

- Put in place a CSCG audit programme which links to key areas of patient safety and risk;
- Strengthen the range of CSCG Quality Indicators in place to provide the type and depth of organisational intelligence/information required to adequately inform the organisation's CSCG, Risk, Safety and Quality Improvement priorities;
- To foster links with experts in the area of developing and improving on organisational 'safety cultures'.

6 Promoting Wellbeing, PPI and Patient Client Experience

Promoting health and wellbeing and reducing health inequalities remains a key priority for the Trust. The Trust continues to work closely with partners from across the statutory, community and voluntary sectors to ensure effective collaborative approaches to address the needs of local communities:

- The Trust has established a cross-Directorate and cross-sectoral structure to support the implementation and outworking of the regional *Public Health Framework, Making Life Better* and the ongoing development of local council community plans. 19/20 will see a continued focus on and leadership in the implementation of these community plans in collaboration with local councils and other statutory, community and voluntary sector partners; this will include Trust investment into enhancing Ageing Well, Mental and Emotional Health and Wellbeing, and Physical Activity opportunities;
- Local implementation of the regional Tobacco Control Strategy through the provision of stop smoking support services and by leading the ongoing implementation of Smoke Free sites for the Trust;
- Leading on development and delivery of health improvement action plans to progress physical activity opportunities, nutrition and cooking skills, sexual health, home accident prevention, mental health, suicide prevention, stop smoking support and health improvement for children and young people;
- Implementation of the Trust Staff Health and Wellbeing strategic action plan – including ongoing promotion and updating of the *UMatter Hub*, planning and delivery of an annual action plan of activity including physical activity classes, and support of Workplace Health Champions;
- Development and implementation of a Trust *Arts for Health and Wellbeing Strategic Action Plan*;
- Health Improvement/Community Development action plans for 2019/20 have been tailored to meet the needs of vulnerable and harder to reach groups as indicated by the commissioner and in keeping with collaborative working arrangements linked to local council community planning processes and structures;
- Specific plans will be developed to target the health and wellbeing needs of Looked After Children and Adults with a Learning Disability. Promoting wellbeing will continue to work with Learning disability services and support the health and wellbeing support worker for adults with a learning disability;
- The MacMillan Cancer Health and Wellbeing programme will continue to increase access to cancer information and support, and health and wellbeing events across the Trust. A bid for funds to develop a navigator service for people

affected by cancer will be progressed and a delivery model developed informed by those affected by cancer and wider stakeholders;

- Work with Macmillan and Newry, Mourne and Down Council to promote uptake of the Move More Physical Activity programme for people affected by cancer;
- Co-ordination and delivery of Early Interventions programmes including “*Roots of Empathy*” in primary schools and a portfolio of parenting support programmes being commissioned by the Public Health Agency and related primarily to the Delivering Social Change (DSC) Early Intervention Transformation Programme;
- Participation in the PHA’s Implementation and Innovation Board and sub-groups to further develop the framework for the expansion of community development approaches;
- Support for sustainable approaches to community development for health and social wellbeing including delivery of Community Sector Training programme (that now provides adult safeguarding modules in addition to the range of child safeguarding modules), further development of the role of and support for Community Health Champions and Trainers across the community, and implementation of Neighbourhood Renewal Health Improvement Plans in Newry, Craigavon, Lurgan, Portadown, Dungannon and Coalisland;
- Continue to implement Traveller health and wellbeing training and support programme and co-produce Traveller friendly information and guidance to meet identified need;
- Work with others as above to develop a strategic approach to the improvement of social support and health and wellbeing for older people in the community;
- The Trust’s Access and Information Service will continue to be developed to provide a single, centralised point of access and a single access strategy for referral for a range of social and health care services within the Older People and Primary Care (OPPC) Directorate as well as reaching out into the community, voluntary sectors and other statutory providers;
- Continued implementation of EU-funded *CoH-Sync* (Population Health) and *mPower* (Older People) projects under the auspices of the Co-operation and Working Together (CAWT) partnership;
- Continue to deliver the transformation funded Pre-Diabetes prevention programme increasing referrals from primary care and delivery of programmes at Trust level as agreed by the regional Transformation Implementation Group;
- Support for social prescribing models of health and social wellbeing, including continued implementation of a frailty pilot with a GP practice and support for the development of a social prescribing network across the Southern Area;
- Support for the development and implementation of a Trust Infant Mental Health strategic action plan.

6.1 Workplace Health and Wellbeing

The Trust is committed to maintaining and improving the health and well-being of all staff from induction through to retirement. The Trust Health and Wellbeing Strategy 2018-2021 is based on 6 key objectives to help the Trust achieve this over the 3 years. The Health and Wellbeing (H&WB) Steering Group will ensure the strategic leadership and direction in the development and implementation of the Strategy and Action Plan. A range of health campaigns and workshops will continue to be shared with staff throughout the year focusing on physical, psychological and emotional issues via a range of communication mediums including desktop messages, U-matter website and fortnightly email, desktop messages and organised events. The health calendar is promoted among the Trust's Health Champions enabling it to be used as a planning tool.

During 2019-2020 two additional H&WB workstreams will be established to support the Trust's aim of achieving and maintaining a healthy workforce providing a safe, supportive, and health promoting workplace. In addition to the Better Physical Health and Wellbeing work stream these will also include the Better Psychological Health and Wellbeing and Employee Experience workstreams.

A broad range of policies are in place in support of health and wellbeing. During 2019/20 the Trust will develop Guidance for staff and managers affected by cancer to ensure they access the support they need and a Menopause at Work Policy to increase the guidance and support available to managers and staff.

A review of the Trust's Occupational Health Service has been completed. Key recommendations from the review focused on a number of issues including: more focus on broader health and wellbeing activities, potential relocation of the service to achieve greater visibility for staff, development of a communication strategy to change the perception of the work of Occupational Health. These will be a key focus of work for 2019-2020.

With the appointment of a new Clinical Psychologist, a referral pathway will now be established for the Clinical Psychology Service in Occupational Health. Referrals will be for individual or team groups who need psychological assessment and intervention for difficulties related to their work. Future service development plans include the provision of group-based psychological interventions which will be co-delivered with a member of the Occupational Health team. The Clinical Psychologist will also begin to offer psychological assessment, consultation, training and therapeutic intervention for teams within the Trust and support the work of the Organisational Development team.

6.2 Personal and Public Involvement and Patient Client Experience

The Trust is committed to ensuring the active and meaningful involvement of individuals, communities and stakeholders in improving the design, delivery and efficiency of services.

In promoting Personal and Public Involvement the Trust will:

- Provide effective leadership and support across all areas to create and implement appropriate mechanisms and opportunities for involvement for all those who wish to engage with the Trust, including service users and carers, in identifying needs and priorities and in the design, planning and delivery of services as per the regional standards for Personal and Public Involvement (PPI) and Patient Client Experience (PCE);
- Review and up-date PPI support resources for staff and service users/carers and develop new resources to meet identified need;
- Evaluate the process and the impact of the **Confidence and Supply Transformation** non-recurrent funding allocated to the Southern Trust to progress **Partnership Working Infrastructure** and determine to what extent this small injection of non-recurrent funding supported service teams in the meaningful involvement of their service users and carers in the planning, management, delivery and evaluation of their services and to test models for the potential development of Trust based Citizens Hubs. The report will assess the impact of these projects for service users and carers and Trust services, identify the positive outcomes for all involved and identify any barriers or challenges which will inform local and regional learning;
- Induct, place and evaluate the impact of the bank of service user/carer consultants recruited under **Confidence and Supply Transformation** non-recurrent funding;
- Evaluate the impact of the Senior PPI Officer resourced through **Confidence and Supply Transformation** non-recurrent funding;
- Identify and support carers to access a wider range of services, improve their health and wellbeing and access financial support through the implementation of the carers support action plan which was co-produced with carers in 18/19;
- Review and up-date carer support resources for staff and carers and develop new resources to meet identified need;
- Influence regional approach to the auditing and analysis of PCE and PPI processes and outcomes across health and social care – to streamline and improve reporting processes and build capacity for wider involvement across Trust services;

- Build on the work of the Trust Volunteer Service through the targeted recruitment of volunteers and the development of new volunteer roles as needed to address a range of needs in the community and enhance patient experience through befriending and social support;
- Complete the assessment process for achieving the Investing in Volunteers quality standard award;
- Continue to work in partnership with Volunteer Now to develop an OBA framework for volunteering;
- Embed community development approaches to support local involvement and innovation in the future delivery of services including working in partnership with other key stakeholders to encourage support for a mixed economy approach to the provision of health and social care across all sectors;
- Involve and engage patients, service users, carers and representative groups in establishing priorities and plans and supporting the evaluation of health and social care delivery to provide learning and continuous improvement, e.g. PPI Panel, Carers Reference Group, Mental Health Service User Groups, Maternity Services Liaison Committee, Traveller Action Group, etc.;
- To play a leading role in the development of regional and local implementation structures for *Making Life Better* including participation in the newly established MLB network ;
- Continue to participate in the *10,000 Voices Project* in line with the agreed regional action plan for 2019/20.

APPENDIX 1 FINANCIAL TEMPLATES

INFORMATION FOR TRUST DELIVERY PLANS 2019/20

Trust	Southern Health and Social Care Trust
Table No.	
FP1	Forecast Financial Position This should reflect both the planned 2019/20 in -year and full year projected financial position. In respect of a pay award for 2019/20 neither assumed income for pay nor estimated pay expenditure should be factored into the financial position at this point. Income to offset the additional 6.2% Employers Superannuation costs should be assumed, including income for the 6.2% impact on superannuation costs of C&S Transformation projects. Expenditure for the 6.2% superannuation costs of C&S Transformation Fund projects should be included in the financial plan but all other Transformation project costs should be excluded from the plan.
FP2	Reconciliation of RRL Income This table should be used to indicate income assumptions by reconciling current RRL to planned income anticipated from HSCB and PHA. Once agreed as part of the TDP, additional Trust income is not to be assumed without the approval of HSCB / DoH.
FP3	Trust Savings Target 2019/20 (excluding Regional Pharmacy - see Table 3a) In regard to the advised Trust Savings Target for 2019/20, this table should reflect the savings plan proposals included within the calculation of the financial position. Where a range of savings / expenditure control measures are required to be put in place to ensure in year financial balance, these should also be included on this template. As appropriate, a commentary should be included against planned measures together with a RAG status. Additional rows can be inserted as required. Each proposal should be identified by Programme of Care.
FP3a	Regional Pharmacy Prescribing Savings 2019/20 This table is to indicate the proposals to address the Trust's Pharmacy Prescribing Savings target for 2019/20, which it is expected will be delivered to the target level set. All Medicines efficiency savings are to be reported against this target.
FP4	Workforce Planning - Indicative Impact on WTE Trusts should provide estimate of staffing impact of the cash releasing plans detailed on FP3 and indicative allocations/investments on paid WTE.
FP5	Workforce Planning - Total Staff This should indicate the projected paid WTE for the Trust analysed between Trust's staff and Agency/Locum staff and across all staff groups
FP6	Detail of Income This table should analyse all income in 2019/20 by Programme of Care

FP7**Detail of Expenditure**

This table should analyse all expenditure in 2019/20 by Programme of Care **before** impact of any savings delivery

FP8**Demography**

Gross pressure by Scheme by Programme of Care should be recorded with slippage identified separately in the proforma and the Trust identifying:

- The level of modelled demand that will be avoided in year by the reform and transformation investments made by LCGs in prior years
- The level of demand that is realised in year that can be addressed through productivity and other cash avoidance means

FP9**Reconciliation Check**

This table provides high level reconciliation between FP1 in year position and the tables on Income (FP2), Expenditure (FP7) and Savings (FP3 & FP3a).

INFORMATION FOR TRUST DELIVERY PLANS 2019/20

FP1

TRUST: SHSCT

Contact Name: Carol Cassells
Position: ADOFFM
Phone No: 02837565001

Note: This table excludes all Provisions, Depreciation, Impairment Expenditure.

Date Completed: 04.10.19

TABLE 1 FINANCIAL POSITION	2019/20	
	In Year Effect	Full Year Effect
	£'000	£'000
1.0 Expenditure:		
1.1 Staff costs	459,963	457,998
1.2 Other expenditure	270,137	268,891
1.3 Total expenditure	730,100	726,889
2.0 Income:		
2.1 Income from activities	31,378	31,157
2.2 Other income	9,229	6,823
2.3 Total income	40,607	37,980
3.0 Net expenditure	689,493	688,909
add: RRLs agreed for services provided by other HSC bodies		
4.1 BSO		
4.2 Other (specify)		
4.3 Other (specify)		
4.4 Total RRLs agreed	-	-
5.0 Net resource outturn	689,493	688,909
6.0 Calculation of Revenue Resource Limit (RRL)		
6.1 Allocation from HSCB (as per FP2)	676,838	665,830
6.2 Allocation from PHA (as per FP2)	5,077	4,865
6.3 Total Allocation from HSCB/PHA	681,915	670,695
6.4 NIMDTA	5,813	5,813
6.5 RRL agreed with other HSC bodies (specify)		
6.6 RRL agreed with other gov't departments - NIHE Supporting People	1,765	1,765
6.7 Revenue Resource Limit	689,493	678,273
7.0 Surplus / (Deficit) against RRL	0	(10,636)
7.1 % Surplus / (Deficit) against RRL	0.00%	-1.57%

Notes:

Please note FYE Deficit excludes the following:-
DECC/MDTs, Mental Capacity Act, Superannuation increase to 22.5%, Impact of 19/20 Pay Awards, 2nd CT Scanner Funding, New Pressures that may emerge over the remainder of 19/20, C&S Transformation Projects, Elective, Allocations received on a non-recurrent basis every year e.g. Grant in Aid, Legacy Transformation.

