issue and use of prescription pads. Pads are held in consulting rooms and may be used by multiple consultants who apply their own name labels to the scripts.

If a patient takes the script to the Trust pharmacy for dispensing, the pharmacy have no mechanism to identify whether the patient is private or has come from a NHS outpatient appointment. Similar to the rest of private practice, the Trust are reliant on the Consultant declaring activity as private and in this case, writing the prescription advising that the patient is private so that pharmacy can ensure that the cost of the medications are invoiced.

Internal Audit discussed 6 sampled cases with Pharmacy to identify if any of these patients had received medication while still private patients. No issues were identified.

Laboratory Services:

The Head of Laboratory Services advised that within the Trust they are reliant on the Consultant/doctor who completes the laboratory request ticking a box to identify a private patient. There is no other mechanism to identify private patients.

Laboratory results are put on NIECR and there is nothing to identify private tests unless the consultant has declared this on the lab request.

Diagnostic Services:

The Head of Acute Information in conjunction with the NIPACS Manager confirmed referrals received for scans etc are all completed on the same referral form and there is no mechanism to identify private or change of status patients on the system. Consultants order scans etc directly themselves on the NIPACS (Sectra) system.

As per Section 2 of this report, radiology activity was identified that should potentially have been declared and treated as private.

Recommendations Specific to Review of Mr A's Practice:

Recommendation 1.1	The Trust should review Mr As job plan and actual APAs worked in order to ascertain if overpayments have occurred, and seek recompense if required.
Management Action	ACEPTED
Responsible Manager	Medical Director and Director of Acute Services
Implementation Date	October 2021

General Recommendations Regarding Trust Process:

Internal Audit completed an audit in 2019/20 (finalised in October 2020 following delay in obtaining Management Response to the report due to COVID-19) and provided limited assurance in relation to Management of Private Medical Practice (including patient change of status processes). A number of the recommendations included in the 2019/20 report have been restated throughout this report.

Recommendation 1.2	As previously recommended in the 2019/20 Management of Private and Paying Patients audit report and as per the 'Code of Conduct for Private Practice - recommended standards of practice for HPSS consultants (November 2003)', the Trust must ensure that: • All consultants have an annual job planning review. • All consultants completing private practice declare any private practice and as part of the annual job planning process, consultants should

	disclose details of regular private practice commitments, including the timing, location and broad type of activity, to facilitate effective planning of HPSS work and out of hours cover. • As part of the job planning process, the Trust should consider total working hours across HSC and private practice. Job plans should be signed and dated by the consultant and their Clinical Director.
Management Action	**ACCEPTED**
Responsible Manager	Medical Director/Deputy Medical Director and all Divisional Medical Directors
Implementation Date	Februaury 2022

Recommendation 1.3	The Trust should strengthen their management arrangements in scenarios where a Consultant declares that they conduct private outpatient work only, specifically where the work is carried out outside the NHS including premises not regulated by RQIA. The following specific measures are suggested: • Assurances should be sought as to how associated diagnostics/subsequent required treatment are managed. • Medical Director approval should be introduced in the event that Consultants conduct outpatient work privately. • Trust monitoring processes should be alert to ensuring Change of Status patients are placed on the waiting list based on clinical priority. • The Trust "Declaration of Private Practice" form should be amended to clearly identify the type of private practice undertaken (ie outpatient/daycases/inpatients). Trust management should review these declaration as and triangulate the information with appraisals and job plans.
Management Action	ACCEPTED
Responsible Manager	Medical Director/Deputy Medical Director and all Divisional Medical Directors
Implementation Date	February 2022

Recommendation 1.4	The findings in this report indicate issues around patients being able to pay to see a Consultant privately and then receiving preferential treatment in the NHS. The Trust should consider whether these issues are isolated to this one Consultant or indicative of a wider cultural issue. The Trust should review and strengthen management of private patient procedures. As part of this process the new procedures should be shared with all relevant trust staff and roles and responsibilities should be reiterated where required. Specifically consulants must be reminded of their responsibility to ensure that all private work and change of status patients are declared. Consideration should be given as to how Radiology, Laboratories and Pharmacy can strengthen their processes, scrutiny and challenge of service requests that could potentially originate from the private sector.

Management Action	ACCEPTED
Responsible Manager	Assistant Director Systems Assurance,
Implementation Date	February 2022

Recommendation 1.5	As previously recommended in the 2019/20 Management of Private and Paying Patients audit report, Consultants should be instructed to complete the required declaration in relation to Private practice for the current year.
Management Action	**ACCEPTED**
Responsible Manager	Medical Director/Deputy Medical Director and all Divisional Medical Directors
Implementation Date	October 2021

Recommendation 1.6	The Change of Status process should be strengthened. Specifically: • The Change of Status form currently in use within the Trust for patients transferring from Private Practice to NHS must be reviewed and updated to include all relevant information including clear documentation of the reason for change. The effective date of change of status should be amended to the approved date for change of status and it should be clear on the form that the effective date of change will be the date that the form is approved by the agreed appropriate senior clinical and operational leads. The agreed appropriate senior clinical and operational leads should sign and date all change of status forms. Patients should only be added to the HSC waiting list when the change of status form has actually been signed and dated by the by the agreed appropriate senior clinical and operational leads. *Previously reported in 2019/20* • The Trust should increase scrutiny and challenge over Change of Status forms that have been completed and sent to the Private Patient Office. The Trust should appropriately enforce the stated condition on the Change of Status form, namely until the form is approved, the patient will remain private and may be liable for charges. *Previously reported in 2019/20*
Management Action	**ACCEPTED**
Responsible Manager	Assistant Director Systems Assurance
Implementation Date	February 2022

Recommendation 1.7	As previously recommended in the 2019/20 Management of Private and Paying Patients audit report, the Trust should develop a process to monitor change of status patients and to ensure that the process for changing status is effectively controlled and documented as an assurance that the delivery of service is equitable.

	The Trust should implement the regional PAS code for patients transferring from private to NHS and develop a mandatory requirement to indicate changes of status on PAS. A printout from PAS should then be regularly reviewed and reconciled to Change of Status forms received.
Management Action	**ACCEPTED** The Trust have now set up two codes PHS & PTN, 1 for Inpatients and 1 for Outpatients. A report has been set up in Business Objects and shared with the Private Patient Officer to cross check. All secretaries have reminded of codes and when to use them.
Responsible Manager	Assistant Director Systems Assurance, Assistant Director Functional Support Services
Implementation Date	February 2022

Recommendation 1.8	The Trust should increase controls over prescription pads held in consulting rooms. These should be maintained as controlled stationery.
Management Action	**ACCEPTED**
Responsible Manager	Assistant Diector ATICS
Implementation Date	February 2022

2 REVIEW OF MR A's COMPLIANCE WITH RELEVANT PRIVATE PRACTICE GUIDANCE/AUTHORITIES – CHANGE OF STATUS PATIENTS

2.1 Change of Status Activity During the Period January 2019 to June 2020

The "Management of Private Practice in Health Service Hospitals in Northern Ireland: A Handbook – November 2007" requires that patients changing status from Private to NHS must have a Change of Status form completed by the consultant. The form must also detail the clinical priority for treatment as a health service patient. The Trust should be able to clearly identify these patients for monitoring purposes. It is important that the process of changing patient status is effectively controlled and documented as an assurance that the delivery of service is equitable.

The Trust's procedures and Change of Status form states "It is important to note that until the change of status form has been approved by the Medical Director, the patient's status will remain private and they may well be liable for charges."

Internal Audit requested all of Mr A's patient Change of Status forms for the period January 2019 to June 2020, from the cash office at Daisy Hill Hospital. Internal Audit were provided with the database which recorded 21 Change of Status Patients.

Internal Audit requested and reviewed the 21 Change of Status forms completed by Mr A from January 2019 to June 2020 and noted the following issues:

- 16 Change of Status forms had the Medical Director stamp on them as evidence of approval but it is not possible to establish who applied this stamp or the date it was applied.
- 4 Change of Status forms were still with the Medical Director at the 7 December 2020 awaiting approval. The dates that these patients transferred to NHS as per the change of status forms ranged from 2 - 14 months earlier than December 2020. Internal Audit were unable to establish when the forms were received in the Medical Directors Office.
- 1 Change of status form had been physically signed by the Medical Director, approximately 10 weeks after the effective Change of Status date.

2.2 Management of Patients Transferring from Private to NHS, Joining the HSC waiting list

Management of Private Practice in Health Service Hospitals In Northern Ireland: A Handbook (November 2007) states:

"A change of status from private to Health Service must be accompanied by an assessment, by the appropriate consultant, of the patient's clinical priority for treatment as a Health Service patient. It is important that any private patient who wishes to become a Health Service patient should gain no advantage over other Health Service patients by so doing."

"No patient should proceed –except in emergencies – to an investigation or treatment in a Health Service hospital until some mechanism has been applied which makes their status clear. Whichever system is introduced it must be capable of identifying the patient's status at every stage."

Internal Audit reviewed PAS data (provided by the Trust) for the 21 patients who changed status from private practice to NHS during the audit period January 2019 to June 2020. 13 of the 21 Change of Status forms related to day case or inpatient referrals and the remaining 8 forms were for outpatient appointments.

A range of issues were found in respect of Mr A's practice and administration of these 21 Change of Status cases (as outline below). However the issues also demonstrate the inadequacies in Trust monitoring processes around Change of Status patients and the limited control in the current process. The following issues were identified on review of the Change of Status forms:

Approved Effective Change of Status Date

The date the patient is added to PAS as an NHS patient is the effective date as per the Change of Status form, not the date the Change of Status form was approved by Medical Director. *This is contrary to Trust's procedures and Change of Status form which state "It is important to note that until the change of status form has been approved by the Medical Director, the patient's status will remain private and they may well be liable for charges."*

On all 21 Change of Status forms, the effective date of transfer to NHS was the same as the date the patient was last seen privately.

Change of Status Patients who had Diagnostic (Radiology) Tests

In 10 of the 21 change of status cases, the patient had been referred for a diagnostic test (radiology) in the period 1 January 2019 to 30 June 2020:

- In 3 of the 10 cases, the diagnostic work was performed prior to the date of change of status. This diagnostic work was performed at a time when there was no referral on PAS for the patient ie whilst they were still a private patient.
  - One patient had a change of status date of 31/08/2019 – this patient had 2 imaging tests requested and performed in June 2019 whilst still private.
  - One patient had a Change of Status date of 09/11/2019 - this patient had 3 imaging tests requested and performed in June 2019 whilst still private.
  - One patient had a change of status date 09/11/2019 and had 1 imaging test requested in June 2019 with the test performed in July 2019 whilst still private.
- 5 of the 10 diagnostic tests were requested on the same date as the effective change of status date and the same date the patient was last seen privately (according to the Change of Status Form). Given that these Change of Status forms are unlikely to have been submitted and approved by the Medical Director on the same day as the patients' private appointments, these patients should potentially have been treated by the Trust as private patients.
- 2 of the 10 Change of Status patients had an exam/diagnostic test requested after the effective date on the Change of Status form (1 was 3 weeks, 1 was 4 months). However given the weaknesses in the Change of Status process, it is unclear if this NHS test was performed after the change of status was approved.

3 (including 1 of the 3 patients found to be private) out of the 10 patients were seen sooner than the Trust waiting time for the diagnostic/imaging test:-

- 1 of the 3 patients identified as private (above) was seen within 6 weeks against a waiting list of 21-32 weeks (at least 15 weeks earlier than Trust waiting time). This patient was seen in South Tyrone Hospital.
- For 1 patient the Trust waiting time for the imaging was 16-20 weeks and the patient had their imaging test within 5 weeks of request (at least 11 weeks earlier than Trust waiting time).
- For 1 patient the Trust waiting time was 5-10 weeks and the patient had their imaging test within 3 weeks of request (at least 2 weeks earlier than Trust waiting time).

Patients who changed Status and had Inpatient/Daycase Procedure

Out of the 13 Change of Status cases transferred into the NHS for an inpatient/day procedure, 5 had subsequently had their procedure. The other 8 patients, whilst added to waiting list, had not had their procedure as at June 2020.

Internal Audit in conjunction with Senior Trust staff reviewed the patient journeys of the 5 cases who have had their inpatient/daycase procedures. All 5 cases were classed as URGENT on PAS per the report received by Internal Audit.

As part of this audit review, a Trust Urology Consultant considered the waiting times for treatment in the context of the clinical priority and Trust standard waiting times. The Consultant advised that:

- 3 cases were in line with Patient Target List (PTL) waiting times/ for the procedure for the relevant clinical priority.
- 2 of the 5 patients were not seen in line with the Trust waiting list time. The Trust Consultant Urologist assisting Internal Audit in this review considered that these cases were not Urgent/red flag procedures and were seen significantly sooner than other patients on the waiting lists:
  - Patient 1 - the time between being added to waiting list and the procedure taking place was 23 days (approx. 3 weeks). The PTL waiting times for the same procedure for Mr A patients at this time were between 15 weeks and 217 weeks so we can conclude this Change of Status patient was seen much quicker than other patients waiting on the same procedure.
  - Patient 2 - the time between being added to the waiting list and the procedure taking place was 12 days. The Consultant Urologist advised that given the symptoms, this patient was seen much quicker than other patients requiring the same procedure at that time.

Retrospective Entry to PAS
Through review of change of status patients on PAS, it was noted that two change of status forms had been added retrospectively to PAS:

- One patient was added to the waiting list from 09/09/2018 but this was not actually added to PAS until 12/05/2020. At December 2020 this Change of Status had not been approved by Medical Director.
- One patient had a Change of Status on 11/10/2019 however the patient was not added to PAS by the consultant secretary until 01/02/2020, 4 months after the Change of Status.

See section 6 for related registration issue.

2.3 Protected Reviews

Internal Audit understand from the Trust that most Consultants retain a number of protected review appointments at each of their outpatient clinics. These slots should be for patients that the Consultant needs to see urgently (for example cancer patients) however there is no documented Trust procedure around the use of protected review clinic slots. The Trust does not monitor the use of protected review appointments and there is a risk that private patients or Change of Status patients could potentially be seen quicker in a protected review appointment slot.

Internal Audit were advised that the central booking team at the Trust are responsible for booking new and review outpatient appointments. However Mr A's secretary was responsible for booking Mr A's Protected Review appointments.

Internal Audit have not specifically tested Protected Review bookings however we identified 1 case where a routine outpatient was seen in a protected review slot, 15 days after being added to the waiting list. Internal Audit queried this case with the Trust and the Consultant Urologist agreed that the protected review appointment had not been used for the correct purpose and therefore the patient would have been seen ahead of NHS patients with the same clinical priority.

2.4 Capturing and Invoicing of Private work Conducted on HSC Premises

In line with the "Management of Private Practice in Health Service Hospitals In Northern Ireland: A Handbook (November 2007)" Consultants have a contractual obligation to cooperate in recording all private outpatient and day patient attendances, treatments and procedures. The patient's records and referral forms etc should always be suitably marked. Records kept in departments away from the main outpatient area (e.g. x-ray, pathology and physiotherapy) should identify private patients.

As per Trust procedures no private activity was declared to the Cash Office in Daisy Hill Hospital during the audit period by Mr A and no invoices have been raised for private treatment – both indicating that Mr A did not perform private work on HSC premises.

However, as outlined above, upon review of the 21 Change of Status Forms, Internal Audit noted cases whereby Mr A's Private Patients had received treatment in the NHS while still being a private patient.

Furthermore as described below, there are examples of patients seemingly switching several times between private and NHS and potentially receiving private treatment on the NHS, without declaration or charging. As per the *NHS A Code of Conduct for Private practice and* The Trust Change of Status Form – *"Consultants are reminded that in good practice a patient who changes from private to NHS status should receive all subsequent treatment during that episode of care under the NHS as outlined in A Code of Conduct for Private practice"*

In 5 of the 21 cases where a change of status form had been completed, the patient moved between NHS to Private to NHS for the same referral.

- In one case the patient had been under the care of another urology consultant within the Trust around the time of seeing Mr A privately.
- In one case from the review of PAS it was determined that the patient has seen a number of urology consultants and had been NHS and moved to Private and then subsequently transferred back to NHS.
- One patient had been seeing another Urology Consultant in 2018 and was called for a follow up outpatient appointment in July 2018 but didn't attend. It would appear that this patient then attended Mr A privately who completed a Change of Status form with an effective date of 17/08/2019.
- One patient had been under the care of the Trust at 31/01/2019 and was due for review at the end of 2019. This appointment was delayed and it would appear that this patient then attended Mr A privately who completed a Change of Status form with an effective date of 15/02/2020 and added the patient to the waiting list.
- One patient who had been added to the Elective waiting list for a procedure on 09/11/2019 (effective date of Change of Status) but had a consultation with Mr A in early March 2020 which is not on PAS. This patient would have had a procedure done in late March 2020 except for COVID-19 resulting in all elective procedures being cancelled from approximately w/c 16 March 2020.