INFORMATION FOR TRUST DELIVERY PLANS 2019/20

FP2

Name of Trust:

SHSCT

RECONCILIATION OF RRL TO PLANNED INCOME

Date Completed: 19.09.19

INCOME FROM COMMISSIONERS	2019/20	
	In-Year Effect	Full Year Effect
1. HSCB	£'000	£'000
RRL as at 1st April 2019	590,838	590,838
<u>Indicative Allocations:</u>		
<u>Ring Fenced (if applicable)</u>		
Mental Health	2,488	2,488
Legacy Transformation	155	0
<u>Other</u>		
Learning Disability	1,342	1,342
Renal Services additional consultant	15	0
Renal Services NR 18/19 FYE	120	0
Paediatrics - 0.5 theatre session		
gastro	25	0
External Support for unscheduled care	50	0
RCCE	61	61
Childrens	1,218	512
Drugs	50	50
Elective	4,601	0
Cancer	50	0
18/19 Pay Awards - Recurrent	10,402	10,402
18/19 Pay Awards - Non Recurrent	1,711	0
18/19 Control Total	102	102
Prior year pressures	6,166	6,166
Demography 18/19 FYE	3,163	3,163
Childrens - implementation of SEN act	173	0
Implementing Adult safeguarding		
prevention and protection policy	45	45
Domiciliary Care regrading	2,300	2,300
Energy Costs	1,053	1,053
Independent Sector Fostering / LAC	1,626	1,626
Renal services and transplant	30	0
Demography 19/20	4,508	4,508
Non Pay (including National Living		
Wage)	9,180	9,180
Apprenticeship Levy	80	80
Drugs and Therapies	1,201	1,201
MORE Savings Target	-1,040	-1,040
Car parking charges target	-112	-112
Total Indicative Allocations	50,762	43,127
<u>Other Assumed Allocations</u>		
SUMDE	1,944	1,944
Surestart	4,512	4,512

SAUCS	4,621	4,621
GIA commissioned courses	900	0
Superannuation Rate Increase 19/20	18,736	18,736
Additional Spec Drugs funding	1,552	1,552
General Pressures	500	500
Additional Income In Year	1,500	0
Mobile Cath Lab	705	0
DECC Phase 1 Cataract Non ringfenced	268	0
Total Other Allocations	35,238	31,865
HSCB Income as per FP1	676,838	665,830
2. PHA	£'000	£'000
RRL as at 1st April 2019	4,744	4,744
<u>Indicative Allocations:</u>		
<u>Ring Fenced</u>		
<u>Other</u>		
18/19 Pay Awards - Recurrent	74	74
18/19 Pay Awards - Non Recurrent	12	0
Non Pay	47	47
Total Indicative Allocations	133	121
<u>Other Assumed Allocations</u>		
Roll over of non-recurrent	200	0
Total Other Allocations	200	0
PHA Income as per FP1	5,077	4,865
Total Allocation from HSCB/PHA	681,915	670,695

INFORMATION FOR TRUST DELIVERY PLANS 2019/20

Name of Trust:

SHSCT

FP3

Date Completed: 19.09.19

Trust Savings Target 2019/20

	Recurrent/N on recurrent	RAG Status	POC	POC	POC	POC	POC	POC	POC	POC	POC	Total	Commentary
Project Title			1	2	3	4	5	6	7	8	9		
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
1 Slippage on Dungannon Supported Living	NRR	Green	0	0	0	0	140	0	0	0	0	140	
2 Vacancy factor	NRR	Green	176	27	34	124	40	53	17	10	20	500	
3 Non-direct Clinical Goods & Services	R	Green	209	27	34	124	40	53	17	10	20	533	
4 Demography Slippage	NRR	Green	285	0	78	468	166	0	56	0	0	1,053	
5 Slippage on allocations	NRR	Green	167	25	32	118	38	50	16	10	19	475	
6 Car Parking Income	NRR	Green	19	0	0	0	0	0	0	0	0	19	
etc												0	
Total			856	79	178	834	423	156	106	30	58	2,720	

INFORMATION FOR TRUST DELIVERY PLANS 2019/20

Name of Trust:

SHSCT

FP3a

Date Completed: 19.09.19

Regional Pharmacy Prescribing Savings 2019/20

	Recurrent/N on recurrent	RAG Status	POC	POC	POC	POC	POC	POC	POC	POC	POC	Total	Commentary
Project Title			1	2	3	4	5	6	7	8	9		
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
1 Switching c/f 18/19	R	Green	138	0	0	0	0	0	0	0	0	138	
2 Price Reduction (inc Discounts)	R	Green	257	0	0	0	0	0	0	0	0	257	
3 Procurement	R	Green	216	0	0	0	0	0	0	0	0	216	
4 Rebates	NRR	Green	214	0	0	0	0	0	0	0	0	214	
5 Switching 19/20	R	Green	272	0	0	0	0	0	0	0	0	272	
6 Benchmarking	R	Green	25	0	0	0	0	0	0	0	0	25	
etc												0	
Total			1122	0	0	0	0	0	0	0	0	1122	

Trust

SHSCT

Date Completed: 19.09.19

2019/20 Gross Planned Workforce Reductions (Savings Plans on FP3)*(Show Reductions as Negatives)*

	Admin	AHP	Support Services	Nursing / Midwifery	Social Work	Professional / Technical	Medical / Dental	Ambulance	Totals
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Permanent Staff	0.0								0.0
Temporary Staff									0.0
Decreases in Overtime & ADH Payments									0.0
Agency/Bank Staff (Equivalent)									0.0
Independent Sector Staff									0.0
Totals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

This table is expected to capture the WTE (or WTE Equivalents) of all Reductions incorporated in the Trust Savings Plan.

2019/20 Planned Increases due to Backfill (Increases due to Re-Provision to facilitate Savings Plans on FP3)

	Admin	AHP	Support Services	Nursing / Midwifery	Social Work	Professional / Technical	Medical / Dental	Ambulance	Totals
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Permanent Staff	0.0								0.0
Temporary Staff									0.0
Increases in Overtime & ADH Payments									0.0
Agency/Bank Staff (Equivalent)									0.0
Independent Sector Staff/foster carers									0.0
Totals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

This table is expected to capture the WTE (or WTE Equivalents) of increases due to re-provision to facilitate savings (e.g. Skill mix adjustments) in the Trust Savings Plan.

2019/20 Planned Workforce Increases (New Investments)

	Admin	AHPs	Support Services	Nursing / Midwifery	Social Work	Professional / Technical	Medical / Dental	Ambulance	Totals
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Permanent Staff	0.0								0.0
Temporary Staff									0.0
Increases in Overtime & ADH Payments									0.0
Agency/Bank Staff (Equivalent)									0.0
Independent Sector Staff								0.0	0.0
Totals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

This table is expected to capture the WTE (or WTE Equivalents) of increases due to indicative HSCB Investment (e.g. Demography and other Service Development)

2019/20 Net Planned Workforce Increases (Decreases)

	Admin	Estates	Support Services	Nursing / Midwifery	Social Work	Professional / Technical	Medical / Dental	Ambulance	Totals
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Permanent Staff	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Temporary Staff	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Increases in Overtime & ADH Payments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Agency/Bank Staff (Equivalent)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Independent Sector Staff	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Totals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

INFORMATION FOR TRUST DELIVERY PLANS 2019/20

FP5

Name of Trust:

SHSCT

Workforce Planning

Date Completed: 19.09.19

Staff Group	Actual WTE as at 31 March 2019			Staff on Payroll	Agency/Locum Staff	Total
	On Payroll	Agency/locum	Total	Projected WTE 31-Mar-20	Projected WTE 31-Mar-20	Projected WTE 31-Mar-20
Admin & Clerical	1637	75	1712	1670	86	1756
Estate Services	0	0	0	0	0	0
Support Services	1028	88	1116	1049	101	1150
Nursing & Midwifery	3373	551	3924	3440	634	4074
Social Services	2265	51	2316	2310	59	2369
Professional & Technical	1086	8	1094	1108	9	1117
Medical & Dental	629	127	756	642	146	788
Ambulance Service	0	0	0	0	0	0
Total	10018	900	10918	10218	1035	11253

INFORMATION FOR TRUST DELIVERY PLANS 2019/20

TRUST: SHSCT

Date Completed: 19.09.19

Detail of Income 2019/20

	POC	POC	POC	POC	POC	POC	POC	POC	POC	Total
Description	1	2	3	4	5	6	7	8	9	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Opening HSCB RRL 2019/20	207,830	31,503	40,011	146,667	46,713	62,640	20,096	12,115	23,262	590,838
Opening PHA RRL 2019/20	0	0	0	0	0	0	0	4,744	0	4,744
<u>Indicative Allocations:</u>										
<u>Ring Fenced</u>										
£10m Mental Health inescapables CYE (exc Psychological Therapies)	0	0	0	0	876	0	0	0	0	876
£10m Mental Health inescapables FYE	0	0	0	0	428	0	0	0	0	428
£10m Mental Health - Psychological Therapies	0	0	0	0	1,069	0	0	0	0	1,069
19/20 Mental Health	0	0	0	0	103	0	0	0	0	103
Regional Mental Health Trauma	0	0	0	0	12	0	0	0	0	12
Legacy Transformation - ICT Reform	35	5	7	25	8	11	3	2	4	100
Legacy Transformation - Direct Access Physio	0	0	0	55	0	0	0	0	0	55
<u>Other</u>										
2018/19 Learning Disability FYE	0	0	0	0	0	1,041	0	0	0	1,041
2019/20 Learning Disability	0	0	0	0	0	301	0	0	0	301
Renal Services additional consultant	15	0	0	0	0	0	0	0	0	15
Renal Services NR 18/19 FYE	120	0	0	0	0	0	0	0	0	120
Paediatrics - 0.5 theatre session gastro	25	0	0	0	0	0	0	0	0	25
External Support for unscheduled care	50	0	0	0	0	0	0	0	0	50
RCCE	61	0	0	0	0	0	0	0	0	61
17/18 Recurrent Funding for Prior year Pressures- Autism	0	0	79	0	0	0	0	0	0	79
Childrens Services - Autism - Framework	0	0	232	0	0	0	0	0	0	232
Children's Services - Autism - Framework - NR	0	0	9	0	0	0	0	0	0	9
19/20 Childrens Services - Autism framework	0	0	250	0	0	0	0	0	0	250
Implementation of SEN Act (DOH advised expenditure dependent on Legislation)	0	0	201	0	0	0	0	0	0	201
Intensive Outreach for Young People in Accommodation in the Community	0	0	120	0	0	0	0	0	0	120
Social Services PSS Training Support	0	0	115	0	0	0	0	0	0	115
GEM 16/17 - scheme expansion	0	0	202	0	0	0	0	0	0	202

GEM (17/18 funding) existing scheme pressure	0	0	10	0	0	0	0	0	0	10
Drugs	50	0	0	0	0	0	0	0	0	50
Elective	4,601	0	0	0	0	0	0	0	0	4,601
Cancer	50	0	0	0	0	0	0	0	0	50
2018/19 AfC Recurrent	3,158	479	608	2,228	710	952	305	184	353	8,976
2018/19 Increase in BSO charges recurrent	26	4	5	18	6	8	2	1	3	73
2018/19 Adjustment for National Living Wage recurrent	-141	-21	-27	-99	-32	-42	-14	-8	-16	-400
2018/19 DDRB 2018 -issued 2018/19 recurrent	467	71	90	330	105	141	45	27	52	1,329
2018/19 Locum/Agency Pay Uplift recurrent	175	27	34	124	39	53	17	10	20	498
2018/19 AfC Non Recurrent	606	92	117	428	136	183	59	35	68	1,723
18/19 Control Total	102	0	0	0	0	0	0	0	0	102
18/19 prior year pressures - recurrent	4,520	119	351	554	176	237	76	46	88	6,166
Demography 18/19 FYE	2,113	65	83	344	97	345	42	25	48	3,163
Childrens - implementation of SEN act	0	0	173	0	0	0	0	0	0	173
Implementing Adult safeguarding prevention and protection policy	0	0	0	45	0	0	0	0	0	45
Domiciliary Care regrading	0	0	0	2,300	0	0	0	0	0	2,300
Energy Costs	370	56	71	261	83	112	36	22	41	1,053
Independent Sector Fostering / LAC	0	0	1,626	0	0	0	0	0	0	1,626
Renal services and transplant	30	0	0	0	0	0	0	0	0	30
Demography 19/20	1,243	4	207	2,325	303	231	104	0	91	4,508
Non Pay (including National Living Wage)	3,246	492	625	2,290	730	978	314	189	363	9,227
Apprenticeship Levy	28	4	5	20	6	8	3	2	3	80
Drugs and Therapies	1,201	0	0	0	0	0	0	0	0	1,201
MORE Savings Target	-1,040	0	0	0	0	0	0	0	0	-1,040
Car parking charges target	-112	0	0	0	0	0	0	0	0	-112
										0
<u>Other Assumed Allocations:</u>										
SAUCS	0	0	0	0	0	0	0	0	4,621	4,621
Surestart	0	0	4,512	0	0	0	0	0	0	4,512
SUMDE	1,944	0	0	0	0	0	0	0	0	1,944
GIA commissioned courses	900	0	0	0	0	0	0	0	0	900
Roll over of NRR PHA	0	0	0	0	0	0	0	200	0	200
Superannuation Rate Increase 19/20	6,590	999	1,269	4,651	1,481	1,986	637	384	738	18,736
Additional Specialist Drugs funding	1,552									1,552
General Pressures	176	27	34	124	40	53	17	10	20	500
Additional Income In Year	528	80	102	372	119	159	51	31	59	1,500
Mobile Cath Lab	705									705
DECC Phase 1 Cataract Non ringfenced	268									268
Total Income	241,491	34,006	51,120	163,062	53,209	69,395	21,794	18,020	29,819	681,915