Recommendations Specific to Review of Mr A's Practice:

Recommendation 2.1	The Trust should consider charging for the identified private activity. Internal Audit appreciate that this needs to be considered, and may not be feasible, in the wider context of a patient recall.
Management Action	**ACCEPTED** This has been considerd by the Trust and it was felt it would not be appropriate to charge these patients.
Responsible Manager	Medical Director
Implementation Date	July 2021

General Recommendations Regarding Trust Process:

Recommendation 2.2	The Trust should develop a written procedure around the use of protected review clinic appointments. The Trust should also introduce monitoring of compliance with the procedure.
Management Action	**ACCEPTED**
Responsible Manager	Assistant Director Functional Support Services and Operational ADs
Implementation Date	February 2022

Recommendation 2.3	Trust Guidance and Management of Private Practice in Health Service Hospitals In Northern Ireland: A Handbook (November 2007) should be re-issued and sign-off by doctors engaging in private practice. Where concerns are raised about a consultants' compliance, the Department of Health's framework *Maintaining High Professional Standards in the Modern HPSS should be followed*.
Management Action	**ACCEPTED**
Responsible Manager	Assistant Director Systems Assurance
Implementation Date	February 2022

Also see recommendations in section 1

3 REVIEW OF MR A's COMPLIANCE WITH RELEVANT PRIVATE PRACTICE GUIDANCE/AUTHORITIES – DATA ANALYSIS

Internal Audit completed data analysis using information provided by the Trusts Acute Informatics department. Internal Audit were provided with the following reports from PAS, TMS, Pre Operative Assessment Unit:

- Patient Level List of Elective Inpatient Admissions, Daycases and Regular Attenders for Mr A Date of Admission only between 01/01/2019 and 30/06/2020 from PAS
- Patient Level List of Outpatient Attendances (Including Outpatient Urodynamic Attendances) for Mr A Appointment Date only between 01/01/2017 and 30/06/2020 from PAS
- Patient Level List of Outpatient Urodynamic Attendances for Mr A Appointment Date Only between 01/01/2019 and 30/06/2020 from PAS
- Patient Level List of Imaging Exams Performed which were Requested by Referring Clinician Mr A Exams Performed between 01/01/2019 and 30/06/2020 from NIPACS
- Patient Level Report of Theatre Cases Carried out by Mr A – By hospital, theatre and operation date based on operation date between 01/01/2019 and 30/06/2020 from TMS.
- Pre-operative Assessment Database for Urology with the Trust Identifying Mr A's patient's for pre-op assessments performed between 01/01/2019 and 30/06/2020

3.1 Pre-Operative Assessments

All elective patients who require a General Anaesthetic whilst undergoing a procedure are required to have a Pre-Operative Assessment (POAs) to assess their fitness for surgery. The Trust deem the optimum time to complete a patients' POAs is between 13 weeks and approximately 3 weeks ahead of planned admission date for surgery. Consequently to ensure this happens in a timely manner and no patients scheduled for theatre are overlooked, it is essential that all elective theatre lists are prepared and notified to the POA team 6 weeks in advance of the theatre date.

Theatre rotas are compiled by the Head of Service for Theatres, detailing which surgeons have access to the theatres at each session. When Consultants become aware of the theatre rota they then select the patients for each list, any who require pre op should be sent to the pre op assessment unit. Mr A selected his own patients and arranged his own theatre lists. It is understood that Mr A would have provided his secretary with a list of patients to be booked into his theatre lists and she would have completed an "Arrange Admission List".

Completion of POA

According to Trust PAS report provided, during the period January 2019 to June 2020, there were a total of 1,096 elective procedures performed on 576 of Mr A's patients. In consultation with the Head of Urology and Pre-operative Assessment Manager, Internal Audit analysed a PAS report of all elective procedures performed on Mr A's patients during January 2019 to June 2020. With the Trust's expert input, we were able to eliminate procedures where a pre op assessment was not required from our analysis. These cases related to procedures done under a local anaesthetic; or where the patient had previous surgery and the previous POA was still valid.

For 351 of the 1,096 procedures performed by Mr A, a POA was required. In 86 (25%) of these 351 cases, a POA was not completed. Internal Audit reviewed these 86 cases with the Pre-Operative Assessment Manager and found:

- In 24 procedures, the patient was assessed upon admission rather than having a scheduled POA ahead of time. An appropriate POA in line with Trust requirements was not therefore conducted.
- 62 procedures required a POA for the procedure but this was not completed. In 2 of these procedures, the patient did not attend/complete their POA but a POA had been requested in both cases. Both patients underwent surgery nonetheless.

Lack of POA as Potential Indicator that Patient was Seen Privately and then Treated in NHS

Internal Audit reviewed these 86 cases further from information on PAS and NIECR to establish if there was any information that pointed to these 86 cases being private patients. This work identified:

- In 49 procedures, the patient had an appropriate footprint on PAS.
- For the remaining 37 procedures, the patient had either no outpatient appointment (according to the PAS data provided by the Trust) or there was a short timeframe between being seen at an outpatient appointment and the date of surgery. Internal Audit selected a sample of 23 of these procedures for further analysis on PAS and NIECR in conjunction with the Head of Urology. In 22 of the 23 procedures whilst a pre-op assessment was required, the patient was not deemed to be private as they had come in initially through ED and been given date for surgery on discharge, another Speciality or another Consultant was involved in their care. 1 of the 23 procedures related to a private patient who was subsequently treated in the NHS. No Change of Status form had been completed.

Timeliness of POA

As outlined above, the optimum time for a patients' POAs to take place is between 13 weeks and approximately 3 weeks ahead of planned admission date for surgery. In effect, PoAs are valid for a period of 13 weeks pre-admission for surgery.

On review of 265 procedures where a POA was undertaken for Mr A's patients, Internal Audit noted:-

- There were only 8 procedures (3%) where the POA was conducted within the timescale required by the Trust, in advance of surgery.
- 252 procedures (95%) were added to the POA list less than 21 days before their admission:
  - 105 procedures (40%) were added to POA list 5 days or less before admission
  - 131 procedures (49%) were added to POA list 10 days before admission
  - 16 procedures (6%) were added to POA list between 11 and 20 days before admission
- In 5 (2%) cases, there was insufficient information to confirm the timeliness of the POA.

3.2 Elective Surgery With No Outpatient Appointment

From the PAS data received from the Trust Acute Information Department, Internal Audit joined elective surgery data in the period 01/01/2019 to 30/06/2020 to outpatient appointments in the period 01/01/2017 to 30/06/2020. The purpose of this analysis was to establish patients who had surgery but did not have an outpatient appointment potentially indicating that they may have been seen privately for an outpatient appointment by Mr A prior to surgery.

Note: We considered outpatient information for a longer period than the audit period to factor in the waiting list times.

We found that there is no record of a Trust outpatient appointment (either pre or post surgery) for 220 patients who had at least one elective procedure (total 284 procedures) between 1 January 2019 and 30 June 2020.

Where a patient had surgery and no outpatient appointment, the patient could potentially have been a private patient as the normal patient route for elective surgery is to be seen at an outpatient appointment and then if required, listed for elective surgery.

Internal Audit reviewed the 284 procedures where there was no recorded Trust outpatient appointment on PAS. With the expert input of Head of Service for Urology, 138 records were excluded from further analysis because the nature of the procedure did not involve the need for an outpatient appointment (for example stent replacement/removal); or the waiting time for the procedure appeared in line with Trust waiting list; or the patient (5 cases) was declared as a Change of Status patient.

Out of the remaining 146 records, Internal Audit selected a sample of 54 records (relating to 50 patients) which the Head of Service for Urology then reviewed on PAS and NIECR, particularly considering whether referrals had been received for these cases and where patients had been seen in relatively short-timeframe that there were valid clinical reasons for this. Internal Audit then walked through 21 of these 50 patients with the Head of Urology to validate the data. This work identified:

- 1 patient who was initially referred by a GP in January 2018 but was then discharged from this referral on PAS in July 2019 to attend Mr A privately. This patient was added to Mr A's Day Surgery waiting list from the same date in July 2019 as an Urgent case. This was done retrospectively on PAS on 20 August 2019, approximately a week before the patient had their Pre-Op Assessment in late August 2019. The patient had their procedure in early September at CAH Day Surgery Unit, 2 weeks after being entered onto the waiting list on PAS (albeit the entry was made retrospectively to an earlier time in July). The Trust has advised that the normal waiting time for this procedure is 91 weeks.
  In effect, this patient changed from NHS to private and back to NHS in one day, with no Change of Status forms. This is a blatant breach of proper process and is an example whereby a significant advantage has been gained in terms of speed of treatment, by paying privately for an outpatient appointment.
  In the absence of an approved Change of Status form, this is arguably a private patient having a procedure using trust facilities and staffing.
- In 2 cases, there was no outcome letter completed for the procedure potentially indicating that the patient may have transferred back to the private sector for review. It should be noted that the Trust believe that these are poor administration issues rather than private patients.

3.3 Elective Surgery with an Outpatient Appointment

There were 812 records (356 patients) out of the 1,096 (576 patients) that had elective procedures who also had an outpatient appointment in the period under review.

From review of a sample of 29 of these patients, Internal Audit noted 4 occasions where the patient may have potentially been a private patient:

- 1 patient (a retired consultant) who had been seen privately by Mr A in 2017 was then seen in 2020 in the Trust as an NHS patient. A change of status form had not been completed.
- 1 patient was under the care of another urology consultant on PAS but the patient was seen by Mr A. There was no rationale as to why Mr A became involved in the patient's care.
- 1 patient was seen within 2 days of a red flag referral. Internal Audit observed that as per a letter on NIECR, this patient was a close relative of a GP.
- In 1 case, there was no outcome letter completed following the procedure, which potentially could be an indicator that the patient may have been reviewed privately following the procedure. It should be noted that the Trust believe that these are poor administration issues rather than private patients.

3.4 Other Observations

During the course of the audit, Internal Audit identified a number of other issues:

- There were 371 radiology diagnostic tests requested by Mr A from Urology Outpatients in the period 1 January 2019 to 30 June 2020 where the patient had no outpatient/surgical procedure, as per the PAS reports provided by the Trust. Upon further investigation and sample checking by Internal Audit in conjunction with the Head of Service for Urology, Head of Diagnostics and a Urology Consultant, it was identified that these cases were not all Mr A patients. When a junior doctors signs in with their own log-in into NIPACS (Sectra), their request will default to the last Consultant they ordered a scan on behalf of. The junior doctor should amend this to the name of the consultant they are actually making the request on behalf of, however Internal Audit was advised that this is not routine practice. Therefore scan requests are being attributed to

consultants when the patient wasn't actually under their care. If a consultant makes the request themselves, this is not an issue as system maps directly to them it doesn't default to the last user. This means the audit trail on the system in terms of the requesting Consultant is incorrect in some cases and could mean that the test results go to the wrong Consultant, potentially creating a patient safety issue.

- The referral date on PAS, which is the date the referral of the patient is received by the hospital and will be the date the patient enters any relevant waiting lists, should not be changed however the date can be changed on the system. Internal Audit noted instances where the date had been changed, affecting the patient's position on the waiting lists. In the context of this audit, Internal Audit observed referral dates being changed to later dates rather than earlier dates.
- When a patient is entered onto PAS, a registration will be opened for the episode of care, this registration should be closed when a patient is discharged with their treatment complete. Open registrations on PAS should be reviewed on an ongoing basis. Instances were observed where the patient had been discharged but the registration had not been closed.
- Up to 2020 there was no mechanism for electronic signoff on NIECR. From 2020 this became available and is reportedly monitored however it is not routinely used across the Trust. Internal Audit queried how the Trust ensures that consultants are getting their own patient results – and where advised that there is a monthly check completed of all patients who are recorded as "DISCHARGE AWAITING RESULT" by Consultant secretaries. Internal Audit were advised that this is not conducted routinely. Internal Audit were advised that there 1,000 records on NIECR not signed off by Mr A.

General Recommendations Regarding Trust Process:

	As previously recommended in the 2019/20 Management of Pre-Op Assessments audit report, Management should ensure all patients due for elective surgery have an up to date pre-operative assessment completed no more than 13 weeks ahead of planned admission date for surgery. Management should focus on improving processes in those specialties with higher volumes of exceptions including Urology.
	ACCEPTED
	Assistant Director of ATICS
	September 2021

	As previously recommended in the 2019/20 Management of Pre-Op Assessments audit report, Management should review processes to ensure all private outpatients transferring to NHS inpatient waiting lists are promptly notified to the Pre-operative Assessment team.
	ACCEPTED
	Assistant Director of ATICS
	September 2021

Recommendation 3.3	The Trust should liaise with BSO in order to resolve this referring Consultant recording error in the NIPACS system.
Management Action	**ACCEPTED**

Responsible Manager	Director Performance & Reform
Implementation Date	February 2022

Recommendation 3.4	The processes for registration should be reviewed and training given to all appropriate staff on the correct use of PAS, including consultant secretaries.
Management Action	**ACCEPTED**
Responsible Manager	Assistant Director Systems Assurance
Implementation Date	February 2022

Recommendation 3.5	The processes surrounding electronic and manual sign off and review of the "DISCHARGE AWAITING RESULT" should be strengthened and monitored.
Management Action	**ACCEPTED**
Responsible Manager	Assistant Medical Director Clinical Directors and Assistant Operational Directors
Implementation Date	February 2022

See also recommendation 1.4

4 INTERACTION OF MR A's PRIVATE WORK WITH HSC SERVICES AND FACILITIES

A Code Of Conduct For Private Practice - Recommended Standards Of Practice For HPSS Consultants (November 2003) states that HSC facilities, staff and services may only be used for private practice with the prior agreement of the HSC employer.

Internal Audit were advised by the Trust that Mr A's private practice did not interact with HSC services and facilities. However as per the findings in this report, there are a number of issues and exceptions that would indicate a degree of interaction – particularly for services that could not be performed or delivered from Mr A's home practice.

The queries around the timing of changes of status outlined in this report, mean there is a risk that Trust staff have been involved in the administration or treatment of patients that should have been categorised as private.

General Recommendations Regarding Trust Process:

See recommendations in section 1-3

5 CRAIGAVON UROLOGICAL RESEARCH EDUCATION (CURE)

In line with the Terms of reference of this review, Internal Audit also considered whether the Trust has any involvement with CURE - Craigavon Urological Research & Education, to understand if there was a flow of money into the Trust and to check, as much as is possible from review of Trust records and engagement with Trust staff, whether any Directors/staff benefited from the operation of the company.

According to the Companies House website/Articles of Association, a previous Trust Chairperson and Mr A set up CURE in 1996 as a 'Charitable Company Limited by Guarantee and not having Share Capital'.

The objectives of CURE are:

- To advance education for the public benefit in Urological disorders.
- Conducting and commissioning research into Urological disorders and the effective treatment of persons suffering from Urological disorders and to disseminate the useful results of such research.
- Raising public awareness and understanding of Urological disorders and their treatment and promoting training in the treatment of Urological disorders.

The CURE committee is currently made up of Mr A and three other people - 2 of whom are current Trust employees (1 Consultant Urologist and 1 Specialist Nurse in Health Promotion). The CURE committee secretary is a previous Trust employee.

Whilst these Trust staff are members of the CURE Committee, Internal Audit were advised by Senior Trust staff that their role should be separate and independent from their roles in the Trust. Internal Audit met with the two Trust staff who are currently on the Committee of CURE who both confirmed that their role within CURE is entirely independent of their job with the Trust. The Trust advised of some historical Trust involvement with CURE (pre-creation of SHSCT) including preparation of CURE accounts. Internal Audit also note that the registered office of CURE (until July 2012) was on the Craigavon Area Hospital site.

From discussion with Trust Management and Trust staff involved with CURE, there is no indication of any flow of money into the Trust or Trust involvement in fund raising in recent years.

Internal Audit understands from the Committee members that Trust staff may apply to CURE for funding. A written request is completed and will be reviewed/approved by the CURE committee. If approval is granted by the Committee, the staff member will pay for the course and on submission of relevant paperwork invoices, a cheque from the CURE bank account is made payable to the applicant.

It should be noted that Internal Audit did not have access to CURE financial records as part of this review and therefore do not have visibility over payments made by CURE to Trust staff.

Trust procedures do not provide guidance in respect of staff involvement in independent organisations with a potentially perceived affiliation to the Trust by their nature.

General Recommendations Regarding Trust Process:

Recommendation 5.1	The Trust should remind staff that all donations received from the public in respect of their care should be lodged to the Trust's Charitable Trust Funds only and that staff are not permitted to use their position of employment within the Trust to advance personal interests, causes or charities as it could give rise to

	reputational damage to the Trust.
Management Action	ACCEPTED
Responsible Manager	Director of Finance
Implementation Date	December 2021

Note to Report

This audit report should not be regarded as a comprehensive statement of all weaknesses that exist. The weaknesses and 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.