Should agree to FP2

INFORMATION FOR TRUST DELIVERY PLANS 2019/20

TRUST: SHSCT

Date Completed: 04.10.19

Detail of Expenditure 2019/20

	POC	POC	POC	POC	POC	POC	POC	POC	POC	Total
Description	1	2	3	4	5	6	7	8	9	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Opening Deficit	7,353	194	509	3,306	2,348	663	186	75	143	14,777
Less: MH Psychological Therapies, Inescapables & Demography - ringfenced	0	0	0	0	-1,998	0	0	0	0	-1,998
Opening HSCB RRL 2019/20	207,830	31,503	40,011	146,667	46,713	62,640	20,096	12,115	23,262	590,838
Opening PHA RRL 2019/20	0	0	0	0	0	0	0	4,744	0	4,744
<u>Prior Year Pressures :</u>										
Opening Prior Year Pressures	2,200	0	600	0	0	0	0	0	0	2,800
2018/19 AfC Recurrent	3,158	479	608	2,228	710	952	305	184	353	8,976
2018/19 Adjustment for National Living Wage recurrent	-141	-21	-27	-99	-32	-42	-14	-8	-16	-400
2018/19 DDRB 2018 -issued 2018/19 recurrent	467	71	90	330	105	141	45	27	52	1,329
2018/19 Locum/Agency Pay Uplift recurrent	175	27	34	124	39	53	17	10	20	498
2018/19 AfC Non Recurrent	606	92	117	428	136	183	59	35	68	1,723
Apprenticeship Levy	28	4	5	20	6	8	3	2	3	80
<u>2019/20 Inescapable Pressures:</u>										
Auto-enrolment	200	30	39	141	45	60	19	12	22	569
RCCE	61	0	0	0	0	0	0	0	0	61
IS Price Lift Dom Care Sector	0	0	0	800	0	0	0	0	0	800
<u>Ringfenced Pressures:-</u>										
£10m Mental Health inescapables CYE (exc Psychological The	0	0	0	0	876	0	0	0	0	876
£10m Mental Health inescapables FYE	0	0	0	0	428	0	0	0	0	428
£10m Mental Health - Psychological Therapies	0	0	0	0	1,069	0	0	0	0	1,069
19/20 Mental Health	0	0	0	0	103	0	0	0	0	103
Regional Mental Health Trauma	0	0	0	0	12	0	0	0	0	12
Legacy Transformation - ICT Reform	35	5	7	25	8	11	3	2	4	100

Legacy Transformation - Direct Access Physio	0	0	0	55	0	0	0	0	0	55
<u>Other Pressures (list):</u>										
2018/19 Learning Disability FYE	0	0	0	0	0	1,041	0	0	0	1,041
2019/20 Learning Disability	0	0	0	0	0	301	0	0	0	301
Renal Services additional consultant	15	0	0	0	0	0	0	0	0	15
Renal Services NR 18/19 FYE	120	0	0	0	0	0	0	0	0	120
Paediatrics - 0.5 theatre session gastro	25	0	0	0	0	0	0	0	0	25
External Support for unscheduled care	50	0	0	0	0	0	0	0	0	50
17/18 Recurrent Funding for Prior year Pressures- Autism	0	0	79	0	0	0	0	0	0	79
Childrens Services - Autism - Framework	0	0	232	0	0	0	0	0	0	232
Children's Services - Autism - Framework - NR	0	0	9	0	0	0	0	0	0	9
19/20 Childrens Services - Autism framework	0	0	250	0	0	0	0	0	0	250
Implementation of SEN Act (DOH advised expenditure dependent on Legislation)	0	0	201	0	0	0	0	0	0	201
Intensive Outreach for Young People in Accommodation in the Community	0	0	120	0	0	0	0	0	0	120
Social Services PSS Training Support	0	0	115	0	0	0	0	0	0	115
GEM 16/17 - scheme expansion	0	0	202	0	0	0	0	0	0	202
GEM (17/18 funding) existing scheme pressure	0	0	10	0	0	0	0	0	0	10
Elective	4,601	0	0	0	0	0	0	0	0	4,601
Cancer	50	0	0	0	0	0	0	0	0	50
Demography 18/19 Additional FYE	427	65	83	305	97	130	42	25	48	1,223
Childrens - implementation of SEN act	0	0	173	0	0	0	0	0	0	173
Implementing Adult safeguarding prevention and protection policy	0	0	0	45	0	0	0	0	0	45
Energy Costs (Less £400k in prior year pressures)	230	35	44	162	52	69	22	13	26	653
Independent Sector Fostering / LAC (less £600k in prior yr pressures)	0	0	1,026	0	0	0	0	0	0	1,026
Renal services and transplant	30	0	0	0	0	0	0	0	0	30
Demography 19/20	1,243	4	207	2,325	303	231	104	0	91	4,508
Non Pay (including National Living Wage)	3,246	492	625	2,290	730	978	314	189	363	9,227
Drugs and Therapies	2,153	0	0	0	0	0	0	0	0	2,153
2018/19 Increase in BSO charges recurrent	26	4	5	18	6	8	2	1	3	73
SAUCS	0	0	0	0	0	0	0	0	4,621	4,621
Surestart	0	0	4,512	0	0	0	0	0	0	4,512
SUMDE (Less £100k in Prior Year Pressures)	1,844	0	0	0	0	0	0	0	0	1,844
GIA commissioned courses	900	0	0	0	0	0	0	0	0	900
Roll over of NRR PHA	0	0	0	0	0	0	0	200	0	200
Superannuation Rate Increase 19/20	6,590	999	1,269	4,651	1,481	1,986	637	384	738	18,736
Mobile Cath Lab	705									705
DECC Phase 1 Cataract Non ringfenced	268									268
Total Expenditure	244,495	33,984	51,153	163,821	53,238	69,413	21,841	18,011	29,803	685,757

INFORMATION FOR TRUST DELIVERY PLANS 2019/20

TRUST:

SHSCT

Date Completed: 19.09.19

Demography 2019/20

	POC	POC	POC	POC	POC	POC	POC	POC	POC	Total
Description	1	2	3	4	5	6	7	8	9	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
<u>Gross Demography -Programme/Scheme list:</u>										
Demography 2019/20	1,243	4	207	2,325	303	231	104	0	91	4,508
Total Gross Demography	1,243	4	207	2,325	303	231	104	0	91	4,508
Demand avoided through reform investment in prior year(s)										0
Demand avoided through reform investment in 2018/19										0
Other productivity measures										0
Managed Slippage										0
Natural Slippage	285	0	78	468	166	0	56	0	0	1,053
Total Net Demography 2019/20	958	4	129	1,857	137	231	48	0	91	3,455

INFORMATION FOR TRUST DELIVERY PLANS 2019/20**RECONCILIATION CHECK**

		2019/20
		In Year Effect
		£'000
1.0	Surplus / (Deficit) against RRL (FP1)	0
2.0	Income (FP2)	681,915
3.0	Expenditure as per (FP7)	685,757
4.0	Trust Savings Target 2019/20 Delivery (FP3)	2,720
5.0	Regional Medicines Optimisation Efficiency Savings 2019/20 (FP3a)	1,122
6.0	Surplus / (Deficit) against RRL (should agree to 1.0 above)	(0)

Southern Health and Social Care Trust 2019/20

TDP – Indicative volumes (demography allocations) pending Investment Proposal Templates

Appendix 2 Activity Volumes

POC 1 Service Description – Acute Services	Currency	Confirmed SBA Positon for 2018/2019	Additional Demography Volumes 2019/20 FYE	Associated Additional Costs
			FYE when posts in place	FYE
4.0 wte Physician Associates To enhance and support the medical staffing resources on acute hospital wards to meet demand and improve flow and patient care 2 x DHH (ED/Acute Medicine) 2 x CAH (Geriatric Acute & Haematology) No impact on SBA activity	N/A	N/A	0	251
4th Microbiologist 0.68 wte To support antimicrobial stewardship, infection control and Oral Parenteral Antibiotic Therapy (Note part funded 0.34 wte @ 53k from OPPC, see below) No impact on SBA activity	N/A	N/A	0	53
Patient Flow posts Additional posts to support inpatient flow and control room functions as part of management of unscheduled care pressures Posts in place but previously unfunded No impact on SBA activity	N/A	N/A	0	170
Cardiac Telemetry – 5.6 wte nurses To enable cardiac telemetry 24/7 monitoring at DHH hospital Part of ward function. No impact on SBA activity	N/A	N/A	0	244
Pharmacist Essential 8a pharmacist position to provide enhanced support to ICU Ward to ensure effective and safe provision of care No impact on SBA	NA	N/A	0	62
Point of Care Testing 3 WTE Band 3 posts to facilitate point of care testing/assurance processes for kit for provision of safe and effective care Regrading of band 6 post No impact on SBA	NA	N/A	0	114
Social Work Band 7 social worker to facilitate earlier and effective discharge planning from Acute hospital beds (DHH & CAH) with a particular focus on patients <65 year with challenging mental health and disability issues Improving patient care and inpatient flow No SBA impact	N/A	N/A	0	55

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Southern Health and Social Care Trust 2019/20

TDP – Indicative volumes (demography allocations) pending Investment Proposal Templates

Pharmacy 4 wte Band 7 prescribing pharmacists (Surgery and Medicine) Provide support to DHH wards including discharge prescriptions supporting safe and effective care and inpatient flow No SBA impact	N/A	0	0	210
POC 4 Service Description – Older People Services				
Statutory Residential Home Provision of capacity to enable management of more complex cohort (Assistance of 2 people) to enable hospital discharges This investment represents a level of capacity to enable the current service provision to deal with high level of complexity Increased utilisation of the current resources with greater throughput 5.6 WTE Band 3 4 WTE Band 4 No impact on SBA /No increase in physical beds	Stat Homes Beddays	N/A	0	300
Access & Information staff 4 wte Band 4 staff to provide increased capacity for Access & Information centre No SBA impact	N/A	0	0	110
Care Bureau 3 WTE Band 3 Staff to facilitate domiciliary care placements and processing of invoices etc No impact on SBA	N/A	0	0	76
Domiciliary Care Increase service provision to meet demand and incremental grade drift This investment will see additional hours provided to service users increasing independent sector and in house capacity Note: SBA reflected includes memory/dementia hours which are now within the Mental health Programme. SBA adjustment required in 2019/20 to reflect this and potential rebasing of DP/SDS hours (inclusive of proxy figures of 176,836 for SDS/DP)	Domiciliary Care Hours	Opening position for 17/18 (baseline 2,325,546 + uplift 85,326 = 2410,872) Opening position 2018/19: Baseline 2410 872 + uplift 65,190 Hours = 2410,872) Opening position 2019/2020: Baseline 2410,872 + 18/19 uplift of Hours TBC	0	583

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Southern Health and Social Care Trust 2019/20

TDP – Indicative volumes (demography allocations) pending Investment Proposal Templates

Domiciliary Care Enhanced administration staff to support governance and quality management No SBA Impact	N/A	0	0	51
Non Acute Wards 4.67 wte x Band 5 nurses to work across non acute hospitals (Lurgan and STH) To increase complement to ensure nursing workforce at safe working levels and ensure continuity of care No SBA impact ; post already in place	N/A	0	0	159
Primary Care Integrated Care Team Additional MD staff for ICT to support reduced caseload management initiative Recruitment in process 7 WTE Band 4 Social Work Assistant 11.2 WTE Band 6 Social Workers 0.5 WTE Band 7 Physiotherapy 4 WTE Band 6 Physiotherapists 1 WTE Band 3 Physiotherapist Assistant No SBA Impact	N/A	0		915
Microbiology (0.34 wte of 4 th Microbiologists identified above funded from Older People and Primary Care Directorate (53k)) 1 x Band 7 quality assurance nurse 1 x Band 8a microbial pharmacist To support antimicrobial stewardship, infection control and Oral Parenteral Antibiotic Therapy project to provide safer and effective care No impact on SBA activity	N/A	0		102
POC 3 Service Description – Children and Young Peoples Services				
Family Support & Safeguarding 3 wte x Band 4 New Contact Workers for Family Support Division to enhance the existing team capacity	Social Care Contacts	No agreed SBA baselines	TBC	93
Children with Disabilities 2 wte x Band 6 Social Workers Investment to supporting increased complexity and current demand; reduce timescale for unallocated referrals 1 Short breaks team and	Social work Caseload	No agreed SBA baselines	TBC	92

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Southern Health and Social Care Trust 2019/20

TDP – Indicative volumes (demography allocations) pending Investment Proposal Templates

3 children with disability teams with focus on children autism				
CYPs Pressures 1wte x B3 Admin support to health psychology service No SBA impact	N/A	N/A	0	26
POC 5 Service Description – Mental Health				
Rehabilitation Enhanced MD staff to support 7-day working for mental health rehabilitation team support community support and discharge management	TBC	TBC	TBC	400
POC 6 Service Description – Disability Services				
Supported Living To support increase costs in Supported Living (IS facility) Accommodation associated with greater needs of aging profile of individual residents Work ongoing to renew contractual arrangements with Provider and move to block contract No SBA impact	N/A	N/A	0	40
Physical Disability Placement of complex clients into community to facilitate discharge Packages of care will be dependent on individual need and may include a flexible range of provision including residential/nursing home bed/day capacity, independent sector contracted provision, additional domiciliary care provision which may be in the form of Direct Payments, traditional provision or via SDS. Whilst no impact on SBA each placement will have a contracted provision with agreed outcomes	Flexible	N/A	0	135
Domiciliary Care Provision of enhanced domiciliary care provision to meet unfunded demand and increased complexity, particularly in Armagh & Dungannon area Packages of care will be dependent on individual need and may include a flexible range of provision including domiciliary care provision which may be in the form of Direct Payments, traditional provision or via SDS.	Domiciliary Care (Hours) Direct Payments (individuals) SDS (individuals)	Flexible in line with spend	TBC	61

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Southern Health
and Social Care Trust

Quality Care – for you, with you



Corporate Plan 2017/18- 2020/21



IMPROVING TOGETHER

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Section 1: Why have we produced a **Corporate Plan for 2017/18- 2020/21**?

In 2015, the Southern Health and Social Care Trust publically consulted on ‘*Improving through Change*’, its three year Strategic Plan for 2015-2018. This plan emerged from previous strategic plans and reflected recommendations of a review of Northern Ireland Health and Social Care services carried out in 2014 by Sir Liam Donaldson - “*The Right Time: The Right Place*”¹.

In particular, the Trust embraced the need for strategy and actions to increase emphasis on **improving the safety and quality** of our local services.



....So, why update our plan now when we are only part way through our existing planning cycle?

The Trust's Corporate and annual delivery plans develop in line with the strategic direction set by the Northern Ireland Executive **Draft Programme for Government**, regional Health and social care strategies including the report by Professor Bengoa and the Expert Panel ‘**Systems not Structures**’² and most notably the recent publication of the vision set out by the Minister for Health in **Health and Wellbeing 2026: Delivering Together**.³

Figure 1

(Draft) Programme for Government (PfG) sets strategic direction across all public services defining 14 key outcomes

Health and Wellbeing 2026: Delivering Together provides strategic direction specific to Health and Social Care (HSC)

Health and Social Care Board (HSCB) and Public Health Agency (PHA) agree a **Commissioning Plan** that confirms the commissioners priorities, aims and improvement objectives for HSC sector

Corporate Plan 2017/18-2020/21 sets out the Trust's strategic priorities and planned outcomes

Annual Trust Delivery Plan identifies planned actions to deliver against the Corporate Plan and responds to commissioning plans, priorities and targets

¹ ‘The Right Time, The Right Place’, Sir Liam Donaldson, DOH, Jan 14

² ‘Systems Not Structures’, The Bengoa Expert Panel Report, DOH, Oct 16

³ ‘Health & Wellbeing 2026: Delivering Together’, DOH, Oct 16

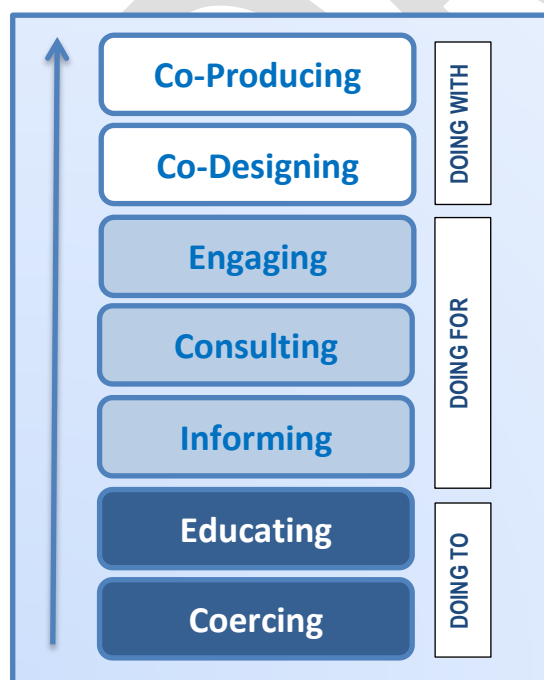
'Delivering Together' provides a roadmap for radical transformation in Health and Social Care (HSC) and highlights the critical role that **'Co-production'** and **'Co-design'** must play in this reform. The Trust welcomes and supports this commitment that will build on the effective community development and strong personal and public involvement (PPI) approaches that are well established in the Southern area.

Co-production therefore is based on the principles that public services should approach service users as assets who have skills that are vital to the delivery of services and that attention should be given to weaving community networks around individuals and organisations.

The implication of this for health and social care going forward during the period of this Corporate Plan is to move beyond consultation, user involvement and citizen engagement to equal partnership: to shift from 'doing to' to 'working with', and from providing to enabling and supporting. This represents a significant shift in 'culture' in public services and within our communities. Figure 2 below summarises.



Figure 2



"We must work in partnership – patients, service users, families, staff and politicians – in doing so we can co-produce lasting change which benefits us all"

(Health and Wellbeing 2026: Delivering Together, 2016)

Our Corporate Plan recognises the need for service reform as a result of the changing needs of our local population, new ways of delivering care and treatment and the resources available to us. In planning for these changes it is important that we work with our staff, service users and carers, families and our wider local communities to better inform and influence how we develop and improve our services.

We want:

- **Our local communities to know what to expect from us.**
- **Our staff to be aware of their specific role in delivering on our priorities**
- **To be able to demonstrate improvements in the services we provide and**
- **To evaluate our success in delivering health and social care transformation in the Southern Trust in line with our strategic priorities.**



1.1 Collaboration to Deliver Improved Outcomes

In addition to working in partnership with local communities, the Trust acknowledges the need for enhanced collaboration with other service providers and agencies across the region to ensure our local services are **effective** and **sustainable** into the future.

The Trust recognises the future success of health and social care is dependent on effective partnerships and our ability to work together providing system leadership and collective ownership of the outcomes we achieve.

This Corporate Plan also embraces our wider responsibility for improvement. The Trust is committed to working in partnership with other agencies to support the aims of the regional public health strategy, ***Making Life Better***⁴ as well as the 14 'outcomes' set out in the Draft Programme for Government Framework, in particular 4 outcomes directly align to the roles, responsibilities and outcomes envisaged for improved health and social care for our population including:



- We give our children and young people the best start in life
- We have high quality public services
- We enjoy long, healthy active lives
- We care for others and we help those in need.

The Minister for Health's Strategy Health and Wellbeing 2026, Delivering Together sets a strong **vision** to:

Improve the quality and experience of care

Improve the health of our people

Ensure sustainability of our services

Support and empower our staff

In delivering the change needed, this Corporate Plan sets out initial priorities the Trust will work towards in delivering the Minister's Vision in each of our programmes of care, regional service strategies, legislative and statutory obligations and service reform that emerges as part of the transformation agenda.

⁴ Making Life Better. A Whole System Strategic Framework for Public Health. June 2014.

1.2 Recognising our Challenges

This Corporate Plan is deliberately set at high level and within the context of a **need for flexibility** to enable us to respond effectively as structural reform, transformation and public consultation progresses on key aspects of the Minister's strategic vision.

Whilst set out as a four year plan, it is anticipated that the Trust's corporate plan may need further refresh to take account of emerging changes that impact on local service provision. Delivery of our local objectives and action plans remains subject to the impact of the **following three key challenges**:

Demographic Growth



A projected increase in population of over 20% between 2016 and 2039 including more significant growth in our ageing population; and

Our local areas also saw a 17% increase in births from 2000 – 2013 compared to a regional average of 10% influencing growth in the 'younger' population

Our population has the highest levels of children with statements of educational need in Northern Ireland and migration of black minority ethnic population now accounts for 4.2% of our population compared to a regional average of 2.2%.

These key population trends suggest we will continue to see increased demand for health and social care services.

Financial Constraints



Within the current climate of no financial growth and a requirement to demonstrate efficiency in service delivery we will need to continue to make the best use of our existing resources.

This will include the need for service modernisation and redesign.

Workforce Pressures



Staff, and the extra discretionary effort they give, are critical to ensuring the right quality of care. It is our staff who ensure the delivery of high quality care 24 hours per day, 365 days per year and they are working hard to maintain and improve the quality of that care in the face of rising demand, pressure to increase efficiency and shortages of key staff across a range of professions.

These staff shortages, which exist in Health & Social Care and across the wider NHS, combined with increasing demand for our services will continue to put growing pressure on service delivery and on our staff who seek to deliver the best care they can.

1.3 Listen to and Support our staff

The Trust recognises that our most important asset in delivering improvements and service transformation is our front line staff who deliver care and support to our local communities and also those staff who support our front line services to be more effective.

2017 is our 10 year anniversary and we believe it is time to take stock and reflect on our current **Values** and ensure our organisational **Culture** aligns to our aspiration for excellence in quality, safety and service user experience to our local population.

We want to be known as an organisation where our people feel engaged, valued and supported, and are empowered to deliver excellent care and services they are proud of. To develop that culture which delivers high quality, safe, compassionate and ever improving care **we will:**



- Engage staff to **refresh and endorse our Trust Vision, Values and Objectives**, and strive to embed these and put them at the heart of all we do.
- Simplify our annual corporate plans moving to a '**plan on a page**' approach to make it easier for staff to connect with the direction of the Trust and how they contribute on a day to day basis
- Take steps to foster a more **inclusive and supportive leadership and management style** at all levels, with a strong focus on coaching, enabling and encouraging staff participation.
- Improve our **communication structures across the Trust** so that they encourage and support the sharing of ideas, information, and feedback, thereby encouraging a structured staff briefing and flow of information
- Ensure that all our staff understand how to and feel able to raise concerns through the launch of our '**See it, Say it**' campaign for raising concerns
- Reduce levels of bullying, harassment and conflict through the launch of our back to basics approach to **civility in the workplace**.
- Continue to develop our **partnership working** with Trade Union colleagues
- Continue to roll out our **customer care** training programme aligned to our core values.
- Support the health and wellbeing of our staff, enabling them to improve their lives inside and outside of work by developing and implementing our next 3 year **Health and Wellbeing Strategy for staff**
- **Recognise and celebrate** our individual, team and Trust successes, within and outside the Trust

Section 2: About the Southern Health & Social Care Trust – At a Glance

The Southern Health and Social Care Trust (Southern Trust) in Northern Ireland provides acute and community health and social care services to a population of some 373,000 adults and children living in the council area of Armagh, Banbridge, Craigavon, Dungannon, South Tyrone and Newry and Mourne.

Figure 3: Our Local Area



The Trust has an income of approximately **£576m** and employs approximately **14,000 people** to provide health and social care to our local population.

We spend almost £1.8m per day delivering care to local people

Each year across our 2 acute hospitals the Southern Trust treats:



120,000
Emergency
Department
Attendances



50,000
Inpatients



190,000
Outpatient
Appointments

Each year across the Southern Trust area we support people to remain Independent in their own homes within our community through:



6,000

people supported
by Domiciliary Care
Services in their
own Home



2,223

Residential
and Nursing
Home
placements



£1.5m

annual
expenditure
on community
equipment

Growing population and changing needs:



- Over the past 10 years, there has been a 15% increase in the number of births in the Southern Area compared to a regional increase of 8% for the same period
- Our community includes areas with high levels of children with statements of educational need.



- The Trust population is projected to increase by over 20% between 2016 & 2039 compared to the NI projected growth of 8.5%.
- European migration accounts for 4.2% of the Trust population compared to the NI average of 2.2%



- 14% of our population is over 65 years. By 2039 this is projected to grow to 60% which is higher than the NI expected growth rate of 54%
- Health inequalities need to be addressed with 23% of the Southern Trust population living in relative poverty. In line with the NI average of 22%, and being more likely to have health and social care needs.

In working together to meet these challenges and deliver improvement in service delivery we will continue to look for opportunities to reshape our services in a way that can improve patient experience and the quality of care they receive.

Section 3: Our **VISION** and **VALUES**

In developing this plan, the Trust Board and Senior Management Team reviewed the current **VISION** for the Trust to reflect what we learned in feedback from our HSC staff survey results and to ensure that in the context of the regional strategies put forward for health and social care that our existing vision is still fit for purpose in setting our clear strategic intent.