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Recommendation 1.1	Medical Director and Director of Acute Services	The Trust should review Mr As job plan and actual APAs worked in order to ascertain if overpayments have occurred, and seek recompense if required.	Oct-21	Surgical Division currently going through past urology schedules to identify sessions that Mr A had done and then matched with job plans No issues identified to date

Recommendation 1.2	Medical Director/Deputy Medical Director and all Divisional Medical Directors	As previously recommended in the 2019/20 Management of Private and Paying Patients audit report and as per the 'Code of Conduct for Private Practice - recommended standards of practice for HPSS consultants (November 2003)', the Trust must ensure that: • All consultants have an annual job planning review. • All consultants completing private practice declare any private practice and as part of the annual job planning process, consultants should disclose details of regular private practice commitments, including the timing, location and broad type of activity, to facilitate effective planning of HPSS work and out of hours cover. • As part of the job planning process, the Trust should consider total working hours across HSC and private practice. Job plans should be signed and dated by the consultant and their Clinical Director.	Feb-22	As part of ongoing medical leadership review and strengthening exercises the following has been actioned: ***All consultants have an annual job planning review*** The Trust is actively progressing a programme of job planning review for all medical staff. As of 2nd February 2022 89% consultant staff signed off by relevant clinical and operational managers ***All consultants completing private practice declare any private practice and as part of the annual job planning process, consultants should disclose details of regular private practice commitments, including the timing, location and broad type of activity, to facilitate effective planning of HPSS work and out of hours cover.*** A revised Trust 'Declaration of Private Practice' has been created and issued to all medical staff (both Consultant and SAS grade) to be completed by all substantively employed staff for return to the Medical Revalidation team. The revised form requires the following information to be provided: • Confirmation to state if the doctor treats /intends to treat private outpatients/ medico–legal patients (inpatient/ day patient/ outpatients) in addition to their contracted work within the Trust • Confirmation they have appropriate medical protection / indemnity arrangements in place to conduct their private practice • Details of location(s) where they undertake your private practice • Confirmation if they intend to treat/intend to treat private outpatients/ medico–legal patients inside the Trust (i.e. on Trust premises) and if so ensuring they agree to complete a quarterly return to the paying patients office • Confirmation that any laboratory tests taken either on or off Trust premises must not be forwarded to the Southern H&SC Trust

				Laboratory for reporting and alternative arrangements for these has been made. • Confirmation that they have read and understood the following: - The Trust's Guidance on Paying / Private Patients and accept the responsibilities outlined therein - the Trust's Code of Conduct relating to on Paying / Private Patients and accept the responsibilities outlined therein - The regional guidance titled Management of Private Practice in the Health Service – November 2007 and accept the responsibilities outlined therein • Confirmation that any work carried out by medical secretaries to assist in paying / private patient work must be completed outside NHS working time and prior approval to retain the services of any member of staff should be agreed in advance with the Trust. • Confirmation that private patient work whether undertaken inside or outside the Trust must be included in my job plan and declared as soon as possible. Staff undertaking private practice are required to ensure their Clinical Director is aware of their intention, this is confirmed by a countersignature from the relevant clinical director on the Declaration of Private Practice form. An audit of job plans of Consultants who have declared their intention to conduct private practice will be undertaken in 2022/23 to ensure compliance with effective job planning processes. ***As part of the job planning process, the Trust should consider total working hours across HSC and private practice.*** The Medical Staff Declaration of Private Practice requires confirmation that any private patient work must be

				included within their job plan and declared as soon as possible. An audit of job plans of Consultants who have declared their intention to conduct private practice will be undertaken in 2022/23 to ensure compliance with effective job planning processes.

Recommendation 1.3	Medical Director/Deputy Medical Director and all Divisional Medical Directors	The Trust should strengthen their management arrangements in scenarios where a Consultant declares that they conduct private outpatient work only, specifically where the work is carried out outside the NHS including premises not regulated by RQIA. The following specific measures are suggested: • Assurances should be sought as to how associated diagnostics/subsequent required treatment are managed. • Medical Director approval should be introduced in the event that Consultants conduct outpatient work privately. • Trust monitoring processes should be alert to ensuring Change of Status patients are placed on the waiting list based on clinical priority. • The Trust "Declaration of Private Practice" form should be amended to clearly identify the type of private practice undertaken (ie outpatient/daycases/inpatients). Trust management should review these declaration as and triangulate the information with appraisals and job plans.	Feb-22	As part of ongoing medical leadership review and strengthening exercises the following has been actioned: • ***Assurances should be sought as to how associated diagnostics/subsequent required treatment are managed.*** The Trust Declaration of Private Practice requires the doctor to confirm that any laboratory tests taken either on or off Trust premises must not be forwarded to the Southern H&SC Trust Laboratory for reporting and alternative arrangements for these has been made. Further to this, a medical appraisal structured reflective template has been created and piloted for deployment in the 2021 appraisal round that is designed to assist reflections on private practice. This includes details of the doctors personal approach to risk and governance around private practice including how they access diagnostic testing. This template requires the clinician to detail volume and type of private practice completed over previous 12-month period including private practice location, inclusion in job plan, governance arrangements and scope. • ***Medical Director approval should be introduced in the event that Consultants conduct outpatient work privately.*** The Medical Director is not able to approve or deny a consultant's indication to conduct outpatient work privately however there is a requirement to declare this type of work to the Medical Directors office via the completion of the declaration of private practice. In addition, via the Appraisal Structured Reflective Template details of this work and the clinical governance processes that provide assurance around this type of private practice. • ***Trust monitoring processes should be alert to ensuring Change of Status patients are placed on the waiting list based on clinical priority.***

				An audit programme is being developed for deployment in 2022/23, which will use multiple sources of information including clinical expertise to provide assurance that private patients are treated equally in terms of assigning of clinical priority as those who are referred via other HSC mechanisms. To support this audit process in 2022 the Trust is piloting an electronic version of the Change of Status form to assist with expediency and strengthen the formal record keeping process. • ***The Trust "Declaration of Private Practice" form should be amended to clearly identify the type of private practice undertaken (i.e. outpatient / daycases / inpatients). Trust management should review these declaration as and triangulate the information with appraisals and job plans.*** The Declaration of Private Practice has been amended to identify the type of private practice undertaken. This information is reviewed by the relevant clinical director and will be used to inform both the appraisal and job planning process.

Recommendation 1.4	Assistant Director Systems Assurance	The findings in this report indicate issues around patients being able to pay to see a Consultant privately and then receiving preferential treatment in the NHS. The Trust should consider whether these issues are isolated to this one Consultant or indicative of a wider cultural issue. The Trust should review and strengthen management of private patient procedures. As part of this process the new procedures should be shared with all relevant trust staff and roles and responsibilities should be reiterated where required. Specifically consulants must be reminded of their responsibility to ensure that all private work and change of status patients are declared. Consideration should be given as to how Radiology, Laboratories and Pharmacy can strengthen their processes, scrutiny and challenge of service requests that could potentially originate from the private sector.	Feb-22	The Trust is in the process of reviewing its private practice guidance and reporting processes to identify any non-compliance. Several elements to strengthen this process are being introduced: • In 2022 an electronic change of status form is being piloted that when submitted will be copied to the relevant Head of Service and Clinical Director. The form has enhanced details of regarding the patients origins and referral details. • As part of the revised medical declaration process consultants are required to assure they are aware of the parameters of which their private practice should be conducted within. • Memo issued to remind medical staff of the following - Requirement of the completion of an Annual Declaration on Private Practice (including those doctors who do not undertake private practice) - Importance of ensuring that each private patient referred to an elective service has an appropriate formal referral letter submitted via the Trust Referral and Booking Centre using the same process as all NHS referrals. Each referral must be clearly marked 'PRIVATE TO NHS TRANSFER'. - That private patients should not join a waiting list via any other entry point including being directly booked by secretarial staff. An audit proposal has been created to provide assurance around these processes. - Ensuring that change of status forms are completed for all relevant private patient transfers to NHS and returned to the Paying Patients Officer

				• An audit programme is being developed for deployment in 2022/23, which will use multiple sources of information including clinical expertise to provide assurance that private patients are treated equally in terms of assigning of clinical priority as those who are referred via other HSC mechanisms. • During 2022/23 a series of information sessions will be offered to inform medical staff to inform / remind all of their responsibility pertaining to private patients.  DRAFT Change of Status Form.pdf  20220112 MEMO Medical Private Prac  20211029 Private Patients Declaration  Memo - Changes to the Process for Decl Pharmacy have a good process for charging identified private patients working in conjunction with the private patient officers and the cashiers. This relies on others to identify that the patient is private and inform Pharmacists. If there was no 'history' on patient centre when a specialist script has been submitted, this would be raised with the consultant's secretary to check if it could be a private case. It is not feasible to check if each discharge or outpatient script received is private or NHS, so can reult in supplying to a private patient. To scope if ECM/electronic discharges and paper scripts could have a tick box for the prescriber to confirm that the patient is eligible - HSCB require prescribers to confirm that on their IFR drug applications. Radiology and Laboratories - current considering how to strengthen their process as per 3.3

Recommendation 1.5	Medical Director/Deputy Medical Director and all Divisional Medical Directors	As previously recommended in the 2019/20 Management of Private and Paying Patients audit report, Consultants should be instructed to complete the required declaration in relation to Private practice for the current year.	Oct-21	The Declaration of Private Practice has been circulated to all clinicians: The Medical Director issued a memo to remind to all of the importance of completing the 'Declaration'. The Revalidation Team are continuing to proactively engage with who have not responded in order to achieve 100% completion rate.  20220112 MEMO Medical Private Prac  20211029 Private Patients Declaration  Memo - Changes to the Process for Decl
Recommendation 1.6	Assistant Director Systems Assurance	The Change of Status process should be strengthened. Specifically: • The Change of Status form currently in use within the Trust for patients transferring from Private Practice to NHS must be reviewed and updated to include all relevant information including clear documentation of the reason for change. The effective date of change of status should be amended to the approved date for change of status and it should be clear on the form that the effective date of change will be the date that the form is approved by the agreed appropriate senior clinical and operational leads. The agreed appropriate senior clinical and operational leads should sign and date all change of status forms. Patients should only be added to the HSC waiting list when the change of status form has actually been signed and dated by the by the agreed appropriate senior clinical and operational leads. Previously reported in 2019/20 • The Trust should increase scrutiny and challenge over Change of Status forms that have been completed and sent to the Private Patient Office. The Trust should appropriately enforce the stated condition on the Change of Status form, namely until the form is approved, the patient will remain private and may be liable for charges. Previously reported in 2019/20	Feb-22	The following actions have been taken to date: ***The Change of Status form currently in use within the Trust for patients transferring from Private Practice to NHS must be reviewed and updated to include all relevant information including clear documentation of the reason for change.*** A revised electronic Change of Status form has been developed which for pilot which includes a mandatory field noting reason for transfer along with other more detailed information regarding the change of status event  DRAFT Change of Status Form.pdf ***The effective date of change of status should be amended to the approved date for change of status and it should be clear on the form that the effective date of change will be the date that the form is approved by the agreed appropriate senior clinical and operational leads.*** The piloted electronic form will contain the following field and statement • *Planned Date of Transfer from Private to NHS to Approved Date of Transfer to NHS (pending Managerial acceptance)*

				• *Please note that your Clinical Director and Head of Service will be required to review the change of status submission prior to the change of status being confirmed. If there are any issues or requirements for additional information you the Clinical Director / Head of Service will contact you within 5 working days of receipt of the completed Change of Status form. Please note that the change of status will only be confirmed by the paying patients office following the expiry of the 5 day period.* ***The agreed appropriate senior clinical and operational leads should sign and date all change of status forms. Patients should only be added to the HSC waiting list when the change of status form has actually been signed and dated by the by the agreed appropriate senior clinical and operational leads.*** The piloted electronic form submission will be duplicated to the clinical director and head of service for review. The management team will have 5 days to review and respond to question or reject the planned transfer. The below text will be included in the piloted form: • *Please note that your Clinical Director and Head of Service will be required to review the change of status submission prior to the change of status being confirmed. If there are any issues or requirements for additional information you the Clinical Director / Head of Service will contact you within 5 working days of receipt of the completed Change of Status form. Please note that the change of status will only be confirmed by the paying patients office following the expiry of the 5 day period.*

				The Trust should increase scrutiny and challenge over Change of Status forms that have been completed and sent to the Private Patient Office. The Trust should appropriately enforce the stated condition on the Change of Status form, namely until the form is approved, the patient will remain private and may be liable for charges. Previously reported in 2019/20 The piloted electronic form submission will be duplicated to the clinical director and head of service for review. The management team will have 5 days to review and respond to question or reject the planned transfer. The electronic form will have validation fields that will require details to be provided to allow the doctor to submit the document.
Recommendation 1.7	Assistant Director Systems Assurance, Assistant Director Functional Support Services	As previously recommended in the 2019/20 Management of Private and Paying Patients audit report, the Trust should develop a process to monitor change of status patients and to ensure that the process for changing status is effectively controlled and documented as an assurance that the delivery of service is equitable. The Trust should implement the regional PAS code for patients transferring from private to NHS and develop a mandatory requirement to indicate changes of status on PAS. A printout from PAS should then be regularly reviewed and reconciled to Change of Status forms received.	01/02/2022 complete	An audit programme is being developed for deployment in 2022/23, which will use multiple sources of information including clinical expertise to provide assurance that private patients are treated equally in terms of assigning of clinical priority as those who are referred via other HSC mechanisms. The Trust has created a report in Business Objects and shared with Private Patient Officer to cross check. All secretaries reminded of codes and when to use. The reports are set up and PP officer runs them. Training re all the codes complete and all secretaries met with. An audit proposal has been created to provide assurance around these processes. This is pending agreement with Finance and Support Services to commence.

Recommendation 1.8	Assistant Director ATICS	The Trust should increase controls over prescription pads held in consulting rooms. These should be maintained as controlled stationery.	Feb-22 Implemented	New Process • Prescription pads are ordered via BSO e-procurement by Nursing staff • Now on receipt these are stored in locked cupboards • Cupboards located in each consultant rooms in outpatients • Only Nursing staff hold the keys for these cupboards and they take the prescription pads out at the start of clinic and return to the locked cupboard at the end. • Still to implemented will be that the Pads will be numbered and signed in and out of each of the cupboards to ensure control.
Recommendation 2.1	Medical Director	The Trust should consider charging for the identified private activity. Internal Audit appreciate that this needs to be considered, and may not be feasible, in the wider context of a patient recall.	01/07/2021 complete	This has been considered by the Trust and it was felt it would not be appropriate to charge these patients.
Recommendation 2.2	Assistant Director Functional Support Services and Operational ADs	The Trust should develop a written procedure around the use of protected review clinic appointments. The Trust should also introduce monitoring of compliance with the procedure.	Feb-22	The Trust has commenced discussions within the divisions to agree and implement a written procedure for the use of protected review clinics appointment. Once agreed this will be shared and implemented with agreed timescales for monitoring compliance.
Recommendation 2.3	Assistant Director Systems Assurance	Trust Guidance and Management of Private Practice in Health Service Hospitals In Northern Ireland: A Handbook (November 2007) should be re-issued and sign-off by doctors engaging in private practice. Where concerns are raised about a consultants' compliance, the Department of Health's framework Maintaining High Professional Standards in the Modern HPSS should be followed.	Feb-22	As part of the revised process to govern the 'Declaration of Private Practice' all medical staff engaging in private practice are required to provide signed confirmation that they are aware and will abide by the Trust Guidance on Private Practice and the regional Management of Private Practice in Health Service Hospitals in Northern Ireland (2007).  20211029 Private Patients Declaration

Recommendation 3.1	Assistant Director of ATICS	As previously recommended in the 2019/20 Management of Pre-Op Assessments audit report, Management should ensure all patients due for elective surgery have an up to date pre-operative assessment completed no more than 13 weeks ahead of planned admission date for surgery. Management should focus on improving processes in those specialties with higher volumes of exceptions including Urology.	Sep-21	Due to covid 19 pressures there is limited theatre capacity. Currently only priority 2 patients according to the Federation of surgical speciality association (FSSA) guidelines are scheduled and these lists are all shared with Pre-OP as soon as they are identified by the consultant and added to the priority 2 spreadsheets.
Recommendation 3.2	Assistant Director of ATICS	As previously recommended in the 2019/20 Management of Pre-Op Assessments audit report, Management should review processes to ensure all private outpatients transferring to NHS inpatient waiting lists are promptly notified to the Pre-operative Assessment team.	Sep-21	All private patients (PP) are listed onto the Patient Administrative System (PAS) by the secretarial admin staff and if they are priority 2 and added to the spreadsheet (3.1) then they are sent to Pre-Op and identified as previous PP. The report advised can be run via Business objects by Pre Op team
Recommendation 3.3	Director Performance & Reform/ AD Cancer & clinical Services	The Trust should liaise with BSO in order to resolve this referring Consultant recording error in the NIPACS system.	Feb-22	There is a flag on NIPACS for private patient but previously, we would be have depended on the referrer to note this as 'free text' in the referral. We can ID a referral as private by the referral source which can hep indicate that likely to be private. Contact was made with BSO but their view is that this is for each Trust to establish their own process. Trust linking with colleagues in other Trusts to confirm their process for dealing with imaging referrals for private patients to influence our approach as there is currently no straightforward way to capture this.
Recommendation 3.4	Assistant Director Support Services	The processes for registration should be reviewed and training given to all appropriate staff on the correct use of PAS, including consultant secretaries.	Feb-22	PAS identifies "open registered patients". These are reviewed and reported on and followed up/ escalated for timely closure.
Recommendation 3.5	Assistant Medical Director Clinical Directors and Assistant Operational Directors	The processes surrounding electronic and manual sign off and review of the "DISCHARGE AWAITING RESULT" should be strengthened and monitored.	Feb-22	This is a PAS function to prompt re "Discharge awaiting results" – DARO is used only for patients awaiting results and is reflected in monthly Service Administrators reports. Process for escalation currently to HOS and AD.