The Trust's 2015 HSC staff survey sent a message that our vision was not clear enough to all our staff.

In delivering our vision we want to be a partner in care – with our patients, families, carers and communities – to deliver the best quality health and social care to meet need.

“Improving Quality and Safety... there needs to be greater alignment between quality improvement, partnership with those who use our services and how we regulate those services”

(Health and Wellbeing 2026: Delivering Together, 2016)

Our **VISION** is simply articulated in our existing ‘strapline’ and is restated here as:

‘Quality Care – for you, with you’

Our vision encompasses our core commitment to deliver safe, high quality care that is co-produced and co-designed in partnership with service users and staff who deliver our services.

The Trust will continue over the next four years to support staff to identify how services can be improved and to enable staff to work with patients and service users to make those changes happen. The Trust has already in place a wide range of new and improved services in our community and within our hospitals to ensure we meet best practice guidelines and improve service user experience including:

- Emphasis on **early intervention and prevention methods** across a range of health and social care services in local communities including for example our continued support to the full implementation of *Healthy Child Healthy Future strategy*⁵.

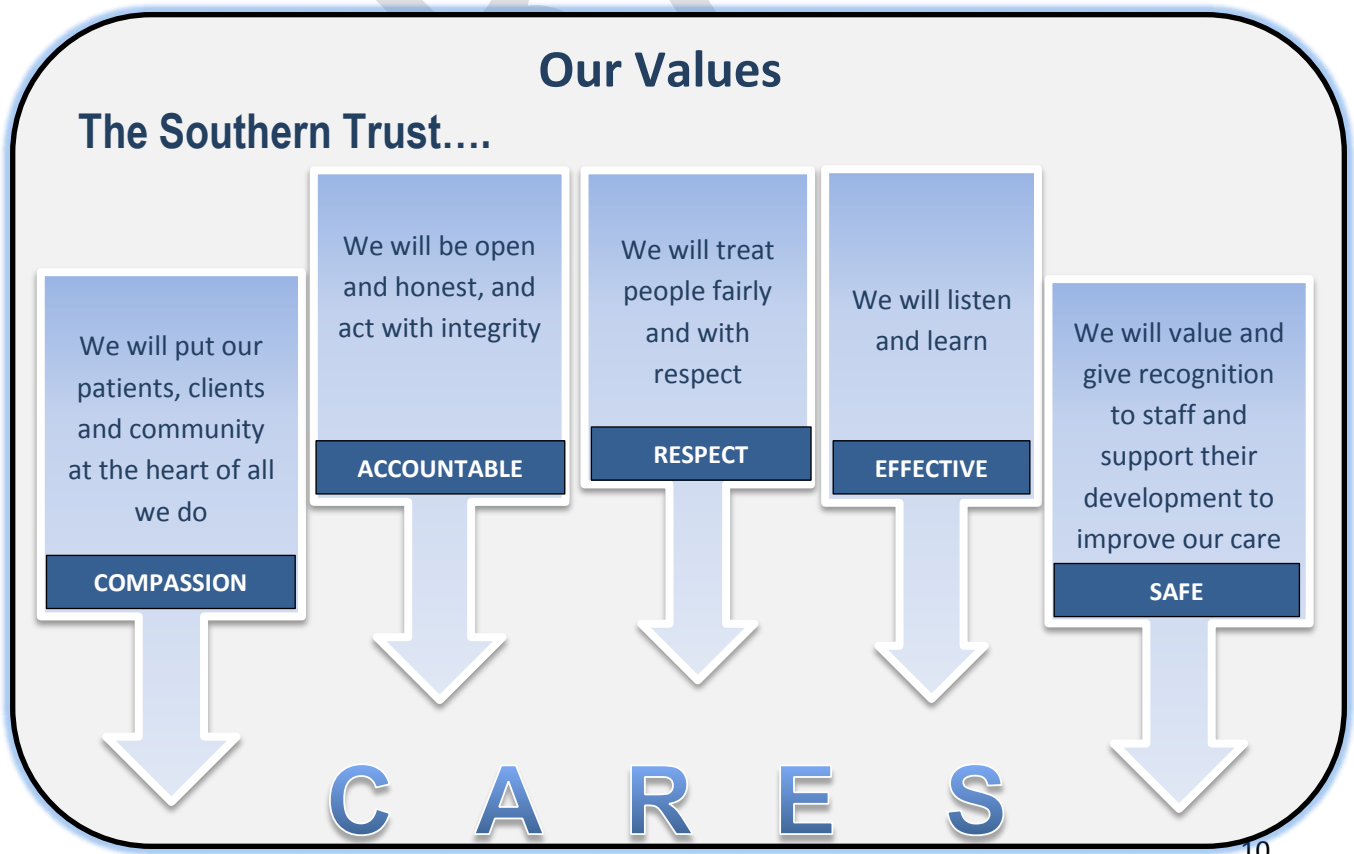
⁵ Health Child Healthy Future. A Framework for the Universal Child Health Promotion Programme in Northern Ireland. Pregnancy to 19 years. May 2010.

- Working in partnership with other providers to deliver **Alternative care pathways** to avoid the need for hospital admissions including GP Out of Hours, Acute Care at Home, and Rapid Assessment models.
- Continued implementation of improved primary and community care infrastructure including **new community care and treatment facilities** in our major towns, and
- Enhanced **hospital infrastructure** and improved access to specialist diagnostic and treatment facilities and equipment across our hospital network

Over recent years, the Trust has demonstrated consistent delivery of a balanced financial position with regard to cash release efficiency and productivity targets. At the same time, the Trust has achieved with respect to relative performance, including inclusion in the **CHKS 'Top 40' hospitals** and positive performance in terms of patient safety indicators.

The Trust acknowledges significant financial challenges facing the wider health and social care environment during the period covered in this Corporate Plan that will challenge our performance across many service areas. We are committed in the first instance to ensure we deliver high quality safe care for all our patients, clients and carers ensuring that the cost of provision does not exceed our overall funding envelope. **To do this, we need to continue to make the best use of our existing resources which will mean changes to the way we currently provide services.**

Our vision is underpinned by **our values** which shape what we do and how we do it.



Section 4: Our Strategic Priorities

Our corporate objectives reflect our priorities for the delivery of health and social care services to our local population. Achieving our objectives and delivering safe, quality care and services which are accessible and responsive to our patients and carers will remain our central focus:





Our Commitment:

- *To provide the best possible experience for all who use our services.*
- *To provide assurance to our patients and carers on the safety and quality of the services we provide.*
- *To be a learning and continually developing organisation, where professional standards, best practice and learning from experience shape how we improve our services.*

The Trust is committed to ensuring our service users receive safe, sustainable and high quality care and treatment in the most appropriate place.

Clinical & social care governance is embedded across all services and our priorities for improvement during the period of this plan are as follows:

Risk Management

- We will **monitor** and review trends to ensure we can identify risks at an early stage and put in place effective systems to mitigate risks.
- We will develop and improve our **reporting** systems to ensure that learning is identified and **actions** are taken to reduce avoidable harm and increase safety.
- We will **share our learning** to improve services within our Trust and across the wider health and social care system.

Measuring the quality of our care

- We will continue to review our **performance** against standards and identify opportunities for improvement.
- We will develop a Clinical and Social Care Governance **Audit strategy** to address key areas of patient safety and risk.
- We will continue to develop robust **corporate metrics** to monitor the quality and safety of our services.

Delivery of effective services based on evidence-based practices

- We will develop a **risk management framework** for improved governance and audit of implementation of standards and guidelines.

Improving patient and carer experience

- We will implement a corporate **Personal & Public Involvement Action Plan** working in partnership with service users and carers to capture patient experience and improve our health and care services.

- We will use patient experiences reported through formal complaints, informal feedback from our service users and compliments to gain a better understanding of the priorities and concerns of service users and to influence how we can further improve our services.
- We will identify specific areas for learning and base our improvements on the best evidence available to us.
- We will continue to develop and improve how we respond to formal complaints keeping the Northern Ireland Public Services Ombudsman's (NIPSO) Principles of Good Investigation (2009) at the centre of our investigations.
- We will contribute to the regional **Quality 2020** work stream that focuses on 'Strengthening our Responses to Adverse Incidents'. This work will support us to improve quality of our care and ensure learning from adverse incidents is shared with our service users, staff and other providers.
- We will continue to develop broader methods for capturing and using service user experiences to improve the quality of our services.
- We will develop new and improved approaches to co-production and co-design, ensuring those who use our services play a pivotal role in service improvement and transformation.





Our Commitment:

- ***The Trust is committed to promoting health and social wellbeing and reducing health inequalities to support people to live healthy lives.***
- ***We will continue to work with our statutory, community and voluntary partners to ensure effective collaborative approaches to address the needs of local communities.***

Over the next four years we will:

- Further develop opportunities to strengthen the Trust's connections to local council **Community Planning** structures and processes.
- Lead the ongoing implementation of **Smoke Free sites** for the Trust including provision of stop smoking support for staff and service users and auditing compliance across the organisation.
- Lead on the development and delivery of **health improvement action plans** to progress physical activity opportunities, nutrition and cooking skills, sexual health, home accident prevention, mental health and suicide prevention.
- Develop **Health Improvement and Community Development Action Plans** to meet the needs of vulnerable and harder to reach groups. Specific plans will be developed to meet the health and wellbeing needs of Looked After Children and Adults with a Learning Disability.
- **Increase access to cancer information** with the development of information points and further development of health and wellbeing events and services for people affected by cancer.
- Co-ordinate and deliver **Early Intervention programmes** including "Roots of Empathy" and 'Mellow Parenting' and a portfolio of parenting support programmes commissioned by the Public Health Agency and related primarily to the Delivering Social Change (DSC) Early Intervention Transformation Programme.
- Support **sustainable approaches to community development** for health and social wellbeing including delivery of Community Sector Training programme, further development of the role of and support for Community Health Champions and Trainers across the community, and implementation of Neighbourhood Renewal Health Improvement Plans in Newry, Craigavon, Lurgan, Portadown, Dungannon and Coalisland.
- Improve **access to information on a range of services and supports for older people.**
- Increase **opportunities for volunteering** across the Trust.
- Provide support to **improve the health and social wellbeing of carers.**



Our Commitment:

- ***We will publish our Quality Improvement Strategy aligned to our corporate objectives.***
- ***We will engage our service users, carers and our statutory, community and voluntary sector partners to develop quality improvement skills that will enable an equal partnership in the co-production and co-design of our services.***
- ***We will nurture a 'listen and learn' culture.***

Over the next four years we will:

- Encourage learning and provide a supportive environment where staff can thrive in leading quality improvement in the services they provide to our community.
- Continue to embed our bespoke Quality Improvement Programmes to sustain capacity & capability for improvement across all staff groups.
- Share good practice and also learn from the experiences of others on a local, national and international basis.

How will we know we have made a difference?

Through the delivery of our plans we will:

- Increase the number of staff trained in Quality Improvement methods by a further 10% above 2016/17 levels.
- Benefit from the experience of service users, carers and wider stakeholders with training in quality improvement methods to influence our improvement plans. We aim to have a minimum of 100 participants trained by 2021.
- Continue to share, sustain, spread and celebrate the success of service improvement initiatives implemented by our staff.



We will also take forward specific plans within each of our programmes of care as follows:

Children and Young People's Services

At the core of our service delivery plans will be the engagement, participation and support of children, families and carers to identify solutions and make choices in the delivery of care to best meet the needs and interests of the child.

This will be supported by appropriately trained, skilled and competent professionals and through partnership working with community and voluntary groups and other statutory agencies to ensure we optimise the best use of our resources.

Our Commitment:

- *We are committed to working in partnership to progress the ongoing development and reform of services to provide for better health and wellbeing outcomes for children.*
- *We recognise the importance of investing in preventative services and early years support to deliver longer term health and social care benefits and ensuring effective safeguarding of children in the Southern area.*
- *We want to enable children and young people to be safe and healthy and support them to learn, achieve and thrive into adulthood.*

What do we want to achieve?

- Children and young people to be given the **best start in life** so that they will have a better opportunity to achieve life and educational goals, improving outcomes for children and their families and enabling successful transition into adulthood.
- All children in need experience **stability** to help them feel safe, happy and resilient in life.



How do we plan to deliver this?

- **Provide robust, timely assessment and agree plans to meet the needs of the child/family. To achieve this, we will:**
 - Continue to support children and families through a range of screening, prevention, early intervention and safeguarding initiatives to promote safety, good health and social care and healthy behaviours.
 - Continue to strengthen the Health Visiting and School Nursing Service to fully deliver the *Healthy Child and Healthy Future Programme* and promote the health and well-being of school age children.
 - Continue to develop and improve the 'Gateway' and Family Intervention Services.

- Provide early psychological support and diagnosis for children to enhance their physical, mental and emotional wellbeing.
- Re-design and re-configure our existing services where necessary to optimise our effectiveness in care planning and delivery.
- **Provide for effective interventions and promote independence. To achieve this, we will:**
 - Work in partnership with other agencies and service providers to sustain, improve and build effective statutory family support and child protection services for children and their families.
 - Provide accessible paediatric services in the community to enable a move from delivering care for children with complex conditions outside of hospitals where appropriate.
 - Develop appropriate permanency plans and placement choices for “Looked After” children and young people and provide greater opportunities to support children to grow up in a family setting.
 - Ensure early engagement with “Looked After” young people from the age of 14 years to inform education and employment choices to improve outcomes when leaving care.
- **Provide access to a range of timely appropriate and integrated supports for children, young people and their families. To achieve this, we will:**
 - Promote greater choice and integration options for children with disabilities and their families by continuing to develop a wide continuum of services.
 - Enhance our Child & Adolescent Mental Health Services to better support specialised needs of children and adolescents with an intellectual disability.
 - Maximise effectiveness of our hospital based paediatric and neonatal services across Daisy Hill and Craigavon Area Hospital including expansion of ambulatory care models to reduce the need for children to be admitted to hospital.
- **Embrace Technology to improve sharing of information/communication across services and with service users. To achieve this, we will:**
 - Develop a Communication Strategy, to support our Integrated Care teams to utilise available technology to share information/communicate with service users and others.
 - Embrace further roll out of the Community Information System (PARIS) across children and young people services and explore mobile working solutions to improve timely communication and information sharing with other professional disciplines and service users.

How will we know we have made a difference?

Through the delivery of our plans we would aim to achieve the following outcomes:

- Increase the number of children who reach developmental milestones
- Improve school attendance and achievement
- Increase the number of children living in a stable and safe environment
- Reduce the number of children requiring teeth extraction
- Improve outcomes for looked after children
- Improve outcomes for children with autism
- Increase service user satisfaction with the services we provide



Mental Health & Disability Services

Our Commitment:

- ***We are committed to improving the health & wellbeing of people with mental health issues and/or disabilities by supporting individuals to achieve their full potential through choice, independence and care in the community.***
- ***We recognise the importance of delivering a “whole life approach” from early intervention, assessment and diagnosis through to treatment, care and support to enable individuals to live as independently as possible within the local community with a reduced reliance on hospital care.***
- ***We will involve, listen and respond to the voice of our patients and carers in co-producing how we plan and deliver our services and support them to have more choice and control in their lives, ensuring they are fully involved in decisions about their own treatment and care.***

We will continue to work in partnership with other public sector organisations, local voluntary and community providers, and our local communities to improve awareness of the supports available and provide for more responsive services in meeting the needs of our service users and carers.

What do we want to achieve?

- People and their carers and/or supporters involved in their care will have improved quality of experience.
- People will be offered services and support appropriate to meet their assessed needs.

How do we plan to achieve this?

- **Embed health improvement practices across our services. To achieve this, we will:**
 - Implement health promotion campaigns focused on increasing the uptake of annual health checks.
- **Develop and embed models of co-production and provide opportunities for people with lived experience to work in mental health and disability services. To achieve this, we will:**
 - Build on established progress in putting service users at the center of design and delivery of our services.
 - Support all people who use mental health or disability services to develop a personal care plan that focuses on the strengths of the individual, encourages participation, and promotes hope and self-determination.
 - Continue to promote the use of social, leisure, training and educational opportunities, to support social inclusion and personal recovery for people using mental health or disability services
- **Continue to lead on and implement Protect Life Strategies. To achieve this, we will:**
 - Lead the local multi-agency Protect Life Implementation Group and take forward actions from the revised Protect Life Regional Strategy aiming to reduce the number of Southern Trust residents who take their own lives.
- **Develop options for enhancing respite provision and day care opportunities. To achieve this, we will:**
 - Support individuals through the development of individual care plans and the use of self-directed support and individual budgets to enable



them to have access to a greater range of care services across a range of providers.

- Enhance the availability and flexibility of short breaks which are tailored to meet individual assessed need for people with a mental health problem or disability.
- Develop new purpose-designed facilities which will enhance environments for people with the most challenging behaviour and complex healthcare needs to attend our centres for rehabilitation and care.

- **Explore means to develop new supported accommodation options. To achieve this, we will:**

- Work with our partners to identify appropriate housing and accommodation options to enable people using our services to remain in the community and prevent the need for admission to hospital. This will include the development of options for adults who would benefit from short-term intervention in a time of crisis.

Develop options in the community for long term placements for people who have very challenging behaviours.

- **Deliver care informed by regionally agreed pathways and better integration with other services. To achieve this, we will:**

- Review, reconfigure and develop our dementia services to reflect the principles of the Regional Dementia Care Pathway to enable early screening, diagnosis and support for patients and their family/carers.
- Review, reconfigure and develop our dementia services to reflect the principles of the Regional Care Pathway to enable early screening, diagnosis and support for patients and their family/carers.
- Continue to improve our interfaces in the delivery of community and inpatient services as part of an integrated pathway to ensure more streamlined care and better outcomes for the patient.
- Working in partnership with our local GPs and the voluntary sector, to develop new ways of working in the delivery of primary care services that ensure people with mental health or disability problems receive services in the right place and at the right time and are better supported to recover.



How will we know we have made a difference?

Through the delivery of our plans we would aim to:

- Increase the number of permanent staff delivering services.
- Establish a baseline of people known to have had an annual health check
- Develop and implement an annual service user experience survey
- Demonstrate positive influence of Independent Advocacy Services on behalf of service users and carers
- Measure our ability to respond to out of hours demand to mental health and disability services including the Emergency Department
- Support all people with a mental health or disability to contribute to their personal development plan
- Increase the number of people with mental health problems involved with the Recovery College

Older People & Primary Care Services

Our Commitment:

- ***We are committed to developing capacity in our local community to enable people to live longer, healthier and more independent lives and provide them with choice in making decisions about their care and support.***
- ***We want to support a culture of self-care and self-management to promote the independence of people and to ensure that they have access to the information they need to enable them to seek appropriate advice, support and services when they need them.***
- ***We recognise that while more people are living longer, fuller lives and are able to maintain their independence, our services require a particular focus for those individuals with more complex needs requiring health and social care services.***

The Trust will be continue to work with local GPs to support the growing number of people with long-term conditions such as asthma, chronic obstructive pulmonary disease and diabetes, many of whom will require support in the on-going management and treatment of their condition.

We want to develop more alternatives to hospital care to ensure that care can be provided close to home, with patients and their families being active participants in their care including at end of life.

What do we want to achieve?

- More people supported to take actions to improve their health and wellbeing.
- Improved access to information, advice and patient education programmes to help people when they need it.
- Appropriate access to safe, effective and high quality care provided in the community and individual homes where possible.

How do we plan to achieve this?

- **Work with our statutory, voluntary and community partners to develop health & wellbeing strategies. To achieve this, we will:**
 - Work in partnership with service users and others to promote healthy lifestyles and early intervention services that optimise individuals ability to care for themselves.
 - Target areas and population groups where the need is greatest including support to carers.
 - Work with service users and others to create opportunities to increase social contact and support through the further development of care pathways.



- **Make information for the public more accessible and user friendly. To achieve this, we will:**

- Improve access to a range of information, support and advice to help older people better meet health and social care needs and ensure that older people at risk of social isolation are appropriately signposted to local support and opportunities to participate.

- **Train and up-skill staff and change roles to better support person centred care. To achieve this, we will:**
 - Ensure staff have appropriate skills to flexibly respond to the changing needs of our patients and their families
 - Provide access to training and resources for professional staff to deliver programmes, information and advice that promotes improved health and wellbeing.
 - Ensure our staff provide high quality care and advice to people, their families and carers to support their care.

- **To develop services in the community which will keep you in the community and facilitate your timely discharge from hospital when needed. To achieve this, we will:**

- Involve service users and carers in the planning, development, evaluation and delivery of services.
- Improve the range of community based support and services available to give people more choice and control about the type of care they can access.
- Provide care and support around the needs of the individual through individual care plans.
- Support the development of Integrated Care Models that join up the planning and delivery of care by primary, independent, voluntary and acute teams, particularly for frail older people and people with long-term conditions, such as diabetes, respiratory conditions and those who have had a stroke.
- Ensure that capacity is built within services to meet identified need to enable people to live independently in the community, prevent inappropriate hospital admission and assist with timely discharge from hospital services.
- Ensure that high quality care within a care home is available for all older people who require to be cared for in this environment.



- **Enhanced use of technology to improve patient care and communication. To achieve this, we will:**

- Make better use of technology to enable more people to be seen, ensuring more accessible services and better use of our resources. This will include the roll out of technology to enable staff to interface from the patient's home through virtual clinics and remote consultations and the use of the NI Electronic Care Record to improve sharing of information and communication between professionals.

- **Work with Partners to develop alternative housing options for older people. To achieve this, we will:**

- Work with the Housing Executive /Supporting People and Housing Association to complete a new Supporting People Scheme in Kilkeel.

- Continue to explore options with an appointed housing association to progress new accommodation in Dromore and Armagh.
- **We will improve sustainability within the GP Out of Hours service. To achieve this, we will:**
 - Implement actions required following the outcome of a demand and capacity modelling exercise of existing services.
 - Enhance the staff skill mix within the service.
 - Maintain open recruitment for GPs.

How will we know we have made a difference?

Through the delivery of our plans we would aim to:

- Measure the impact of service user involvement on our services.
- Establish and increase service user and carer satisfaction based on people's expectations of the service.
- Improve physical, mental and social health and wellbeing of older people who use our services.



Our Hospital Network

The Southern Trust is committed to modernisation and transformation of hospital based care to ensure our services are sustainable into the future.

This means that many services can now be provided without the need for an overnight stay and for those patients who are acutely ill and require more specialist care in a hospital we aim to deliver safe, effective and personal care.

Our Commitment:

- ***We are committed to providing safe, high quality hospital based care to meet the demands of our growing and ageing population and the increase in people living with long term conditions.***
- ***We recognise the need to further integrate our services through innovative approaches and to ensure delivery of safe, effective and personal care ensuring hospital stays are focused on promoting independence and returning individuals to their home environment as efficiently as possible.***
- ***We are committed to delivering modern and innovative approaches to hospital based care in line with prevailing best practice standards to ensure our services remain effective and sustainable into the future***

In line with the Minister's vision and the recommendations coming from the Bengoa Report 'Systems not Structures: Changing Health & Social Care' (Nov 2016) the Trust will work in partnership with our commissioners, other Trusts and providers in the regional service configuration /review process. This could mean changes in how and where we deliver both emergency and planned care services in the future.

Underpinning all our service change plans will be engagement, participation and support to service users and staff to ensure that any proposed service change is fit for purpose and achievable within our available resources.

What do we want to achieve?

- Safe, high quality hospital services.
- Improved quality of patient experience.
- Provision of evidence based care with improved patient outcomes.
- Sustainable services including effective clinical networks where appropriate.
- Best use of our resources – including workforce and infrastructure.

How do we plan to achieve this?

- **Improve the interface across primary, community and secondary care**
To achieve this, we will:
 - Enhance and expand delivery of acute outpatient services in primary and community care settings as alternative to traditional hospital outpatient consultations, where possible.
- **Improve access to senior decision making and assessment earlier in the pathway. To achieve this, we will:**
 - Continue to develop virtual clinics to enable GPs to access specialist advice avoiding the need for patients to come to hospital unnecessarily.
 - Ensure senior decision making at the earliest point for those requiring hospital based care.
- **Move from a model of 'admission' to a model of 'assessment' where appropriate. To achieve this, we will:**
 - Seek to improve our management of emergency care demand alongside delivery of planned activity and establish new ambulatory service models.
 - Further develop 'one-stop' assessment and treatment clinics, in partnership with our primary care partners to streamline patient pathways that enables patients to receive their diagnostic tests, diagnosis and clinical treatment plan on the same day, where possible reducing the need for multiple visits to hospital.
- **Explore opportunities to develop and enhance existing skills and new roles for our workforce. To achieve this, we will:**
 - Continue to provide a quality service delivered by appropriately qualified and trained clinical and support staff at all levels.
 - Engage with staff in a team based approach to grow and develop a workforce responsive to changes in care now and in the future including exploring ways to increase the supply of staff, extend existing job roles, develop new roles and new ways of working.
- **Improve the environment for staff and patients. To achieve this, we will:**
 - Bring forward plans to improve hospital infrastructure and environment to create additional capacity and improve staff and patient experiences.

- Establish a designated 'Lounge' that provides a comfortable area for those awaiting hospital discharge.
 - Consolidate implementation of our Changing for Children Strategy, enabled by the opening of new paediatric facilities at Craigavon Area and Daisy Hill Hospital sites.
 - Progress plans for the redevelopment of Craigavon Area Hospital and in the interim we will plan for shorter term solutions to optimise capacity to meet current demands for service.
- **Use of technology to improve service delivery. To achieve this, we will:**
 - Continue to develop and use technology to support the delivery of modern, accessible and safe services within all our hospitals. This will include improved use of the Northern Ireland Electronic Care Record (NIECR) and implementation of an electronic referrals system and improved use of the electronic white boards for managing patient 'flow' within the hospital system.

How will we know we have made a difference?