Recommendation 5.1	Director of Finance	The Trust should remind staff that all donations received from the public in respect of their care should be lodged to the Trust's Charitable Trust Funds only and that staff are not permitted to use their position of employment within the Trust to advance personal interests, causes or charities as it could give rise to reputational damage to the Trust.	Dec-21	To be completed by December 2022

From the Permanent Secretary and HSC Chief Executive

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Castle Buildings
Upper Newtownards Road
BELFAST, BT4 3SQ

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

Our ref: RP5593

Date: 22 October 2020

Shane Devlin
Chief Executive
Southern HSC Trust

Personal Information redacted by the USI

Personal Information redacted by the USI

Dear Shane

CONFIDENTIAL EARLY ALERT 182/2020 – SOUTHERN TRUST CONSULTANT UROLOGIST

I refer to the above Early Alert which was notified to the Department on 31 July 2020, and the subsequent report submitted to the Department via the HSCB on 15 October 2020, summarising the Trust's ongoing scoping and management of the issues arising from it.

Whilst I fully appreciate the complexity of this task and the intensive efforts by Trust colleagues to date to quantify these issues and to ensure that no patients come to harm as a consequence, the Department's view is that this process will benefit at this stage from a commensurate level of external oversight and assurance. Further to our discussion today I have therefore attached at **Annex A** draft terms of reference for a Department-led assurance group which I will chair in order to review progress and guide the way forward in terms of the Trust's management plan. It is my intention that the Urology Assurance Group will begin to meet from next week in order to agree the terms of reference and discuss the immediate next steps. Michael O'Neill, Acting Director of General Healthcare Policy, will lead on this in the Department and provide secretariat for the group.

Yours sincerely

Personal Information redacted by the USI

RICHARD PENGELLY
ACCOUNTING OFFICER

cc.
CMO
CNO
Lourda Geoghegan
Naresh Chada
Jackie Johnston
David Gordon
Michael O'Neill
Ryan Wilson
Maria O'Kane, SHSCT
Sharon Gallagher, HSCB
Paul Cavanagh, HSCB
Olive MacLeod, PHA
Brid Farrell, PHA
Tony Stevens, RQIA
Emer Hopkins, RQIA

ANNEX A

UROLOGY ASSURANCE GROUP
DRAFT TERMS OF REFERENCE

Background

The Department received a confidential Early Alert (EA 182/20) from the Southern Health and Social Care Trust on 31 July 2020 regarding potential safety concerns that were initially raised on 7 June 2020 about a consultant urologist who retired at the end of June 2020.

The Trust took a number of initial actions relating to these concerns, including restricting the consultant's clinical practice and access to patient information, notifying the GMC and discussing the matters with the Royal College of Surgeons Invited Review Service to understand the scope and scale of any further independent review.

In order to fully define the areas for concern and quantify the number of patients potentially impacted, the Trust has undertaken an internal scoping exercise of all patients who were under the care of the consultant, initially for an 18 month period. This involves a review of all case notes to identify those which provide any cause for concern.

Officials from the Department, HSCB and PHA have participated in weekly progress update calls with the Trust since 10 September 2020. Upon request a report was provided to the Department on 15 October 2020 summarising the current position, including the quantity of patient case notes that need to be reviewed and progress so far, confirmed SAIs to date, and advising of additional patient safety concerns identified in the course of this exercise.

Objectives

In light of the concerns identified a Department-led Urology Assurance Group will provide external oversight of the various work streams arising from the ongoing scoping exercise Trust. Specifically the Group will:

- review the progress of the initial scoping exercise;
- consider emerging strategic issues;
- commission and direct further work as necessary;
- monitor the impact on urology and related services;
- ensure coordination with other associated reviews / investigations; and
- oversee communication across all stakeholder groups.

Membership

The Group will be chaired by the Permanent Secretary. Membership will include:

- Dr Michael McBride, Chief Medical Officer, DoH
- Sharon Gallagher, Interim Chief Executive, HSCB/PHA
- Jackie Johnston, Deputy Secretary Healthcare Policy Group, DoH
- Olive Macleod, Interim Chief Executive, PHA
- Paul Cavanagh, Director of Commissioning, HSCB
- Dr Brid Farrell, AD Service Development, Safety and Quality, PHA
- Dr Tony Stevens, Interim Chief Executive, RQIA
- Emer Hopkins, Interim Director of Improvement, RQIA
- Shane Devlin, Chief Executive, Southern Trust
- Maria O'Kane, Medical Director, Southern Trust

- Lourda Geoghegan, Deputy Chief Medical Officer, DoH
- David Gordon, Director of Communications, DoH
- Ryan Wilson, Acting Director of Secondary Care, DoH
- Michael O'Neill, Acting Director of General Healthcare Policy, DoH,
- Anne Marie Bovill, General Healthcare Policy

Support

Secretariat will be provided by General Healthcare Policy Directorate and meetings will initially be held fortnightly, but will be subject to review.

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

Chair and Non Executive Director meeting with the Chief Executive

Notes of a virtual meeting on Covid-19 held on 8th October 2020 at 4.00 p.m.

Present:- Roberta Brownlee
Shane Devlin
Geraldine Donaghy
Pauline Leeson
Hilary McCartan
Eileen Mullan
John Wilkinson

Apologies:- Martin McDonald

1. COVID-19 KEY FACTS AND FIGURES

The Chief Executive highlighted the key messages as follows:-

Inpatients – Numbers continuing to increase with 33 Covid-positive in-patients as at 8.10.2020.

Community – continued community transmission of Covid, particularly in Newry, Mourne and Downe with last 7 day rate showing 322 covid positive cases per 100k population.

Staff – 450 staff currently off with Covid related absence.

Care Homes – 69 green, 4 amber, 1 red.

2. DAISY HILL HOSPITAL ED

The Chief Executive confirmed the re-opening of DHH ED on 19th October 2020 as planned.

3. REBUILDING HSC SERVICES

The new Surge Planning Strategic Framework has been announced by the Minister.

The Chief Executive shared the 'No More Silos' 10 point plan with members and outlined the project management and oversight structure. He stated that the biggest challenge was GP capacity for the Urgent Care Centres.

Mr Wilkinson asked about discharges to nursing homes and sought assurance around patient safety. The Chief Executive advised that clear procedures were in place and followed. The Chair made reference to staff in the IS Care Home sector who are off with Covid related absence and asked about financial arrangements in respect of payments to this sector. The Chief Executive stated that guidance had been issued by the Department and he undertook to check the financial arrangements with Ms Helen O'Neill.

The pressure on Acute Services was discussed in which the Chief Executive advised of support for Mrs M McClements at Assistant Director level. He also advised that the DoH had given approval to permanently recruit for the Director of OPPC and Mrs McClements will move to Director of Acute Services on a permanent basis.

4. COVID-19 Cluster SAI process update

The Chief Executive advised that the majority of the Panel has now been appointed. Draft Terms of Reference to be agreed with the families and then timeline will be published.

The Chief Executive agreed to provide a short update at the next confidential Trust Board meeting.

5. CLINICAL CONCERNS WITHIN UROLOGY

The Chief Executive stated that the Trust continues to identify further issues and are now up to 12 SAIs at this point. Concerns had been related to process and administration, but now patient harm concerns are being identified. He added that the Trust has more explorative work to do before any public statement is made. Discussion ensued in which members sought assurance that one Consultant Urologist reviewing files was adequate; that a timeline of action was in place and that there would be no legal recourse if Consultant A was not given prior notice of the case being made public. In respect of the latter point, the Chief Executive advised that the Trust was seeking legal advice. The Chief Executive gave assurance on the actions taken to review aspects of Consultant A's practice and the development of appropriate management plans to minimise risk or harm to patients.

An update will be brought to the next confidential Trust Board meeting.

6. DATE OF NEXT MEETING

To be confirmed.

The meeting concluded at 5.15 p.m.

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

Chair and Non Executive Director meeting with the Chief Executive

Notes of a virtual meeting on Covid-19 held on 15th October 2020 at 4.00 p.m.

Present:- Roberta Brownlee
Shane Devlin
Geraldine Donaghy
Hilary McCartan
Eileen Mullan
John Wilkinson

Apologies:- Pauline Leeson
Martin McDonald

1. COVID-19 KEY FACTS AND FIGURES

The Chief Executive highlighted the key messages as follows:-

Inpatients – Numbers continue to increase with 50 Covid-positive in-patients as at 15.10.2020. The Chief Executive stated that it was important to note that the highest number of Covid positive inpatients in the first phase was 63.

Community – continued community transmission of Covid.

Staff – 535 staff currently off with Covid related absence.

Care Homes – 66 green, 4 amber, 4 red.

Ms Mullan asked about testing in the Care Homes. The Chief Executive advised that staff were regularly tested every 14 days.

Cancellations were discussed and members noted that any cancellations were clinically led and have Chief Executive approval.

2. COVID-19 Cluster SAI process update

The Chief Executive advised that good progress was being made with the full external panel membership soon to be confirmed. A rapid learning event has also taken place.

The Chief Executive agreed to provide a short update at the next confidential Trust Board meeting.

3. CLINICAL CONCERNS WITHIN UROLOGY

The Chief Executive advised that the Trust had submitted a report to the Department of Health on 14th October 2020. Timeframe was discussed in which members emphasised the importance of support to the patients and their families once this case was in the public domain. Members referred to the process and asked if one Urologist reviewing files was adequate. The Chief Executive agreed to further discuss with Dr O'Kane.

An update will be brought to the next confidential Trust Board meeting.

4. DATE OF NEXT MEETING

To be confirmed.

The meeting concluded at 5.10 p.m.

Southern Health and Social Care Trust

Quality Care - for you, with you

Notes of Chair and Non-Executive Director Virtual Meeting with the Chief Executive held on Thursday, 29th October 2020 @ 4 p.m.

Present : Roberta Brownlee
Shane Devlin
Geraldine Donaghy
Pauline Leeson
Hilary McCartan
Eileen Mullan
John Wilkinson

In attendance: Sandra Judt (Notes)

ITEM	NOTE	ACTION
1	**APOLOGIES** Apologies were received from Mr Martin McDonald.	
2	**DECLARATION OF INTERESTS** The Chair advised that in relation to item no. 6, whilst she had no interest to declare in the subject matter, she would not remain in the meeting for discussion on this item for personal reasons.	
3	**NOTES OF PREVIOUS MEETINGS HELD ON 8TH AND 15TH OCTOBER 2020** The Notes of the meetings held on 8th and 15th October 2020 had been previously circulated and were approved.	
4	**COVID-19 UPDATE/PRESSURES** The Chief Executive presented the key facts and figures as follows:- **Admissions/Discharges** – 94 Covid-positive in-patients as at 28.10.2020.	

	Bed Occupancy – 73 Covid-positive patients in Craigavon, 10 in Lurgan Hospital and 6 in Daisy Hill Hospital. The Chief Executive reported that there were 10 patients currently in ICU, therefore additional ICU beds will need to be opened. This mean cancelling urgent elective surgery over the weekend and next week. Ms Donaghy asked about the age profile of these patients. The Chief Executive undertook to provide. In response to a question about oxygen supplies, the Chief Executive advised that there no issues as Dr Boyce had built resilience into the Trust's oxygen supply. Members asked that Dr Boyce be commended for her foresight. **Community** – Downward trend in Newry/Mourne and ABC Council areas. However, continual high number of Covid positive cases in Mid Ulster, particularly in the Dungannon postcode area. The high BME population in this area was discussed. **Staff** – 542 staff currently off with Covid related absence. **Care Homes** – 66 green, 4 amber, 4 red.	***Chief Executive to provide age profile of patients*** ***Chief Executive***
5	**COVID-19 CLUSTER SAI PROCESS UPDATE** The Chief Executive advised that the SAI was progressing well with final Terms of Reference now agreed and Panel membership arrangements completed. The Family Liaison Officer has taken up post and 15 families who were bereaved are involved in the process. The Panel Chair has asked the Chief Executive to write on behalf of the Panel to all the families to share the Terms of Reference with them and to offer engagement with the Panel Chair. The Chief Executive informed members that the Panel Chair has indicated that it will take 4 – 6 months to complete the SAI. He stated that he has asked the Panel Chair for regular learning updates. Ms Mullan asked if consideration had been given to additional resources to complete this SAI and other SAIs across the Trust? The Chief Executive advised that he has asked Dr O'Kane for a profile of staffing requirements. In relation to Mental Health SAIs, he referred to the Royal College of	***Chief Executive to share Terms of Reference with members***

	Psychiatrists Mortality Review Tool and advised of the Trust's intention to profile 10 Mental Health SAIs using this approach. A short overview paper will be provided at the next Governance Committee meeting. Ms Donaghy asked about support for the Director of Acute Services. The Chief Executive stated that the pressure in Acute has reduced slightly given developments such as the re-opening of Daisy Hill Hospital ED etc. and with the additional support into Acute Services provided by both Mrs Magwood and Mrs Leeman. At this point, Mrs McCartan asked about an Early Alert in relation to the Commercially Sensitive Information redacted by the USI.. The Chief Executive stated that the situation was unfolding and agreed to provide an update at the next confidential Trust Board meeting. The Chair left the meeting at this point and Mrs Leeson took over as Chair.	***Update to be provided at next Trust Board Confidential meeting***
6	**CLINICAL CONCERNS WITHIN UROLOGY** The Chief Executive provided an update. He outlined the sequence of events since the Trust Board meeting on 22nd October 2020 when members had discussed the situation and agreed a way forward. He referred to correspondence from the Permanent Secretary on 23rd October 2020 which had been shared with members and the story which had appeared in the Irish News on 26th October 2020. Members noted the establishment of a Department led Assurance Group, chaired by the Permanent Secretary, to review progress and guide on the way forward in terms of the Trust's management plan. The Chief Executive reported that over the weekend, the Trust set up a telephone Helpline for concerned patients and engaged with Consultant A's Solicitors. The Terms of Reference for the Assurance Group were discussed and the importance of assurance being provided to Trust Board was highlighted. Both the Chief Executive and Dr O'Kane are members of the Assurance Board and the Chief Executive agreed to report on progress to Trust Board under the confidential section. Mr Wilkinson stated that this was a complex situation with the potential for significant reputational risk to the Trust.	

	Resources were discussed. The Chief Executive advised that a second Independent Urologist has been brought in to review files and he has asked Dr O'Kane to consider what additional resources might be required. Ms Donaghy raised the media coverage in the Irish News and asked about natural justice and Consultant A's right of reply. The Chief Executive stated that this would be brought into the SAI process. Members discussed the Maintaining High Professional Standards (MHPS) framework. Mr Wilkinson noted that as the nominated NED in the case involving Consultant A, that this was a complex situation with the potential for significant reputational risk to the Trust. Ms Donaghy raised the fact that she was also due to participate in a MHPS case and asked at what stage were NEDs obliged to advise Trust Board. Members raised the need for further clarity/refresher training around the NEDs' role under the MHPS framework. The Chief Executive agreed to discuss with Dr O'Kane and Mrs Toal.	***Chief Executive to discuss with Dr O'Kane and Mrs Toal***
7	**DATE OF NEXT MEETING** Thursday, 5th November 2020 at 4.00 p.m. ***The meeting concluded at 5.25 p.m.***	

Southern Health and Social Care Trust

Quality Care - for you, with you

Notes of Chair and Non-Executive Director Virtual Meeting with the Chief Executive held on Thursday, 5th November 2020 @ 4 p.m.