Through the delivery of our plans we would aim to:

- Achieve commissioned levels of activity and service targets associated with the commissioning plan direction.
- Increase service user and carer satisfaction with the services we provide
- Reduce the number of admissions to acute hospital
- Increase the number of diagnostic tests performed in line with NICE guidance
- Reduce readmission to inpatient wards
- Reduce unnecessary internal ward transfers of patients
- Reduce the vacancy and turnover rate of hospital based staff
- Maintain high performance in terms of average length of Stay
- Reduce mortality and morbidity rates
- Increase virtual and e-triage activity





Our Commitment:

- *We will develop a Workforce Strategy 2017-2021 that aligns to our Trust vision, values and corporate objectives.*
- *We will promote opportunities to listen to and engage with our staff*
- *We will promote opportunities for staff development and recognition of achievements of staff*

We recognise the need for a robust workforce strategy if we are to continue to change our ways of working and develop new models of care. A workforce strategy, in line with our future direction of travel, will ensure we can attract, recruit, develop and retain suitably skilled and experienced staff who are motivated and committed to the delivery of excellent quality services that meet the changing needs of our local population.

Through our Workforce Strategy 2017- 2021 we commit to:

- Ensuring staff are given **clear objectives** that are in line with the Trust's overarching corporate objectives and that they are clear about what we expect from them.
- Ensuring that **workforce capacity, capability and new ways of working** are in line with future service plans and with quality standards.
- Fostering the **growth and development** of staff in order to stimulate and support innovation and effective, compassionate leadership at all levels, including developing **team working** and cooperation within and across teams.
- Implementing **best practice in change management** to equip, engage and support the workforce through service transformation.
- Ensuring that excellent '**customer' care based on and what quality means to service users** ensuring the public remain central to service delivery.
- **Caring for our staff** through further collaborative working with the wider HSC family to strengthen the Trust's existing approach to staff health and wellbeing given the increasing pressures on our workforce.
- Embedding **equality and diversity** as part of our Trust 'DNA'.
- **Supporting our local communities** by promoting and offering opportunities for meaningful and last career opportunities.
- **Recognising staff for their achievements and contribution** to the work of the Trust.

Making the best use of our resources

The Trust is facing into challenging times during the period of this corporate plan.

To achieve our objectives in this context we will be required to make best use of our workforce, our financial resources and ensure we pursue opportunities that modern technology and new approaches to care offer.

Our Commitment:

- ***We are committed to ensuring our resources are used efficiently and effectively to deliver safe, high quality health and social care services.***
- ***We are committed to working with regional and local commissioners to address the demands of our growing population during a highly challenging financial climate.***
- ***We are committed to supporting service transformation and new service models that will deliver enhanced opportunities for service users/carers and our staff in the future.***

Best Use of our Workforce

The Trust recognises that our staff are our most important resource. To ensure we continue to deliver high quality, effective health and social care, the Trust will ensure we make best use of our skilled staff by implementing effective skill mix models and ensuring appropriate support staff are available to make sure that service users receive the right care by the right professional at the right time.

Utilisation of our Financial Resources.

The Financial Strategy for the Trust over the next four years is set in the context of the approach to future financial planning outlined by the Department of Health.

The Trust will aim to identify all available opportunities in seeking to manage a challenging financial position, whilst also securing delivery of reform and service transformation.

As our top priority, the Trust will seek to maintain safety, quality and performance and ensure that patients and clients are at the centre of care at all times. This includes actively influencing opportunities for system wide improvement to ensure service sustainability into the future.

Regional opportunities for service transformation will be led by the Department of Health as outlined in Health & Wellbeing 2026: Delivering Together and the Trust will work closely with Commissioners, other providers and all stakeholders to design and deliver the vision articulated by the Minister for Health and ensure alignment with the Trust's strategic vision and values for the future.

Information and Communications Technology (ICT)

ICT plays a pivotal part in achieving our Trust objectives by supporting growth in demand through modernisation of traditional practices that enables our services to be delivered efficiently and effectively by providing opportunities to increase 'remote' working and through improving access to information in acute hospitals and in community settings.

The Trust's ICT Business Plan recognises that ICT could be used extensively to enable, support and sustain change and drive efficiency through sharing clinical information digitally (Northern Ireland Electronic Care Record - NIECR) and changing the delivery of traditional services such as outpatient clinics through use of 'virtual' technology, such as 'face time' or 'skype'.

Technology also supports a culture of openness, transparency and comparability of information. The use of digital records, such as 'PARIS' Community Information System, help enable the delivery of the Trust's corporate objectives in this respect. The Trust is committed to harnessing information and new technologies to achieve higher quality care and improve outcomes for patients and service users.

At the same time the Trust is committed to the highest standards of information governance and Information Technology security when managing people's information whether this is in traditional forms or in electronic or technology based systems.

How will we know we have made a difference?

Through the delivery of our plans we would aim to:

- Optimise our skill mix across professional groups in line with best practice
- Reduce our reliance on temporary and agency staffing and increase our permanent workforce in line with funded levels
- Deliver a balanced financial position on an annual basis including delivery of any cost improvement plans agreed by the Department of Health.
- Accelerate access to mobile technology devices for staff.
- Regularly review and update our IT security to identify potential risks and mitigation actions required to protect against 'cyber- attack' and other threats.
- Take action to increase staff awareness of information governance and data security issues.



Working in Partnership

Our Commitment:

- *We are committed to ensuring meaningful involvement of our service users, carers, local communities and partners in improving the design, delivery and efficiency of our services.*
- *We will play an active role with partners in our local community planning processes.*

In working with others we will:

- **Involve and engage** patients, service users, carers and representative groups in establishing priorities and plans and supporting the evaluation of health and social care delivery to provide learning and continuous improvement of our services.
- **Extend the good work** we are already doing through our Personal and Public Involvement Panel, Carers Reference Group, Mental Health Service User Groups, Maternity Services Liaison Committee and Traveller Action Group.
- **Provide effective leadership** and support across all areas to create opportunities for the involvement of service users and carers, in identifying needs and priorities and in the design, planning, delivery and evaluation of services.
- **Support carers** to access a wider range of services, improve their health and wellbeing and access financial support.
- **Strengthen the Trust Volunteer Service** through the targeted recruitment of volunteers and the development of new roles to address a range of support needs in the community.
- **Embed community development approaches** to support local involvement and innovation in the future delivery of services including working with our partners to encourage support for a mixed economy approach to the provision of health and social care across all sectors.





- **Expand and develop opportunities for learning from our service user experiences** including ongoing participation in the '10,000 Voices' Projects to give our patients, families and carers the opportunity to share their overall experience and highlight what they liked or disliked about their experience.

- Through our membership of **Co-operation and Working Together (CAWT)** we will work with participating Trusts including the Health Service Executive in the Republic of Ireland and providers in the Scottish health service to deliver projects agreed for funding through the *Interreg V* programme during the period of this corporate plan.

Our role in local Community Planning

The Trust is committed to the overarching principles that underpin the purpose and process of community planning at a local level – including the recognition that health and social wellbeing requires collaborative approaches across sectors and settings to maximise impact for communities, particularly for those who are most disadvantaged.



We are active partners in the development of Community Plans across our 3 locally aligned council areas including:

- **Armagh City, Banbridge and Craigavon**
- **Newry, Mourne and Down, and**
- **Mid- Ulster Councils**

These Community Plans will be implemented from 1st April 2017. This will provide a process for shared ownership of and responsibility for public health and well-being, with particular reference to the Regional Framework **"Making Life Better"**. The Trust welcomes the fact that each of our councils includes a clear focus on public health and social wellbeing.

Alignment of our Corporate Plan with local community plans offers a renewed focus on partnership development, opportunities to explore synergies between different organizations and local communities, and the potential over time for sharing resources and reducing duplication of effort, while building resilience and capacity within communities for longer term gains for health and social wellbeing.

Section 5: Making our **Vision** happen

The previous sections have set out our proposed strategic direction for our services, identifying the outcomes we aim to achieve and the actions we propose to deliver on these outcomes.

We have been engaging with our staff on an ongoing basis through our corporate planning processes to inform our strategic priorities and agree how best we can deliver on these in line with **our vision** and **core values**. We will want to hear more from our staff, families, carers and our other partners to help us inform changes and improvements in service delivery in the future.

We are continuing to look at how we can further develop how services are delivered across the Trust. Some of this work will be informed by public consultations and more detailed thinking and planning will be important to ensure any changes we make deliver improved outcomes for our patients and families/carers.

We will also be continuing to review our plans in the context of wider Health and Social Care changes, including how the recommendations of the Bengoa Report are to be progressed to deliver on the radical changes proposed in the Ministers vision document set out in *Health & Wellbeing Strategy 2026- Delivering Together*.

We will be continuing to engage with staff, users, carers, staff representatives, voluntary and private providers, and local communities, the Department of Health, Health and Social Care Board, Public Health Agency, Southern Local Commissioning Group, Integrated Care Partnership, GPs and primary care providers and our local Councils. We will work in partnership with them to manage the challenges we are faced with and ensure we maximise opportunities to secure safe, high quality, effective, efficient and affordable local services.

The Trust plans to effectively communicate this plan **to our staff, patients and the wider community** using a range of methods of engagement including: -

- Senior Management Team and Trust Board Meetings
- Team Meetings with Staff
- 'Southern-i' Electronic Newsletter
- 'Global' emails to staff
- Meetings with Commissioners and Service User Groups
- Sharing electronic 'links' to documentation with local Councils and Assembly members and where appropriate meet to discuss
- Trust Internet Website
- Our Social Media sites – Twitter, Facebook

Section 6: Equality and Human Rights Considerations

Section 75 Equality Duties

The Southern Trust is committed to fulfilling its statutory equality duties as set out in Section 75 of the Northern Ireland Act 1998 (the Act) which requires public authorities, in carrying out their functions relating to Northern Ireland, to have due regard to the need to promote equality of opportunity and regard to the desirability of promoting good relations.

In carrying out our functions relating to Northern Ireland we are required to have *due regard* to the need to promote equality of opportunity between:

- persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation
- men and women generally
- persons with a disability and persons without
- persons with dependants and persons without.

In addition, without prejudice to the obligations above, in carrying out our functions in relation to Northern Ireland we are required to have *regard* to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.

In developing our Equality Scheme, the Trust fully adopted the model scheme devised by the Equality Commission for Northern Ireland – the purpose and intent of which is to set out best practice. In so doing we commit to having effective internal arrangements in place for ensuring our effective compliance with the Section 75 statutory duties and for monitoring and reviewing our progress.

We realise the important role that the community and voluntary sector and the general public have to play to ensure the Section 75 statutory duties are effectively implemented. Our Equality Scheme demonstrates how determined we are to ensure there are opportunities, for people affected by our work, to positively influence how we carry out our functions in line with our Section 75 statutory duties.

Human Rights

The Trust is also mindful of the Human Rights Act, which came into effect on 2 October 2000, makes it unlawful to act in a way which is incompatible with the European Convention on Human Rights.

Disability Duties

The Trust when carrying out its function will also pay due regard to the need to:

- promote positive attitudes toward disabled people; and
- encourage participation of disabled people in public life.

Equality Screening

In keeping with the commitments in its Equality Scheme the Trust has carried out a preliminary equality screening of its Strategic Plan the outcome of which was the decision to subject the Plan to '**on-going screening**' given its strategic nature - which is in line with the Equality Commission for NI Guidelines which state that .. *"for more detailed strategies or policies that are to be put in place, through a series of stages, a public authority should then consider screening at various times during implementation"*.

The Trust is committed to subjecting the proposals contained within its **finally agreed Plan** to further robust equality screening and fuller Equality Impact Assessment (EQIA), where necessary and appropriate, and as they further develop.

The Trust fully accepts its obligations to take appropriate steps to mitigate any adverse impacts and to consider alternative policies in furthering its section 75 statutory equality duties.

Consultation

The Trust recognises the importance of consultation and is committed to carrying out consultation in accordance with the principles contained in its Equality Scheme together with its arrangements detailed in its PPI Strategic Action Plan. It is therefore planned that there will be a full consultation process undertaken as part of any service change proposal following from this Corporate Plan in line with departmental guidance.

The Trust will take into account any views provided in relation to its Draft Corporate Plan in informing its final Plan.

Management of Change

In order to manage and mitigate any potential differential impact of any service change proposals on existing staff the Trust will adopt a project management approach. As part of this approach a project management group will include a human resources and trade union representative(s) so as to ensure robust, fair and agreed human resources processes are in place to manage any future staff changes. The Trust's Management of Change Framework is the main vehicle for effecting change within the Trust.

The Trust Equality Scheme and a copy of the Equality Screening template for this proposal are available upon request, in alternative format or in languages for those who are not fluent in English by contacting the Equality Assurance Unit as follows:

Mrs Lynda Gordon
Head of Equality Assurance Unit
Southern Health and Social Care Trust
Hill Building
St Luke's Site
Loughgall Road
Armagh
BT61 7NQ

Tel: Personal Information redacted by the USI

Email: Personal Information redacted by the USI

Section 7: Rural Proofing

The Department of Agriculture and Rural Development has published guidelines for rural proofing in the development of new policies or policy proposals. The Trust remains committed to the principles set out in these guidelines and routinely consider the impact of any of its service change proposals on staff, patients and the wider public.

The Trust's Corporate Plan for the next 4 years provides an overview of the strategic direction of the Trust. Any specific service changes proposed will be subject to a formal public consultation process which will involve a review of specific information on those areas or communities which may be impacted by the proposal. Consideration will be given to any adverse differential impact that proposals may have on people living in rural areas, how any differential impact could be addressed and the costs and benefits of doing so.