Present : Roberta Brownlee
Shane Devlin
Geraldine Donaghy
Pauline Leeson
Hilary McCartan
Eileen Mullan
John Wilkinson

In attendance: Sandra Judt (Notes)

ITEM	NOTE	ACTION
1	**APOLOGIES** Apologies were received from Mr Martin McDonald.	
2	**DECLARATION OF INTERESTS** The Chair advised that in relation to item no. 6, whilst she had no interest to declare in the subject matter, she would not remain in the meeting for discussion on this item for personal reasons.	
3	**NOTES OF PREVIOUS MEETING HELD ON 29TH OCTOBER 2020** The Notes of the previous meeting had been previously circulated and were approved.	
4	**COVID-19 UPDATE/PRESSURES** The Chief Executive presented the key facts and figures as follows:- **Admissions/Discharges** – 106 Covid-positive in-patients as at 5.11.2020 - 80 in Craigavon, 10 in Lurgan and 16 in Daisy Hill Hospital. 16 ICU beds now opened resulting in reduction in	

	elective surgery as a result of deploying nursing staff to enable ICU to reach maximum surge capacity of 16 beds. Further wards being opened in South Tyrone and Lurgan hospitals to provided additional capacity. As requested at the previous meeting, the Chief Executive provided an age profile of Covid patients. This showed no significant increase in younger patients. **Staff** – 556 staff currently off with Covid related absence. **Care Homes** – 6 amber, 3 red, with remainder green. Mrs McCartan noted the additional bed capacity in Lurgan and South Tyrone Hospitals and asked about staffing. The Chief Executive stated that some day care and day opportunities were closed due to Covid outbreaks and Mr McNeany and Mr Beattie were working through redeployment of those staff to these wards. Mr Wilkinson asked about how the Trust balances Covid related and non-Covid related patients in ICU. The Chief Executive spoke of the regional modelling applied which suggests for the 16 ICU beds in the Trust, two-thirds would be for Covid-related patients and one-third for non–Covid patients. Ms Mullan raised the numbers of patients requiring admission to hospital and the limited side room capacity which limits the Trust's potential to respond adequately to Covid-19. The Chief Executive acknowledged the high risk of nosocomial transmission of Covid-19 due to the limitations of side rooms and general infrastructure. The Chief Executive reported that in an attempt to reduce footfall through ED, the Phone First service will be introduced in the Trust on 17.11.2020. Members asked about the Covid-19 Lessons Learned Report. The Chief Executive agreed to bring a summary update to the next Trust Board confidential meeting.	***Summary report to Trust Board confidential meeting on 12.11.2020***

	The Chair asked about patients being able to continue to be cared for in a Care Home as opposed to hospital. The Chief Executive provided useful data on ED attendances from Care Homes. At this point, Mrs McCartan asked about the situation in respect of the Commercially Sensitive Information redacted by the USI. The Chief Executive stated that the Trust was continuing to give attention to [redacted] Commercially Sensitive Information redacted by and he spoke of the ongoing work between the Trust, RQIA and Western Trust to ensure individuals receive the care they require. An update paper will be brought to the next Trust Board confidential meeting.	***Update to be provided at Trust Board Confidential meeting on 12.11.2020***
5	**COVID-19 CLUSTER SAI PROCESS UPDATE** The Chief Executive advised that the final Terms of Reference would be posted to the families that day. He stated that there has been a lot of engagement with the 15 families involved in the process which members welcomed. The Panel Chair has indicated that it would take 6 months to complete the SAI. Ms Donaghy queried if there was sufficient Estates expertise/advice to the Panel. The Chief Executive advised that the Panel may call on external advice, including Estates. The importance of a communications strategy was highlighted to which the Chief Executive confirmed that this was in place. He also confirmed that the families involved understand that a SAI is a learning event. The Chair left the meeting at this point and Mrs Leeson took over as Chair.	
6	**CLINICAL CONCERNS WITHIN UROLOGY** The Chief Executive provided an update on progress to date in relation to the patient facing information line, the Independent Sector clinic work and the two all day clinics set up for patients on the drug Bicalutamide identified as needing an urgent appointment. The SAI process was discussed. Members were advised that all 9 patients/families identified through the SAI process have been spoken to with some of them being offered a further	

	appointment with a Consultant Urologist, taking place this week. The Chief Executive advised that the Urology Assurance Group has begun to meet weekly and discussion will be required as to whether a separate process to the SAI process will be required as additional incidents are identified. Mrs McCartan asked if the Trust had adequate resources to cover the additional costs associated with current and projected work. The Chief Executive advised that Dr O'Kane was considering the resources required. Mr Wilkinson requested that an update paper to the next Trust Board confidential meeting includes all the various strands being explored under this review and the progress made to date. The Chief Executive advised that he has had an initial discussion with Mrs Toal in relation to the NED role in the MHPS process.	***Chief Executive to provide for Trust Board confidential meeting on 12.11.2020***
7	**DATE OF NEXT MEETING** Thursday, 19th November 2020 at 4.00 p.m. ***The meeting concluded at 5.15 p.m.***	

Southern Health and Social Care Trust

Quality Care - for you, with you

Notes of Chair and Non-Executive Director Virtual Meeting with the Chief Executive held on Thursday, 19th November 2020 @ 4 p.m.

Present : Roberta Brownlee
Shane Devlin
Geraldine Donaghy
Pauline Leeson
Hilary McCartan
Eileen Mullan
John Wilkinson

In attendance: Sandra Judt (Notes)

ITEM	NOTE	ACTION
1	**APOLOGIES** Apologies were received from Mr Martin McDonald.	
2	**DECLARATION OF INTERESTS** The Chair advised that in relation to item no. 8, whilst she had no interest to declare in the subject matter, she would not remain in the meeting for discussion on this item for personal reasons. The Chief Executive declared an interest in relation to item no. 7 and did not remain in the meeting for discussion on this item.	
3	**NOTES OF PREVIOUS MEETING HELD ON 5TH NOVEMBER 2020** The Notes of the previous meeting had been previously circulated and were approved.	

4	**COVID-19 UPDATE/PRESSURES** The Chief Executive presented the key facts and figures as follows:- **Admissions/Discharges** – downward trend with 94 Covid-positive in-patients as at 19.11.2020. The Chief Executive stated that regional bed modelling forecasting is suggesting a flat line for the Southern Trust as opposed to downward trend. If this is the case then Trust plans will have to be changed. Mr Wilkinson raised the public frustration that the regional figures/projections are not being articulated in a way that is easily understood. In response to a question from the Chair on the cancellation of some red flag surgeries, the Chief Executive stated that the issue is lack of Theatre staff as opposed to lack of surgical beds. All decisions to cancel are clinically based and he undertook to reinforce that message. **Care Homes** – slight increase in Covid positive numbers. Ms Donaghy asked about the death per 100,000 rate. The Chief Executive agreed to check. The Chief Executive advised of a recent unannounced visit from the PHA where they were supportive of the Trust's good work and extensive efforts to reduce risk of Covid-19. As a result, the Trust has been asked to submit a number of bids to the DoH for further support and funding. Members commended this excellent outcome and congratulated all staff involved.	***Chief Executive***
5	**COVID-19 CLUSTER SAI PROCESS UPDATE** The Chief Executive advised that work was progressing well. He has written to the 15 families involved and shared the Terms of Reference with them.	
6	Commercially Sensitive Information redacted by the USI. **UPDATE** The Chief Executive advised that Commercially Sensitive Information redacted by the USI. has officially withdrawn from the process, leaving no-one prepared to come in and run this Home. The Trust currently has 30 residents	

	placed in this Home, 17 from OPPC and 13 from MHLD. The options open to the Trust are to either to find a new home for these residents or step in to provide care. The Western Trust has 20 residents and are in the process of moving these residents out. The Chair stated that this Home has a specialized head injury unit for the region and she raised her concern for those residents. *The Chief Executive left the meeting at this point.*	
8	**CLINICAL CONCERNS WITHIN UROLOGY** The Chief Executive advised of the Department's intent that this will be subject to an Independent Review and the Minister will be making an oral presentation to the Assembly on 24.11.2020. The Chief Executive advised that concerns about this clinician's private practice are now being raised. In light of this, he has instigated an Internal Audit review and the Head of IA is currently drafting up the Terms of Reference. Mrs Leeson asked if there were concerns about any other Consultants. The Chief Executive advised that he believed that any issues or concerns identified will be at a system level e.g. appraisals as opposed to individual level. In response to a question about individual patients, the Chief Executive explained that the Independent Review will move away from individual patient journeys and focus at system level.	
9	**DATE OF NEXT MEETING** Thursday, 26th November 2020 at 4.00 p.m. ***The meeting concluded at 5.15 p.m.***	

Southern Health and Social Care Trust

Quality Care - for you, with you

Notes of Chair and Non-Executive Director Virtual Meeting with the Chief Executive held on Thursday, 26th November 2020 @ 3.15 p.m.

Present : Roberta Brownlee
Shane Devlin
Geraldine Donaghy
Hilary McCartan
Eileen Mullan
John Wilkinson

In attendance: Sandra Judt (Notes)

ITEM	NOTE	ACTION
1	**APOLOGIES** Apologies were received from Mr Martin McDonald and Mrs Pauline Leeson.	
2	**DECLARATION OF INTERESTS** The Chair advised that in relation to item no. 7, whilst she had no interest to declare in the subject matter, she would not remain in the meeting for discussion on this item for personal reasons.	
3	**NOTES OF PREVIOUS MEETING HELD ON 19TH NOVEMBER 2020** The Notes of the previous meeting had been previously circulated and were approved.	
4	**COVID-19 UPDATE/PRESSURES** The Chief Executive presented the key facts and figures as follows:- **Admissions/Discharges** – continued downward trend with 82 Covid-positive in-patients as at 26.11.2020 (53 in	

	Craigavon; 11 in Lurgan; 9 in South Tyrone and 9 in Daisy Hill Hospitals). **Care Homes** – 8 amber, 4 red, remainder green. From Covid-19 perspective, the number of Covid positive patients is reducing. **Staff Absence** – numbers starting to reduce with 437 covid related staff absences as at 26.11.2020 The Chief Executive stated that the ICU was now back to medium surge thus enabling staff to be released for elective work. He further stated that staff are tired, but beginning to see light at the end of the tunnel and it is hoped that the actions of the Assembly for a fortnight long new lockdown will further drive down the rate of Covid-19 infection. In response to a question from Mr Wilkinson on Winter pressures, the Chief Executive advised that plans are in place and as the level of staff available starts to increase, this will enable delivery against these plans. ED was raised in which the Chief Executive advised of a meeting with ED Consultants the previous week to agree the beginning of a possible escalation plan. Members noted that the patient call line 'Phone First' will start in the Trust on 30.11.2020. The Chief Executive updated on the Covid-19 vaccination. Mrs Vivienne Toal is the Lead Director for the vaccination programme. The aim is to start with the immunisation of healthcare workers and discussions continue to identify a suitable venue. In response to a question from Mr Wilkinson on the Trust's approach, the Chief Executive stated that the Trust would be encouraging and supporting the uptake of the vaccination.	
5	**COVID-19 CLUSTER SAI PROCESS UPDATE** The Chief Executive advised that work was at the information gathering stage and was progressing well.	
6	Commercially Sensitive Information redacted by the USI. **UPDATE** The Chief Executive advised that the Trust is working proactively with families to find alternative placements for the 30 residents placed in the Commercially Sensitive Information redacted by the USI. . He stated that	

	this is the safest option and confirmed that there is capacity within the Southern Area to accommodate these residents. *The Chair left the meeting at this point.*	
7	**CLINICAL CONCERNS WITHIN UROLOGY** The Chief Executive raised the Minister's announcement with respect to the Urology Statutory Public Inquiry. Mr Wilkinson stated that it was particularly important from a NED perspective that the various strands were unraveled and the learning taken from them. The Chief Executive advised that the SMT was discussing the preparations necessary to support not only the work of the Inquiry, but to look into the organisation on such areas as appraisal etc. The Non Executive Directors emphasised that it was critical the Trust had the requisite resources in place to support this detailed process.	
8	**DATE OF NEXT MEETING** Thursday, 3rd December at 3.15p.m. ***The meeting concluded at 4.15 p.m.***	

Southern Health and Social Care Trust

Quality Care - for you, with you

Notes of Chair and Non-Executive Director Virtual Meeting with the Chief Executive held on Thursday, 3rd December 2020 @ 3.15 p.m.

Present : Pauline Leeson (Chair of meeting)
Shane Devlin
Geraldine Donaghy
Hilary McCartan
Martin McDonald
John Wilkinson

In attendance: Sandra Judt (Notes)

ITEM	NOTE	ACTION
1	**APOLOGIES** Apologies were received from Ms Eileen Mullan.	
2	**DECLARATION OF INTERESTS** There were no interests to declare.	
3	**NOTES OF PREVIOUS MEETING HELD ON 26TH NOVEMBER 2020** The Notes of the previous meeting had been previously circulated and were approved.	
4	**COVID-19 UPDATE/PRESSURES** The Chief Executive presented the key facts and figures as follows:- **Admissions/Discharges** – continuous downward trend with 55 Covid-positive in-patients as at 3.12.2020. **Community –** Decreasing number of Covid-positive patients per 100,000 population. **Care Homes** – 17 care homes have declared an outbreak with only 5 residents hospitalized as a result. Only 4 homes RAG rated red.	

	Staff Absence – numbers reducing with 357 covid related staff absences as at 3.12.2020 Mr Wilkinson asked about Covid positive patients in Daisy Hill Hospital. The Chief Executive stated that there were currently six Covid positive patients in Daisy Hill Hospital and it was now back to a fully functioning acute hospital. Meetings with the Pathfinder Group are now being held on a monthly basis as opposed to weekly. Mrs McCartan raised the recent media coverage in relation to surgeons across NI carrying out operations at the South West Acute Hospital (SWAH). The Chief Executive advised that the plan is to deliver regional elective services at SWAH. The Regional Board had agreed a proposed short term way forward for the stabilisation of surgical services at SWAH, with the option to include the opportunity to combine provision of theatre capacity to visiting Consultants for elective surgery. The first stage involves Consultants from the Belfast Trust. Work is ongoing across the region to identify high priority patients for elective surgery that could be delivered at SWAH in order to reduce the backlog. The Chief Executive updated on the Phone First service which went live in the Trust on 30.11.2020.	
5	**COVID-19 CLUSTER SAI PROCESS UPDATE** The Chief Executive advised that the Panel has asked for a significant amount of data which the Trust has provided. Engagement with the families continues.	
6	**CLINICAL CONCERNS WITHIN UROLOGY** The Chief Executive stated that the Trust would be seeking clarity with regard to the approach of the Statutory Public Inquiry with a meeting of the Department Led Assurance Group being held the following day. In relation to the Consultant's private practice, Internal Audit has completed their Terms of Reference and hope to commence their review of patients transferred into the Trust as HSC patients the following week. Referring to the Patient Information line, the Chief Executive advised of some new information regarding potential private practice still occurring despite an undertaking to the GMC that this would cease. A third party has been	

	engaged to validate Mr Mark Hayne's work in reviewing the cases files. The Chair of the Public Inquiry has yet to be determined. Mr Wilkinson asked if the Trust was starting to see themes as the various strands of the process were unraveled. The Chief Executive acknowledged that themes were starting to emerge, for example, appraisals. He advised that he will be appointing an Assistant Director within the Medical Directorate to lead an internal team within the Trust to manage this work.	
7	**ANY OTHER BUSINESS** 7.1 Mrs Leeson referred to the recent Governance Committee meeting when the Director of Mental Health and Disability informed members of a Judicial Review being taken by two service users in the Learning Disability Service and asked for an update. The Chief Executive explained that the applicants are seeking relief in the form of a reinstatement of the same level of day care and short break provision they had prior to the outbreak of Covid 19 earlier this year. Whilst most of the legislation that governs the provision of health and care services was derogated under emergency provisions during Covid 19 by the Department, one piece was unfortunately not derogated within these emergency provisions. The Chief Executive agreed to provide an update as the situation unfolds at the next Governance Committee meeting. 7.2 Mr Wilkinson raised the number of Early Alerts in relation to the GP Out of Hours service. The Chief Executive stated that this service was being carefully managed on a day to day basis with a longer term plan to create an unscheduled out of hours service as agreed with the HSCB. 7.3 In response to a query, the Chief Executive confirmed that there will be performance indicators for the Trust on the Covid vaccination.	***Update to Governance Committee on 11.2.2021***
8	**DATE OF NEXT MEETING** **Thursday, 17th December at 3.15p.m.** ***The meeting concluded at 3.55 p.m.***	

Southern Health and Social Care Trust

Quality Care - for you, with you

Notes of Chair and Non-Executive Director Virtual Meeting with the Chief Executive held on Thursday, 17th December 2020 @ 3.15 p.m.

Present : Eileen Mullan (Chair of meeting)
Shane Devlin
Geraldine Donaghy
Pauline Leeson
Hilary McCartan
John Wilkinson

In attendance: Sandra Judt (Notes)

ITEM	NOTE	ACTION
1	**APOLOGIES** Apologies were received from Martin McDonald.	
2	**DECLARATION OF INTERESTS** There were no interests to declare.	
3	**NOTES OF PREVIOUS MEETING HELD ON 3rd DECEMBER 2020** The Notes of the previous meeting had been previously circulated and were approved.	
4	**COVID-19 UPDATE/PRESSURES** The Chief Executive presented the key facts and figures as follows:- **Admissions/Discharges** – increasing number of Covid-positive in-patients across both acute hospitals. Outbreak in 1 South, CAH, resulting in 29 infected patients being moved within a 36 hour period. The Chief Executive stated a balanced risk managed approach has been taken with regard to reopening wards within the 28 day period as the safest option for patient safety in the current circumstances.	

	The Chief Executive reported that evidence is suggesting that shared toilets are a source of transition of the Covid-19 virus. Toilet wardens and being put on wards. **Community –** Increasing number of Covid-positive patients per 100,000 population. The Chief Executive stated that modelling projections are showing the peak of the current wave to be mid-January and therefore additional restrictions are being considered from Boxing Day onwards. **Staff Absence** – numbers remaining stable with 377 covid related staff absences as at 17.12.2020	
5	**COVID-19 VACCINATION** The Chief Executive reported that the roll out of the Covid-19 Vaccination programme has begun in the Trust with care home staff and residents. N.I. has a limited amount of the vaccine with the Trust receiving 2,000 vaccines this week. The Trust's main vaccination site will be South Lake Leisure Centre and it is hoped that roll out to identified priority groups will commence on 21st December 2020.	
6	**COVID-19 CLUSTER SAI PROCESS UPDATE** A position report from the SAI Chair had been circulated to members. The Chief Executive highlighted the significant amount of data which the Panel has requested and the Panel's recognition of the challenge for the Trust to provide this in a timely fashion.	
7	**CLINICAL CONCERNS WITHIN UROLOGY** The Chief Executive stated that the Trust awaits details of the approach of the Statutory Public Inquiry. He advised members that the Department has agreed that for any new information that comes to light, a clinical judgement review will be used to undertake a high level evaluation as part of the Pubic Inquiry. The Chief Executive agreed to provide updates on the process at the open section of Trust Board meetings.	***Chief Executive***

8	**ANY OTHER BUSINESS** The Chief Executive advised of the following:- 8.1 Recent custodial sentence for Radiology Doctor for secret toilet recordings. 8.2 Mr McNeany has formally advised of his intention to retire on 31.3.2021. Recruitment process for his successor to be put in place.	
9	**DATE OF NEXT MEETING** **To be confirmed.** ***The meeting concluded at 4.00 p.m.***	

Southern Health and Social Care Trust

Quality Care - for you, with you

Notes of Chair and Non-Executive Director Virtual Meeting with the Chief Executive held on Thursday, 7th January 2021 @ 4.00 p.m.

Present: Eileen Mullan (Chair of meeting)
Shane Devlin
Geraldine Donaghy
Pauline Leeson
Martin McDonald
John Wilkinson

In attendance: Sandra Judt (Notes)

ITEM	NOTE	ACTION
1	**APOLOGIES** Apologies were received from Hilary McCartan.	
2	**DECLARATION OF INTERESTS** There were no interests to declare.	
3	**NOTES OF PREVIOUS MEETING HELD ON 17th DECEMBER 2020** The Notes of the previous meeting had been previously circulated and were approved.	
4	**COVID-19 UPDATE/PRESSURES** The Chief Executive presented the key facts and figures as follows:- **Admissions/Discharges** – increasing number of Covid-positive in-patients with 163 as at 7.1.2021. The Chief Executive stated that it is expected that these numbers will increase over the next 2-3 weeks. He shared information on forecasted occupied beds for the Southern area which suggests 330 Covid positive in-patients at 23.1.2021 with 28 ICU beds required. He advised that the Trust was now activating plans for this serious situation with a draft Surge Plan to be	

	completed by 8.1.2021. He explained that this will require such actions as stopping elective surgery next week, stepping down some services etc. He advised that staff are required to care for the increased number of patients and, in order to do the best for as many people as possible, actions will require to be taken such as the redeployment of staff and a diluted Nursing ratio. Staff will be asked to give up planned leave in January and the Trust intends to manage this in a partnership approach with staff. Mr Wilkinson asked how aware were staff of the challenging situation and the surge projections. The Chief Executive advised that the Southern i staff newsletter was being issued the following day which includes a clear video message from himself, Dr Gormley and the Chair on the challenges the Trust is facing in January 2021. The re-opening of Nightingale was raised. The Chief Executive stated that the Trust would be sending patients and staff to Nightingale. Ms Donaghy asked about the current in-patient split between Covid and Non-Covid inpatients. The Chief Executive advised of 112 Covid and 270 non-Covid patients in Craigavon Hospital as at today's date. Mrs Leeson asked about the profile of Covid in-patients to which the Chief Executive advised that the average age was 60 which was now a shift to a younger age profile than previous surges. Mr Wilkinson asked about equality of care for Non Covid patients, particularly those with severe illnesses. The Chief Executive spoke of the difficult decisions for clinicians for all patients and advised that very ill patients whether Covid or non-Covid will always be prioritized. Mr Wilkinson asked about nosocomial infection rates. The Chief Executive stated that the levels of nosocomial transmission in the Trust had been low over the past 5-6 weeks as evidenced in the weekly report from the PHA.	
5	**COVID-19 VACCINATION UPDATE** The Chief Executive reported that the Trust achieved vaccination of care home staff and residents by the target date of 30.12.2020 with the exception of a small number who were in outbreak. Staff vaccination commenced on 4.1.2021 in the	

	South Lake Leisure Centre and was working well. He advised the Trust was using the Pfizer vaccine and reported that there were no issues with the supply of the second dose of the vaccine for care home staff and residents and Trust staff.	
6	**COVID-19 CLUSTER SAI PROCESS UPDATE** The Chief Executive reported that work was progressing and he will continue to be provided with monthly updates.	
7	**CLINICAL CONCERNS WITHIN UROLOGY** The Chief Executive advised that the next meeting of the Urology Assurance Group was the following day and he agreed to update members thereafter.	***Chief Executive***
8	**ANY OTHER BUSINESS** 8.1 **Judicial Review in Learning Disability** The Chief Executive agreed to provide members with an update via email. It was agreed that Judicial Reviews would be reported to Governance Committee going forward. 8.2 **Weekly SitRep** The Chief Executive agreed to include members in the weekly circulation of the SitRep. Members also to receive training on the Covid-19 Dashboard. 8.3 **GP Out of Hours** Mr McDonald referred to the Early Alerts on the GP Out of Hours Service and queried whether it was appropriate to continue to name it as a GP service given that it was not adequately resourced to GP level. The Chief Executive undertook to consider.	***Chief Executive*** " "
9	**DATE OF NEXT MEETING** **14th January 2021 at 4.00 p.m.** ***The meeting concluded at 3.50 p.m.***	

Southern Health and Social Care Trust

Quality Care - for you, with you

Notes of Chief Executive weekly update meeting held virtually on Thursday, 14th January 2021 @ 4.00 p.m.

Present: Eileen Mullan (Chair of meeting)
Shane Devlin
Geraldine Donaghy
Pauline Leeson
Hilary McCartan
Martin McDonald
John Wilkinson

In attendance: Sandra Judt (Notes)

ITEM	NOTE	ACTION
1	**APOLOGIES** None.	
2	**DECLARATION OF INTERESTS** There were no interests to declare.	
3	**NOTES OF PREVIOUS MEETING HELD ON 7th JANUARY 2021** The Notes of the previous meeting had been previously circulated and were approved.	
4	**COVID-19 UPDATE/PRESSURES** The Chief Executive spoke of the immense pressure over the past week which has put a huge strain on the Trust's hospitals. He presented the key facts and figures as follows:- **Admissions/Discharges** – the number of Covid-positive in-patients has increased significantly – now up to 275. The Chief Executive advised that the biggest risk was hospital oxygen supplies given the current high demand. He stated that the Trust's hospitals have limited infrastructure, particularly Daisy Hill Hospital, to manage high numbers of patients requiring oxygen therefore a regional agreement was put in	

	place to share resources across Trusts to support Covid-positive patients. As a result, some Southern Trust patients were diverted to the Mater Hospital during the week. Work is underway to enhance the oxygen supply at CAH, but the Trust is unable to do likewise at Daisy Hill Hospital due to limited infrastructure. Members discussed the Trust's high rate of Covid-positive cases per 100,000 population and the fact that the volume of sicker, younger patients is much greater now. Ms Donaghy asked for an update on the 330 forecasted occupied beds for the Southern area at 23.1.2021. The Chief Executive advised that latest projections are forecasting lower numbers for the region, but he waits the breakdown for the Southern area. In relation to staffing, the Chief Executive stated that the busiest and difficult situation over the past week has put a hugh strain on staff in the hospitals. 802 staff are currently off work with Covid related absence. The Department has released the minimum standard for nursing on wards with the worst case scenario a 1:10 ratio. The Trust's current nursing ratio is 1:6. Mrs McCartan asked about the option for the Nightingale Hospital to accept patients from the Southern Area given the Trust's current oxygen constraints. The Chief Executive advised that Nightingale will be available to the Trust for ICU patients when required, but currently the Trust was using the respiratory beds in the Mater for its patients. In response to a question from Ms Donaghy about decanting patients to care homes, the Chief Executive advised that there are currently 2 sets of 10 beds available in the Trust's own statutory residential homes to discharge patients to.	
5	**COVID-19 VACCINATION UPDATE** The Chief Executive reported that the roll out of the Trust's vaccination programme was progressing well with 50% of staff having received the first vaccine. He stated that the ten-week rescheduling of the second dose following administration of the first dose has caused challenges with some staff. The Trust is following the vaccination rollout in accordance with Department of Health approach and JCVI guidance which prioritises first doses of the vaccine to as many people as possible. Mr McDonald raised the excellent uptake to date and	

	asked if the Trust anticipated any reluctance on the uptake of the vaccine going forward. The Chief Executive stated that there was still high interest from staff to get the first vaccine with 640 slots a day, all of which are currently filled. However, he did accept that numbers may drop and advised that the vaccine has been opened up to other groups such as Dentists, Pharmacists etc. Mr Beattie is working on encouraging more uptake from the domiciliary care workforce.	
6	**COVID-19 CLUSTER SAI PROCESS UPDATE** The Chief Executive reported that work was progressing. He spoke of an issue in relation to access to all test results of those involved in the outbreak, which under GDPR regulation is not automatically available to the Trust. Discussions are ongoing with the Information Commissioners Office and legal advice is being sought. He agreed to provide an update at the February 2021 Trust Board meeting.	***Chief Executive***
7	**CLINICAL CONCERNS WITHIN UROLOGY** The Chief Executive advised that the Panel has concluded on the 9 SAIs, as well as a 10th (short learning report) and these are with the families to review. Early learning has identified lack of multi-disciplinary working as an issue. The Head of the Public Inquiry has yet to be appointed as has the Chair.	
8	**ANY OTHER BUSINESS** **8.1 Restricted Hospital visiting and feedback to relatives of patients** Mr McDonald advised of feedback he had received from relatives of patients in which they had raised concerns at their experience when they called the hospital for an update on the patient's condition. He asked if a process could be put in place whereby feedback to relatives is consistent and timely as where this feedback happens well, it is of great help to families. The Chief Executive spoke of a proactive 'call out' system being introduced by Mrs McClements. He also spoke of the Virtual Visiting Service which continues to be very successful.	

	8.2 **Judicial Review in Learning Disability** The Chief Executive advised that the Court Hearing took place the previous week and a formal Judgement is awaited. 8.3 **Finance Report** Mr Wilkinson referred to the Finance Report and asked about the Mental Health & Disability Directorate with a current surplus of almost £6.5m. The Chief Executive spoke of the Return to Financial Balance element whereby Mr McNeany has to spend more, but is constrained by service provision – lack of qualified nurses and social workers. He advised that Mr McNeany has a 3-Year Plan in place to address.	
9	**DATE OF NEXT MEETING** **21st January 2021 at 4.00 p.m.** ***The meeting concluded at 5.00 p.m.***	

Southern Health and Social Care Trust

Quality Care - for you, with you

Notes of Chief Executive weekly update meeting held virtually on Thursday, 21st January 2021 @ 4.00 p.m.

Present: Eileen Mullan (Chair of meeting)
Shane Devlin
Geraldine Donaghy
Pauline Leeson
Hilary McCartan
Martin McDonald
John Wilkinson

In attendance: Sandra Judt (Notes)

ITEM	NOTE	ACTION
1	**APOLOGIES** None.	
2	**DECLARATION OF INTERESTS** There were no interests to declare.	
3	**NOTES OF PREVIOUS MEETING HELD ON 14th JANUARY 2021** The Notes of the previous meeting had been previously circulated and were approved.	
4	**COVID-19 UPDATE/PRESSURES** The Chief Executive presented the key facts and figures as follows:- **Admissions/Discharges** – 216 Covid-positive in-patients as at 21.1.2021. This is a drop from a peak of 293 on 10.1.2021 as a result of a regional approach whereby 79 Covid-positive patients from the Southern Area were transferred to the Belfast Trust, as well as a high number of discharges over two days in January. ICU is currently under pressure with 15 out of 16 beds occupied.	

	Community – Armagh City, Banbridge and Craigavon Council has the highest number of positive cases. For the last three 7-day periods, the rate of Covid-positive cases per 100,000 population has been decreasing. Regional modelling is suggesting that the peak for Covid-positive hospital admissions is 21.1.2021. **Staffing** - 802 staff are currently off work with Covid related absence. In response to a question from Mr McDonald, the Chief Executive advised that data was not currently available to determine what percentage of these staff have been vaccinated. Ms Donaghy asked about hospital discharges and if there were any trends emerging in relation to Covid-19 readmissions. The Chief Executive agreed to look at the Trust's re-admission data.	***Chief Executive***
5	**COVID-19 VACCINATION UPDATE** The Chief Executive reported that the Trust has administered 20,000 vaccinations to date, the vast majority of which are the first dose. Maintaining the pace of the vaccination rollout was raised to which the Chief Executive stated that there was still high interest from staff to get the vaccine with all daily slots currently filled. The Trust is also trialing a 'roadshow' approach with a pop up clinic arranged in Daisy Hill Hospital the following day. A communication message will be issued to encourage staff who have yet to avail of the first dose to book. In response to a question, the Chief Executive stated that there was no issue with the supply of the Pfizer vaccine. Mr Wilkinson asked about EU Exit plans and the potential impact on the supply of medicines. The Chief Executive stated that there have been no issues in relation to medicines supply to Trusts. The option of military aid was raised to which the Chief Executive advised that he had not been formally approached. Ms Mullan raised the issue of staff burnout and asked if military assistance was not available, was staff sharing from other Trusts an option? The Chief Executive stated that he would raise this with his counterparts in the other Trusts, but felt this was an unlikely option given the workforce pressures across the system.	

6	**COVID-19 CLUSTER SAI PROCESS UPDATE** The Chief Executive advised that work was progressing well and the Panel has completed the RCA of the 15 deceased patients.	
7	**CLINICAL CONCERNS WITHIN UROLOGY** The Chief Executive advised that confirmation has been received from Consultant A via his Solicitor that he will not destroy any patient records. The Chair of the Public Inquiry has yet to be appointed and the final reports from the SAIs are awaited. In response to a question from Mr Wilkinson about emerging themes, the Chief Executive stated that some of the early learning from the SAIs indicates issues around multi-disciplinary working.	
8	**ANY OTHER BUSINESS** None.	
9	**DATE OF NEXT MEETING** **4th February 2021 at 4.00 p.m.** ***The meeting concluded at 4.50 p.m.***	

Southern Health and Social Care Trust

Quality Care - for you, with you

Notes of Chief Executive weekly update meeting held virtually on Thursday, 4th February 2021 @ 4.00 p.m.

Present: Eileen Mullan (Chair of meeting)
Shane Devlin
Geraldine Donaghy
Pauline Leeson
Hilary McCartan
Martin McDonald
John Wilkinson

In attendance: Sandra Judt (Notes)

ITEM	NOTE	ACTION
1	**APOLOGIES** None.	
2	**DECLARATION OF INTERESTS** There were no interests to declare.	
3	**NOTES OF PREVIOUS MEETING HELD ON 21st JANUARY 2021** The Notes of the previous meeting had been previously circulated and were approved.	
4	**COVID-19 UPDATE/PRESSURES** The Chief Executive presented the key facts and figures as follows:- **Admissions/Discharges** – the number of Covid-positive inpatients is on a decline with 183 as at 4.2.2021. However, in-hospital deaths remaining continuously high and admissions are currently averaging 20 per day. ICU is at maximum capacity. **Community** – the rate of Covid-positive cases per 100,000 population for Southern Trust remains much higher than the rest of NI.	

	Regional modelling is suggesting a slow decrease in inpatient Covid-positive beds in NI. Mr McDonald asked if regional modelling takes account of any new variants of the virus to which the Chief Executive advised that this was something the Department was working on. **Staffing** – 650 staff currently off work with Covid related absence which is an improving position. In response to a question, the Chief Executive agreed to look at the average age of Covid positive hospital deaths. Mr Wilkinson raised the impact of the inpatient Covid pressures on those with other critical illnesses, particularly cancer patients. The Chief Executive acknowledged the difficult decisions for clinicians and advised that there was an emergency surgery list each day for the most critically ill patients achieved by all Trusts working together. Mr Wilkinson raised his concern that if Covid positive cases start to decline, the community will challenge why the numbers of critically ill non-Covid patients are not then being seen. In anticipation of this, the Chief Executive stated that Chief Executives have asked the Department to explore a strong consistent message with the Minister.	***Chief Executive***
5	**COVID-19 VACCINATION UPDATE** The Chief Executive updated on the vaccination programme advising that up to 1,000 people are being vaccinated each day. Ms Donaghy referred to the Early Alert where one vial was returned with some remaining vaccine and raised concern at the 4 week delay from the incident occurring to the early alert being raised. The Chief Executive confirmed this as a concern to be looked at. The Chief Executive also advised that the Trust will shortly be vaccinating inpatients against set criteria.	
6	**ASSISTANCE** At this point, the enormous pressures on the Trust were discussed, not only in relation to Covid-19, but also the Independent Pubic Inquiry, Level 3 SAIs etc.	

	In relation to the increased risk of nosocomial infections, the Chief Executive referred to 2 nosocomial visits by the Department to the Trust to consider what further action the Trust could take to reduce transmission. Those reports have been received by the Trust in draft form and re-affirm the Trust's position that IPC practices are compromised by the Estate which is not suitable for providing modern day healthcare. The Chief Executive advised of his recent meeting with the Permanent Secretary regarding pressures on the Trust going forward. The Trust has been asked to consider where they feel assistance would be beneficial. To that end, the Chief Executive stated that he has written to the Permanent Secretary suggesting potential support that could be offered to the Trust from three angles: i) Buildings – a co-joined approach to capital planning, funding and delivery between the Department and the Trust; ii) Support for the IPC teams and iii) Senior Leadership support. Members supported the three areas identified and emphasized the importance of getting the right help to ease the current pressures faced by the SMT.	
7	**COVID-19 CLUSTER SAI PROCESS UPDATE** The Chief Executive advised that work was progressing well and the Panel Chair remains committed to meet the completion deadline of April 2021.	
8	**CLINICAL CONCERNS WITHIN UROLOGY** No further update. The Department has not yet appointed the Chair of the Public Inquiry. The final reports from the SAIs are awaited.	
9	**ANY OTHER BUSINESS** **8.1 Health Committee Inquiry Report on the impact of Covid-19 in Care Homes** The Chief Executive advised that the Trust would be reviewing and reflecting on this report.	
10	**DATE OF NEXT MEETING** **11th February 2021 at 4.00 p.m.** ***The meeting concluded at 5.00 p.m.***	

Southern Health and Social Care Trust

Quality Care - for you, with you

Notes of Chief Executive weekly update meeting held virtually on Thursday, 11th February 2021 @ 4.00 p.m.

Present: Eileen Mullan (Chair of meeting)
Shane Devlin
Geraldine Donaghy
Pauline Leeson
Hilary McCartan
Martin McDonald
John Wilkinson

In attendance: Sandra Judt (Notes)

ITEM	NOTE	ACTION
1	**APOLOGIES** None.	
2	**DECLARATION OF INTERESTS** There were no interests to declare.	
3	**NOTES OF PREVIOUS MEETING HELD ON 4th FEBRUARY 2021** The Notes of the previous meeting had been previously circulated and were approved.	
4	**MATTERS ARISING** **Early Alert re Covid vaccination** The Chief Executive updated on the concern raised at the previous meeting at the delay from the vaccination incident occurring to the early alert being raised. He advised that whilst the incident had been reported and recorded on DATIX in a timely way, the issue arose when the routing from DATIX went to Mrs Siobhan Hynds as opposed to Mrs Vivienne Toal, the lead Director for Covid vaccination, and therefore was not picked up until 3 weeks later. The Chief Executive confirmed that all six staff have been contacted to explain what happened, the action to be taken and reassurance offered.	

	He advised that Mrs Toal, Mrs Trouton and Dr O'Kane are looking into the possibility of implementing some checkers for the vaccination vials.	
5	**COVID-19 UPDATE/PRESSURES** The Chief Executive presented the key facts and figures as follows:- **Admissions/Discharges** – the number of Covid-positive inpatients continues to reduce – 159 as at 10.2.2021 compared to a high of 324 on 10.1.2021. The Chief Executive stated that although this is a good reduction, it is important to note that this is still the highest of any Trust and is still higher than the peak in the first surge. ICU remains at a continuous high occupancy level. The Chief Executive explained that the Trust's ability to re-start services is dependent on ICU returning to normal capacity. In response to a question from Mr Wilkinson, the Chief Executive explained the regional approach in place for ICU. Mrs Leeson asked about the age profile of patients in ICU to which the Chief Executive agreed to find out. At this point, the Chief Executive referred to the proposed budget for the upcoming financial year which is a 'stand still' budget and stated that this will mean that the HSC system and the Trust will not have the resources to catch up on demand. Ms Mullan advised that the HSC Chairs' Forum would be making a submission on both the draft budget and the Programme for Government. **Community** – the rate of Covid-positive cases per 100,000 population for the Southern Trust has reduced to 182 per 100,000 currently, but remains higher than the rest of NI. Recent nosocomial outbreaks in South Tyrone Hospital and Gillis wards were discussed. The Chief Executive advised that he has asked for the learning from these two wards to be brought back. The Chief Executive advised of the Chief Medical Officer's concern that an ending of lockdown before the Easter holidays would have a detrimental effect.	***Chief Executive***

6	**COVID-19 CLUSTER SAI PROCESS UPDATE** The Chief Executive advised that the Panel Chair remains committed to meet the deadline of April 2021 for return of the initial outbreak report. He spoke of an issue in relation to access to all test results of those involved in the outbreak, which under GDPR regulation is not automatically available to the Trust. Discussions are ongoing with the Information Commissioners Office.	
7	**COVID-19 VACCINATION UPDATE** Mrs McCartan asked if the Trust had considered if there was the need to carry out a risk assessment on those staff who do not wish to have the Covid vaccination. The Chief Executive agreed to discuss with Dr O'Kane and Mrs Toal.	***Chief Executive***
8	**CLINICAL CONCERNS IN UROLOGY** The Chief Executive reported a four week delay on the completion of the SAIs due to a misunderstanding about dates between the Panel Chair and the PHA. The draft report will now be completed on 15.2.2021 and shared with the families with a view to being finalised by first week in March 2021.	
9	**ANY OTHER BUSINESS** **8.1** Personal Information redacted by the USI The Chief Executive advised of the increasing challenges faced by the Trust to maintain GP cover. This matter will be brought to the Trust Board meeting on 25th February 2021.	
10	**DATE OF NEXT MEETING** **18th February 2021 at 4.00 p.m.** ***The meeting concluded at 5.00 p.m.***	

Southern Health and Social Care Trust

Quality Care - for you, with you

Notes of Chief Executive weekly update meeting held virtually on Thursday, 4th March 2021 @ 4.00 p.m.

Present: Eileen Mullan (Chair of meeting)
Shane Devlin
Geraldine Donaghy
Pauline Leeson
Hilary McCartan
Martin McDonald
John Wilkinson

In attendance: Sandra Judt (Notes)

ITEM	NOTE	ACTION
1	**APOLOGIES** None.	
2	**DECLARATION OF INTERESTS** There were no interests to declare.	
3	**NOTES OF PREVIOUS MEETING HELD ON 11th FEBRUARY 2021** The Notes of the previous meeting had been previously circulated and were approved.	
4	**COVID-19 UPDATE/PRESSURES** The Chief Executive presented the key facts and figures as follows:- **Community** – the rate of Covid-positive cases per 100k population for the Southern Trust continues to reduce and is now around the average NI figure. **Admissions/Discharges** – the total number of Covid-positive inpatients continues to reduce – 69 as at 4.3.2021. The Chief Executive stated that there are still in-hospital Covid deaths. Mrs Leeson asked about inpatient deaths and the age profile. The Chief Executive advised that the World Health	

	Organisation was about to publish their research which he agreed to share with members, once available. The Chief Executive reported that ICU was heading in the right direction towards its normal occupancy rate. This means that staff can be deployed back to their substantive roles and enable the Trust to re-start other services. Re-start of services was discussed. Ms Donaghy noted the number of cancelled surgeries as detailed in the Sitrep and asked about the ability to re-start services. The Chief Executive advised that as pressure on ICU starts to ease and staff in ICU return to theatres, the number of surgeries can be increased. He advised that the Trust was working to find ways of supporting these staff as they return to their substantive positions and providing them with the opportunity for rest and recharge. Mr Wilkinson asked if the Trust was taking the opportunity to look at services now in advance of them starting up again. The Chief Executive stated that the Trust was working constructively with the region on plans to re-start services and to prepare for the management of the accrued backlog. Trust Directors of Planning are taking this work forward with a draft paper expected by 23rd March 2021 which will be shared with Trust Board. Mrs McCartan made reference to Mark Taylor's view about re-starting surgery 7 days/week on green sites and asked how realistic this was given the budget constraints. The Chief Executive stated that without additional funding, the Trust would be unable to deliver on this. Mr McDonald welcomed the green pathways approach and the fact they would not be defined by Trust geographical boundaries. The Chief Executive reported that the regionalization of surgery started last week. Ms Donaghy asked if there was the staff to do the surgery to which the Chief Executive advised that initially, this was not the case, but a blend of private and public sector was being considered.	***Chief Executive***
5	**COVID-19 CLUSTER SAI PROCESS UPDATE** The Chief Executive advised that the Panel Chair remains committed to meet the deadline of mid April 2021 for return of	

	the initial outbreak report. An action plan is in place against the early learning.	
6	**COVID-19 VACCINATION UPDATE** Members were advised that the 60-65 age group was now open for booking and the commencement of 2nd doses had begun. The Trust has now administered 56,000 vaccinations. The Chief Executive advised of the poor uptake of the vaccine from HSC staff in the 20-30 age group and this has been fed back to the PHA. Mr McDonald raised the vaccination for carers. The Chief Executive spoke of some initial challenges, but stated that since this has been channeled through the Carers Co-ordinators, negative feedback has been minimal.	
7	**CLINICAL CONCERNS IN UROLOGY** The Chief Executive advised that he received the draft report on 2nd March 2021. He stated that this will be shared with the Urology Team on 8th March 2021 and he has arranged to meet with them on 9th March 2021. The draft report is also with the families for factual accuracy checking. Mr McDonald stated that given the SAIs and the Public Inquiry, there was a need to agree a mechanism to ensure that Non Executive Directors see reports in the most appropriate way. The Chief Executive stated that once the final report has been received, it will be shared with the Non Executive Directors. Ms Donaghy asked if it was right to presume that litigation cases would follow to which the Chief Executive stated that he believed this would be the case. In response to a question from Mrs McCartan, the Chief Executive stated that the Chair of the Public Inquiry had not yet been appointed, but he hoped to have an update on this at the meeting of the Urology Assurance Group the following day. The Chair asked about the learning from these 9 SAIs and emphasized that when the final report is received, a discussion is needed on actions to be taken forward rather than wait on the outcome of the Public Inquiry.	

8	**OBSTETRICS AND GYNAECOLOGY WHISTLEBLOWING INVESTIGATION** The Chair stated that following the recent Governance Committee meeting, some members had raised concerns in relation to the origin, timeline and process of the Obstetrics and Gynaecology whistleblowing investigation. The Chief Executive stated that as reported to the Governance Committee, a Whistleblowing Investigation was conducted in respect of the Obstetrics service in July 2019. A report outlining a number of key actions and learning from this investigation was brought to the Governance Committee on 11th February 2021. A draft report of the investigation has been received which has a number of factual inaccuracies and there are ongoing discussions with the external investigation team regarding the finalisation of the report. In response to a question from Mrs McCartan, the Chief Executive provided assurance that a range of improvement actions are being actively progressed as detailed in the report to the Governance Committee. A full and final list of actions will be agreed once the report is concluded. A final report will be brought to the Governance Committee on 13th May 2021. Discussion ensued in which members emphasized the importance of a process to ensure Non Executive Director involvement at the appropriate time when issues are being raised from different directions e.g. whistleblowing, SAIs etc. It was agreed that a meeting between the Non Executive Directors and the Chief Executive would take place within the next 6 weeks to develop a process. Mrs Leeson asked if there had been SAIs in relation to this issue in O&G to which the Chief Executive confirmed that there had been SAIs in O&G, but not directly related to this particular whistleblowing. Mrs Leeson spoke of her concern at the issues raised in relation to patient safety in the whole area of O&G and asked that the Trust keeps under consideration an Invited Review with the Royal College of Obstetricians and Gynaecologists. The Chief Executive advised that it was still the Trust's intention to explore capacity with the Royal College to undertake an Invited Review.	***ALL***

9	Personal Information redacted by the USI The Chief Executive advised that he had formally written to the HSCB on 26th February 2021 to advise of the Trust's intention to retire from this contract. The GP Unit in the HSCB will now be in discussion with GP practices to ascertain interest in taking over this practice. In the meantime, the practice is functioning with locum GPs.	
10	**SMT** The Chief Executive informed members that Ms O'Neill has formally advised of her intention to retire as Director of Finance, Procurement and Estates in July 2021. Given this retirement and that of Mr McNeany on 31st March, he advised of his intention to review the overall senior management structure and would appreciate input from the Non Executive Directors in this work.	
11	**ANY OTHER BUSINESS** The Early Alerts in relation to GP Out of Hours were raised. The Chief Executive stated that it is hoped that the situation as regards GP cover will improve, as activity in the Covid centres reduces.	
12	**DATE OF NEXT MEETING** **11th March 2021 at 4.00 p.m.** ***The meeting concluded at 5.15 p.m.***	

Southern Health and Social Care Trust

Quality Care - for you, with you

Notes of Chief Executive weekly update meeting held virtually on Thursday, 11th March 2021 @ 4.00 p.m.

Present: Eileen Mullan (Chair of meeting)
Shane Devlin
Geraldine Donaghy
Pauline Leeson
Hilary McCartan
John Wilkinson

In attendance: Sandra Judt (Notes)

ITEM	NOTE	ACTION
1	**APOLOGIES** Martin McDonald.	
2	**DECLARATION OF INTERESTS** There were no interests to declare.	
3	**NOTES OF PREVIOUS MEETING HELD ON 4th MARCH 2021** The Notes of the previous meeting had been previously circulated and were approved.	
4	**COVID-19 UPDATE/PRESSURES** The Chief Executive presented the key facts and figures as follows:- **Community** – the rate of Covid-positive cases per 100k population for the Southern Trust continues to reduce and is now at the average NI figure. **Admissions/Discharges** – the total number of Covid-positive inpatients continues to reduce – 43 as at 11.3.2021, 22 of which are in Lurgan Hospital. There are currently 2 Covid-positive patients in ICU. The Chief Executive stated that as pressure on the ICU eases, this will enable the Trust to re-start other services. A draft Trust	

	Restart Plan for April/May/June 2021 will be brought to the Trust Board meeting on 25th March 2021. Mrs McCartan raised the recent Press coverage in relation to the re-opening of Nightingale as a site for elective cancer surgery and asked about the Trust's elective cancer surgery. The Chief Executive explained that the Trust was utilizing its theatres and scaling up surgery. He spoke of the regional clinically led prioritization group which meets week to prioritise cancer and time critical/urgent cases across clinical specialties. A discussion needs to take place as to where general surgery would be best placed. Mr Wilkinson asked if there was a Southern Trust specialty in the regional plan. The Chief Executive stated that in terms of Breast and general surgery, the Trust was ahead of the curve. He stated that it would be useful to bring the regional position to the Performance Committee. Ms Donaghy referred to the Sitrep and welcomed the fact that for the first time, there were no bed closures. At this point. Ms Donaghy asked about an Early Alert involving a Trust employee on suspension following posting inappropriate videos on social media with anti-vaccination messages. She asked if this was a disciplinary matter to which the Chief Executive advised that the individual had since resigned and had they remained in the Trust's employment, the disciplinary process would have been followed given this incident had the potential to bring the Trust into disrepute.	
5	**COVID-19 CLUSTER SAI PROCESS UPDATE** The Chief Executive advised that work was progressing well with the Panel Chair committed to meet the deadline of April 2021 for return of the initial outbreak report. The vast majority of the families have been very involved in the engagement process with the Family Liaison Officer, with one family choosing to be disengaged.	
6	**COVID-19 VACCINATION UPDATE** Members noted the good progress being made with the vaccination programme. Commencement of 2nd doses has begun.	

7	**CLINICAL CONCERNS IN UROLOGY** The Chief Executive advised that as reported at last week's meeting, he received the draft report on 2nd March 2021 and his intention was to share this with AOB, the families and the the clinical team. Since then, AOB's legal team threatened to invoke an emergency injunction which would have prevented sharing of the report with the families or the clinical team. AOB has been asked to reply by 16th March 2021 at which point the draft report will be shared with the families and the team. All are to respond with comments on factual accuracy within three weeks for review by the report author. The importance of the families having sight of the report was emphasized and the deadlines in place were welcomed. In response to a question from Ms Donaghy, the Chief Executive explained that as per the normal SAI process, each contributor has sight of the SAI report at the same time. However, AOB's legal team has stated that given the nature of this case, they believed their client was entitled to see the report before the families. Members welcomed the appointment of Christine Smith QC as the Chair of the Public Inquiry on a fulltime basis. Mrs McCartan asked the Chief Executive if the Trust had sufficient resources to service a full-time Inquiry. He advised that as requested by the HSCB, the Trust has submitted a bid for resources.	
8	**STRUCTURES** The Chief Executive informed members that Mr Paul Morgan has formally advised of his intention to retire at end of September 2021. Re-structuring was discussed. The Chief Executive advised that he has arranged a workshop with the SMT for the following day to begin this work. This will include looking at other Trusts' structures both in N.I. and in England. He spoke of the structure in the Northern Trust which is similar to other Trusts in England, whereby operational divisions report to a Director of Operations/Deputy Chief Executive allowing the Chief Executive to focus on governance and improvement. He	

	advised that he will share his thinking in a draft paper with the Non Executive Directors for their review. It is hoped to have a new structure in place by the Autumn. Mrs Leeson raised the concept of a regional mental health service. The Chief Executive stated that the Department has issued a Project Initiation Document (PID) on the need to standardize mental health services. Ms Donaghy asked about emergency care/urgent care out of hours and GP involvement. She raised the possibility of some areas of primary care being brought into some of the Trust services under restructuring. The Chief Executive stated that this was outwith his gift as GPs are employed sessionally to work in the OoH service. The fundamental issue is the lack of GPs.	
9	Personal Information redacted by the USI The Chief Executive advised that the HSCB is in discussion with a GP practice who has expressed an interest in taking over the Personal Information redacted by the USI practice.	
10	**DATE OF NEXT MEETING** **18th March 2021 at 4.00 p.m.** ***The meeting concluded at 5.00 p.m.***	

Southern Health and Social Care Trust

Quality Care - for you, with you

Notes of Chief Executive weekly update meeting held virtually on Thursday, 18th March 2021 @ 4.00 p.m.

Present: Eileen Mullan (Chair of meeting)
Shane Devlin
Pauline Leeson
Hilary McCartan
Martin McDonald
John Wilkinson

In attendance: Sandra Judt (Notes)

ITEM	NOTE	ACTION
1	**APOLOGIES** Geraldine Donaghy	
2	**DECLARATION OF INTERESTS** There were no interests to declare.	
3	**NOTES OF PREVIOUS MEETING HELD ON 11th MARCH 2021** The Notes of the previous meeting had been previously circulated and were approved.	
4	**COVID-19 UPDATE/PRESSURES** The Chief Executive presented the key facts and figures as follows:- **Community** – the rate of Covid-positive cases per 100k population for the Southern Trust continues to reduce and is now at the average NI figure. **Admissions/Discharges** – the total number of Covid-positive inpatients has remained consistent over the past week.	
5	**COVID-19 VACCINATION UPDATE** Mrs McCartan raised the recent coverage in the Press regarding a shortage of supply of the Oxford/AstraZeneca	

	vaccine. The Chief Executive advised that this was not having an impact in Northern Ireland currently.	
6	**CLINICAL CONCERNS IN UROLOGY** The Chief Executive advised that the Trust had received correspondence from AOB on 15th March 2021. It has been agreed that this correspondence would be shared with the SAI reports and the overarching SAI report to families and the clinical team. Following the sharing of the reports, the Chief Executive is meeting with the clinical team on 23rd March 2021 and the SAI Panel Chair will meet with the families. The Trust will continue to offer support to those patients / families who feel they require this. Following discussion, the Chief Executive undertook to seek legal advice as to what information can be shared with Trust Board members and when.	***Chief Executive***
7	**STRUCTURES REVIEW** The Chief Executive updated members on the initial workshop held with the SMT to progress this work. The concept of a single governance division was discussed. Members noted that any proposed structure would have to be cost neutral. The Chief Executive advised that further sessions with the SMT are planned after which he will produce a short paper and share with Non Executive Directors for comments.	***Chief Executive***
8	**DATE OF NEXT MEETING** **19th April 2021 at 4.00 p.m.** ***The meeting concluded at 4.45 p.m.***	

Southern Health and Social Care Trust

Quality Care - for you, with you

Notes of Chief Executive monthly update meeting held virtually on Monday, 17th May 2021 @ 3.30 p.m.

Present: Eileen Mullan (Chair of meeting)
Shane Devlin
Geraldine Donaghy
Pauline Leeson
Hilary McCartan
Martin McDonald
John Wilkinson

In attendance: Sandra Judt (Notes)

ITEM	NOTE	ACTION
1	**APOLOGIES** None	
2	**DECLARATION OF INTERESTS** There were no interests to declare.	
3	**NOTES OF PREVIOUS MEETING HELD ON 19th APRIL 2021** The Notes of the previous meeting had been previously circulated and were approved.	
4	**OBS AND GYNAE UPDATE** The Chair welcomed Mrs Toal, Mrs McClements and Mrs Trouton to the meeting for discussion on this item. An apology was noted from Dr O'Kane. A redacted report on the Whistleblowing Investigation had been issued to members. Mrs Toal took members through the timeline, approach and rationale at each juncture from the Whistleblowing concerns were raised in respect of the Obstetrics service in July 2019. She set the context in which the Trust received the concerns in relation to how the Obstetric service was being delivered and advised that in November 2019, the Trust agreed to commission an external investigation to obtain a level of independence given these concerns ranged	

	across two acute sites. Two individuals were approached to take forward the investigation, terms of reference were agreed, as outlined in the report, and the timescale for completion was 8 weeks. Mrs Toal stated that this was a difficult and protracted investigatory process, not helped by Covid-19 related delays. In response to a question from Mrs Leeson, Mrs Toal clarified that the investigation did not commence until end of January/early February 2020 with the first draft of the report received in early September 2020. Initial comments were sent back from the Trust's Oversight Group and individuals who were interviewed were given the opportunity to view the sections of the report that were applicable to them and comment on factual accuracy. The Medical Director and the Director of Nursing both met with the investigation team to discuss the report, before their final version was provided to the Trust. Mrs Toal advised that the person who facilitated the coordination of the whistleblowing letter took up a management post in Obstetrics working in the same service as one of the investigators after the investigation had commenced. Members commented on the poor standard of the report in terms of format and the length of time taken to produce it. Concern was also expressed by Mr Wilkinson at the reliability of the sources of evidence. Mr McDonald raised concerns regarding the perceived conflict of interest regarding the individual who was the Chair of the Maternity Services Liaison Committee who co-ordinated the raising of the concerns, then working closely with the Consultant Midwife involved in the investigation. Mrs Toal acknowledged that there was learning regarding perceived conflicts of interests and declarations regarding this at the outset of any investigation process. She stated that Human Resources staff come under criticism in the report and stated that how one staff member in particular was portrayed in the report would not be her view having sought explanations from this individual. Mrs Toal stated that there is learning in relation to ensuring careful selection of experienced investigators who are clinicians. Ms Mullan stated that there are themes emerging which the Trust Board needs to be mindful of and Mrs McCartan asked about an action plan. Mrs McClements advised that a range of improvement actions have been actively progressed both before and during the Whistleblowing Investigation and these	

	were detailed in a paper to Governance Committee. She noted that the Investigating Team reported that it was satisfied that the clinical competency of both Obstetricians and Midwives met the required standards and there were no significant issues in relation to patient safety. Work is ongoing to build relationships and capacity. Culture and behaviours in CAH Delivery Suite were discussed. Mrs McCartan asked about the potential for disciplinary action being brought against two individuals to which Mrs Toal advised of ongoing intervention and the opportunity to use this Whistleblowing Investigation to review trends and have some challenging conversations with the two individuals. Mr McDonald referred to the long standing issues with these individuals and asked if they will be monitored via the performance appraisal process. Mrs Trouton stated that the Trust was aware of issues in the Delivery Suite before the Whistleblowing Investigation and whilst significant work has been undertaken, this will require ongoing attention. Staff have reported that relationships have improved, but there is a need to formally review this progress. Mr Wilkinson referred to the cultural issues that need to be addressed and stated that he was content with the work the Trust was doing in this area. Ms Donaghy asked if the Whistleblowers were kept informed throughout the process. She also asked why access to some records and a member of staff were denied to the Investigating Team contrary to the Terms of Reference. Ms Donaghy commented on the absence of patient/service user feedback which she felt would have made the investigation more robust. Next steps were discussed. The Chief Executive stated that a full and final list of actions will be agreed once the report has been brought to a conclusion and these will be brought to the Governance Committee. He stated that it was still his intention to commission an external review of the Obs and Gynae service as a whole at a future point. Mrs McClements stated that the action plan shared with Governance Committee has been updated and she agreed to share this with the Non Executive Directors.	***Mrs Toal*** ***Mrs McClements***

	Mrs Leeson asked if there was an audit plan to which Mrs McClements advised that audits were underway as well as development of dashboard indicators (KPIs) to enable scrutiny against performance, quality and governance issues. Mrs Leeson asked if the high rate of C-section births was a concern. Mrs McClements stated that there were no concerns and explained that during Covid-19, all elective C-sections moved to DHH and that increased the numbers. She added that expectant mothers have the option to choose a c-section as part of maternal choice in childbirth.	
5	**CLINICAL CONCERNS IN UROLOGY** The Chief Executive advised that meetings with the DoH continue on a regular basis. The Trust has agreed that it will formally apologise to the 9 families. The Public Inquiry is scheduled to commence in September 2021 with public hearings in approximately Summer 2022. Terms of Reference are awaited. Members raised the need for a workshop to prepare for the PI. The Chair advised that time would be dedicated to this at the Directors' workshop in August 2021. The Chief Executive informed members that in relation to Mr AOB's private patients, his Solicitor has confirmed that a letter has been issued to all of his private patients. This letter includes contact details for the patient information line, but no patient has been in contact. The Internal Audit review of Mr AOB's compliance with relevant authorities/guidance in terms of his private work will be brought to the Audit Committee. The Chief Executive updated on the review progress to date. Additional support for reviewing patients is required and the Trust will be looking to outsource capacity for the provision of Urology outpatient reviews from Independent Sector providers to support the Urology Team in seeing the patients identified as needing a review.	
6	Personal Information redacted by the USI The Chief Executive stated that there was no further update from that provided to members at the Governance Committee meeting on 13th May 2021. The Trust continues to work closely with the PSNI.	

7	**EARLY MEDICAL ABORTION – DAISY HILL HOSPITAL AND PROTESTS** The Chief Executive advised that the Trust has been working closely with the PSNI and local Politicians to ensure staff safety during the protests. He further advised that he has written to the Minister recently on this matter and it is important to stress that this is a political issue and not a delivery issue.	
8	**SAI OUTBREAK – EARLY LEARNING, FINDINGS AND TIMELINE** The Chief Executive reported that he has agreed to the SAI Panel Chair's request for an extension to the end of June 2021. The initial feedback is that the Trust did everything that was expected of it to manage the outbreak.	
9	**INQUESTS/JUDICIAL REVIEWS** There was nothing further to report.	
10	**REPORTING AND SAFETY BAROMETER – EARLY THOUGHTS FROM SMT** There was nothing further to report.	
11	**MENTAL CAPACITY ACT** The Chief Executive referred to ongoing discussions on the Mental Capacity Act and advised that Trust Chief Executives had written to the DoH re their concerns on meeting the 31st May 2021 deadline.	
12	**ANY OTHER BUSINESS** At the request of Mr McDonald, the Chief Executive updated on the incident in DHH over the weekend. There was a short discussion on the need to consider a different model for those patients going through detox.	
13	**DATE OF NEXT MEETING** **7th June 2021 at 9.00 a.m.**	

	The meeting concluded at 5.00 p.m.	

Southern Health and Social Care Trust

Quality Care - for you, with you

Notes of Chief Executive monthly update meeting held virtually on Monday, 7th June 2021 @ 9.00 a.m.

Present: Eileen Mullan (Chair of meeting)
Shane Devlin
Geraldine Donaghy
Pauline Leeson
Hilary McCartan
Martin McDonald
John Wilkinson

In attendance: Sandra Judt (Notes)

ITEM	NOTE	ACTION
1	**APOLOGIES** None	
2	**DECLARATION OF INTERESTS** There were no interests to declare.	
3	**NOTES OF PREVIOUS MEETING HELD ON 17th MAY 2021** The Notes of the previous meeting had been previously circulated and were approved.	
4	**MATTERS ARISING** **Obs and Gynae update** Assurance was sought at the previous meeting that the Whistleblowers were kept up to date during the investigation process. Ms Donaghy referred to the progress update which stated that '*the Trust has committed to link with RCM to provide feedback and this will be undertaken via Executive Director of Nursing office.'* Ms Donaghy sought clarification as to whether it was the role of RCM to provide this feedback as opposed to the Trust. ***Action: The Chief Executive to clarify with Mrs Toal***	***Chief Executive***

	Ms Donaghy made the point that it would have been helpful for the management response to accompany the report and asked that future reports include the management response. ***Action: The Chief Executive to discuss with the SMT***	***Chief Executive***
5	**CLINICAL CONCERNS IN UROLOGY** The Chief Executive advised that there has been no further meeting with the DoH since his last update to members. He raised the leaked report to the Irish News this week which he stated was regrettable and unhelpful. Terms of Reference for the Public Inquiry are awaited. The Chair advised that time would be dedicated to preparing for the Public Inquiry at the Directors' workshop in August 2021.	
6	**WHISTLEBLOWING** The Chief Executive informed members of an investigation following a Whistleblowing in [redacted]. The Ward Sister and two other members of staff have been suspended. A formal paper will be brought to Trust Board. There was discussion on culture in which the Chief Executive advised of work underway by the SMT on a culture framework/pathway. Mrs McCartan suggested the concept of Culture Champions which the Chief Executive agreed to explore with Mrs Toal. In light of other Whistleblowing investigations that have been brought to members' attention, members raised the need for staff management, performance appraisals and rotation of staff to be addressed.	
7	**CULTURE** Members welcomed the development of a Culture Framework/roadmap for the next three years plus.	
8	**NO MORE SILOS** There was discussion as to how to connect the Regional Management approach to the Trust Board agenda. It was agreed that this would be a standing item for progress update	

	going forward as well as a focused presentation on salient points, when appropriate.	
9	**INQUESTS/JUDICIAL REVIEWS** The Chief Executive advised that the Cawdery Preliminary Inquiry was held the previous week. June 2022 is the date of the Inquiry. Updates on Inquests and Judicial Reviews will be brought to Governance Committee.	
10	**REPORTING AND SAFETY BAROMETER** Members were advised of discussions involving the Chair, Chief Executive, Dr O'Kane and Mrs Magwood to look at reporting and creating meaningful indicators for Trust Board and the Trust. Proposed format will be brought to Governance Committee. Mrs Leeson left the meeting at this point.	
11	Personal Information redacted by the USI At the last confidential Trust Board meeting, members had requested that the Trust seek legal guidance on the likelihood of the current Owners taking a legal challenge and seeking financial compensation once they have sold the business. The Chief Executive informed members that the legal advice has been received and this acknowledges that the Wylies could issue proceedings against the Trust at any time, within legal time limits depending on the nature of the proposed claim. Legal advice states that the Trust took a reasonable and proportionate stance and suspended the admission of new residents due to genuine concerns with the owners of the home. Members will recall that Senior Counsel was also consulted on this issue and he felt the Trust's position was defensible. Members welcomed the legal advice received and it was agreed that this will be brought to the Trust Board confidential	

	meeting on 30th September 2021 to close this matter off.	
12	**ANY OTHER BUSINESS** The Chief Executive advised that the Board Assurance Framework was on the agenda of the upcoming Trust Board meeting and asked members to particularly consider the key strategic risks identified by the SMT to aid discussion.	
13	**DATE OF NEXT MEETING** To be agreed ***The meeting concluded at 10.00 a.m.***	

Southern Health and Social Care Trust

Quality Care - for you, with you

Notes of Virtual Chief Executive update meeting with Non Executive Directors held on Monday, 9th May 2022 @ 11.00 a.m.

Present: Eileen Mullan (Chair of meeting)
Dr Maria O'Kane
Geraldine Donaghy
Pauline Leeson

In attendance: Sandra Judt (Notes)

ITEM	NOTE	ACTION
1	APOLOGIES Hilary McCartan; Martin McDonald; John Wilkinson	
2	DECLARATION OF INTERESTS There were no interests to declare.	
3	NOTES OF PREVIOUS MEETING The notes of the previous meeting held on 11th January 2022 were approved subject to one amendment requested by Ms Donaghy as follows:- Page 3 Item ii) Secondment – Director of Performance & Reform – 5th paragraph, second sentence to include the word 'long-term' before interim arrangement.	
4	MATTERS ARISING • Secondment Policy In response to Ms Donaghy's question about a secondment policy, the Chair advised that the Remuneration Committee's Terms of Reference had been revised to include the overseeing of secondment requests at Senior Executive level.	

	• SMT Restructuring Dr O'Kane advised that stabilising SMT is a priority. She reported that the Job Description for a substantive Medical Director was almost finalised for advertisement. In the interim, cover would be provided by the three existing Deputy Medical Directors on a rotational basis.	
5	CURRENT PRESSURES Dr O'Kane provided an update as follows:- <u>Statutory Public Inquiry into Urology Services</u> The Trust has received a number of S21 notices, covering current and former staff. Around 160 staff working in Urology In-patients and Out-patients received detailed questionnaires immediately prior to Easter. All former Chief Executives, Directors of Acute Services and Medical Directors have now received S21 requests. A total of 40 S21 notices were issued on the 28/29th April 2022, all with response timeframe of six weeks. Dr O'Kane stated that the scope of discovery is likely to impact on all areas of the Trust, and have secondary impact on those areas required to provide information eg. the HR department. This will impact on the delivery of general Trust services. Mrs Jane McKimm is finalising a risk assessment and an Early Alert is being prepared for submission to the DoH. The Chair spoke of the negative impact on staff well-being for those involved, as well as the organisational risk. She advised that she would be raising these issues with Ms June Turkington, DLS, at their meeting later that day. The risk has been added to the Corporate Risk Register which will be discussed at the Governance Committee meeting on 12th May 2022. <u>ED attendances</u> Dr O'Kane reported on the high number of attendances at ED. She stated that the challenge was the bed waits which were impacting on the provision of emergency care. She particularly	

	highlighted the concerning statistics of those aged 85+ waiting > 12 hour in ED. Community Care services – Acute Care at Home, Domiciliary Care and Care Home provision were discussed.	
6.	CLINICAL AND SOCIAL CARE GOVERNANCE ROUND-UP Dr O'Kane explained the weekly governance brief attended by Divisional Medical Directors at which each operational Directorate presents on their safety challenges. An oversight of weekly activity in relation to clinical and social care governance is also discussed weekly by SMT and Dr O'Kane shared a flavour of the report with members. Members welcomed the report content and Dr O'Kane undertook to consider a clinical and social care governance round-up report going forward for the Non Executive Director meetings.	***Dr O'Kane***
7.	EARLY ALERT – CARDIAC INVESTIGATIONS Members discussed the Early Alert. Dr O'Kane stated that the issue related to 1383 referrals for cardiac investigations not logged on the system. The identified referrals have now been logged onto the system and the Trust is in the process of writing to the individuals concerned. Member raised the issue of the absence of checks and balances and the lack of quality assurance of information being loaded onto the system. Dr O'Kane stated that this issue will be factored into discussions with Internal Audit in terms of a future audit area. Ms Donaghy made reference to the increasing number of early alerts sent to the Non Executive Directors for information. She asked about those early alerts that Non Executive Directors feel are concerning and sought clarification as to how they could they raise their concerns and question/challenge. She queried if there was a pathway for early alerts and stated that progress updates on actions, lessons learned from early alerts would be useful. Dr O'Kane undertook to explore.	***Dr O'Kane***

8.	SOUTHERN TRUST ACHIEVEMENTS 2021/22 AND REBUILDING FOR THE FUTURE Members commended the service developments and range of improvement projects across the Trust as outlined in the draft Annual Report 2021/22. A presentation on Rebuilding for the Future had been provided at the Board Workshop on 28th April 2022 and Dr O'Kane asked if members had any further questions. In relation to the Executive Director of Social Work, Mrs Leeson stated that in her view, the postholder needs to have a strong background in adult safeguarding. Dr O'Kane stated that the preference is to have a stand alone Executive Director of Social Work to cover both children and adults.	
9.	ANY OTHER BUSINESS • Monthly Update meetings – future dates Members agreed that meetings would be held bi-monthly going forward.	