Where the outcome of equality screening necessitates the need for full Equality Impact Assessments to be undertaken for specific service change proposals, the Trust will identify any accessibility issues for staff and patients and include consideration of issues such as ease of access to services for service users and availability of transport and telecommunications infrastructures.

Section 8: **Managing, Monitoring and Adapting** our Plans

To plan over a four year period is challenging given the complexities that exist in the management and delivery of health and social care services. The Trust expects its plans to evolve as we develop and implement changes and as we adapt to changes identified through regional work being undertaken to deliver on the *Health & Wellbeing Strategy 2026*.

As we work to optimise opportunities to improve and develop our services we will continue to maintain high quality, safe care to meet identified need within the financial envelope available to us.

We will be checking our progress regularly to ensure we keep on track and consider any action required where work is not going to plan. We will be incorporating the plans in this document and reflecting any changes to these in our **Annual Service Management Plans**.

We will continue to report on performance to our Senior Management Team and Trust Board through end of year updates on progress against our Corporate Plan.

PEOPLE PLAN

2021 - 2024



Working together



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Openness & Honesty



Compassion

Our culture

Take us forward to 2025... Marie Louise Connolly is talking to a few of our people who are describing what it is like to work here and what type of organisation we are.

What would you want to hear them saying?



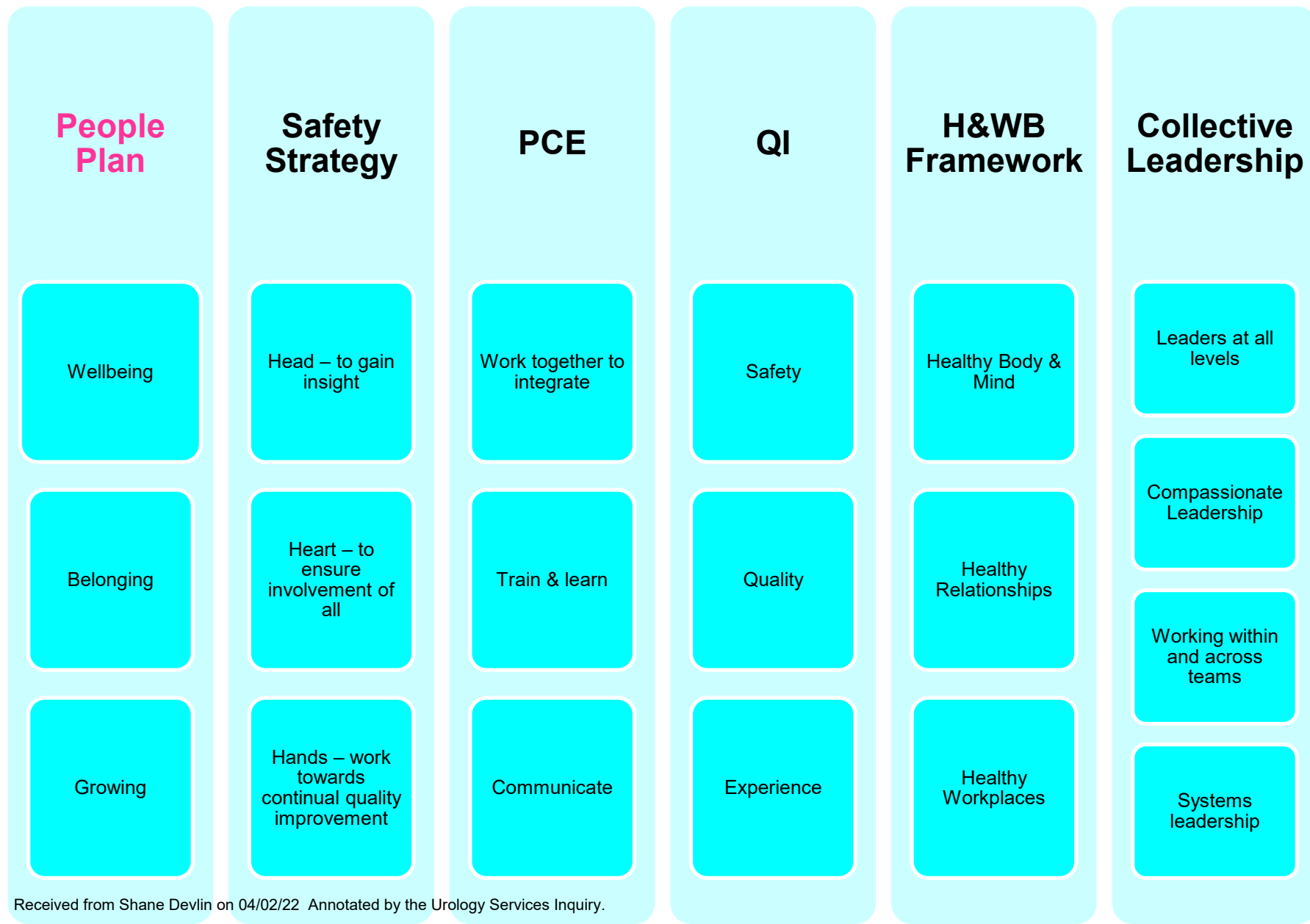


Our Culture?

A safe, high quality,
compassionate,
learning organisation



Integration of our plans.....



WHY

..... is a **People Plan** important?



What we know.....the case for

- Mike West Research
- Francis Report
- Workforce Strategy
- Collective Leadership
- Staff experience – Staff Survey, The Big Coffee Conversations, COVID19 Lessons Learned & Culture Survey
- Trust – FIT, O&G, SAIs



Employee Experience

- **Staff Survey** – Communication & Engagement / Valuing & recognising staff / Leadership / H&WB
- **Coffee Conversation** – H&WB / Relationships & Behaviours
- **COVID19 Lessons Learned** – New partnerships & teamworking / Embracing new ways of working / Communication / Supporting staff
- **Culture Survey** – Compassionate care / Teamworking & values / Vision / Quality & Innovation

WHAT...

.....are key themes you are picking up on?

.....would you like to see us paying attention to?



What we will pay attention to



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Our 3 priorities

Wellbeing

We will look after the wellbeing of our people

Belonging

Ensure people feel a sense of belonging in our Trust

Growing

Grow for our future



Wellbeing

Investing in creating a safe and healthy working environment for our people and promoting a culture of wellbeing, recognising the changing nature of work.

We care about colleagues and ourselves, listening to needs and concerns so that together we can take action to create a safe and supportive environment, that becomes the best place to work for us all.



Belonging

Ensuring our people feel a sense of belonging by being connected to, cared for by, and caring of colleagues, and to feel valued, respected and supported.

We are compassionate and inclusive, investing in our relationships and appreciating the value of good team working.



Growing

Creating the right culture and environment for our people and our organisation to learn and grow together.

We will create a learning culture that drives engagement, improvement and innovation whilst inspiring, attracting and retaining the best talent.



What we will get



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Compassion

3 Outcomes

What we will get:

1. We have a safe and healthy workforce
2. We have a workforce that feels connected, cared for, valued, respected and included
3. We have a reputation as an employer that supports people to thrive and be their best in order to provide the support and care to our population

* *All 3 priorities are interconnected & need to be addressed to achieve these outcomes*



How will we know?

WIT-01581

Safe and healthy workforce

- Sickness absence
- CMT compliance
- No of OH referrals
- Staff Survey

Workforce that feels connected, cared for, valued, respected and included

- Culture Assessment
- Staff engagement scores
- HR metrics
- Appraisal compliance

Reputation as an employer that supports our people to thrive & be their best

- Agency usage
- Turnover rates
- Vacancy rate
- Sickness absence figs
- Training activity



What we will do to make this happen



Wellbeing – to achieve this we will focus on:

- Supporting staff to seek help and develop their skills in compassionate self care and other personal coping mechanisms
- Supporting and developing the capacity and capability of our managers to ensure their approach has a positive impact on the experience and wellbeing of their staff and themselves
- Promoting and nurturing a culture of compassionate leadership and teamwork as a way of ensuring our people feel cared for and supported
- Taking all necessary measures and efforts required to keep our people safe and well
- Continuing to promote, protect, and improve the health and wellbeing of our people
- Creating a safe, healthy and engaging workplace and environment to ensure the best possible experience for everyone

Belonging – to achieve this we will focus on:

- Ensuring a inclusive and diverse workforce
- Living our values and demonstrating associated behaviours
- Supporting development of teams where everyone can get involved, contribute and make a difference
- Recognising and appreciating our people for the work that they do and the contribution they make
- Taking time for sharing, laughter and chat
- Creating networks and communities that develop strong trusting relationships
- Nurturing a culture of collective leadership where everyone in the organisation recognises their role as a leader
- Ensuring everyone understands our vision and the future direction of our Trust

Growing — to achieve this we will focus on:

- Taking time out to reflect, learn, create and innovate
- Inspiring, attracting and recruiting our future workforce to improve staffing levels
- Retaining our people by developing and training them so they can be the best they can be and fulfil their potential
- Embracing new ways of working including the use of technology, automation, and digital transformation
- Supporting innovation and development of new ideas by everyone to improve the safety and quality of our services
- Creating a coaching culture which supports the wellbeing, development and career progression of our people
- Developing our 'SQE South' culture through our relentless focus on the safety, quality and experience for our staff, patients and service users
- Creating a culture of openness and candour to ensure the safety of care and practice

HOW?

..... do we bring it to life?

..... do we get our formal leaders on board?

“what we focus on develops and grows and what we ignore withers and dies...”



Myron's maxims

1. People own what they help create
2. Real change happens in real work
3. Those who do the work do the change
4. Connect the system to more of itself
5. Start anywhere follow it anywhere
6. The process you use to get to the future is the future you get



Thank You!





Southern Health
and Social Care Trust

Quality Care - for you, with you



PEOPLE PLAN 2021 - 2024



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Compassion

WHY

..... is a



important?



What we know.....the case for

- ‘..cultures of engagement, positivity, caring, compassion and respect for all – staff, patients and the public - provide the ideal environment within which to care for the health of the nation. When we care for staff, they can fulfil their calling of providing outstanding professional care for patients.’

Prof Mike West



- **Francis Inquiry (2013)** - openness, transparency and candour & improved **support for compassionate, caring and committed care** and stronger health care leadership.
- **Berwick Report** – Recommendation 6: “The NHS should become a **learning organisation**. Its leaders should create and support the capability for learning, and therefore change, at scale within the NHS”.
- **H&WB Delivering Together 2026**: “We will be an **employer of choice**, leading by example and investing in the wellbeing of staff” “We must **invest in our staff and provide the environment to allow them to do what they do best** – provide excellent high quality care”

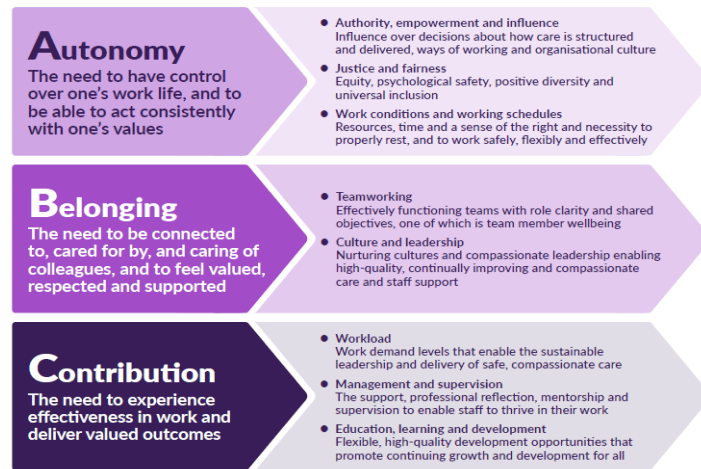


- **Workforce Strategy: Delivering For Our People:** The **workforce is the most valuable asset.....** in social care, and can, at its best, be at the forefront of empowering people's independence and choice and improving their social inclusion, participation and social wellbeing. Delivering this vision requires a confident, capable and well-trained workforce."
- **Collective Leadership Strategy** – Creating a culture where people high quality, compassionate care and support. **Compassionate leadership.....**leadership is responsibility of all.....shared leadership within and across **teams...**



• The Courage of compassion: supporting nurses and midwives to deliver high quality care

Figure 1: The ABC framework of nurses' and midwives' core work needs



- **Covid-19: why compassionate leadership matters in a crisis** *Connection and compassion are certain, unchanging and provide a safe refuge in the face of this onslaught on health and care systems and our wider communities. Compassionate leadership is the most potent way people can deal with what feels frightening and overwhelming and leaders need to focus compassion on all those who provide health and care services whatever their role or grade. (Kings Fund:, Bailey and West)*

● NHS People Plan – focuses on

- Looking after our people
- Belonging in the NHS
- New ways of working and delivering care
- Growing for our future



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Compassion

WHAT should be the focus of our people plan?

WIT-01596

....what are key themes you are picking up on?

.....what should we be paying attention to?



Staff experience

- **Staff Survey** – Communication & Engagement / Valuing & recognising staff / Leadership / H&WB
- **Coffee Conversations** – H&WB / Relationships & Behaviours
- **COVID19 Lessons Learned** – New partnerships & teamworking / Embracing new ways of working / Communication / Supporting staff
- **Culture Survey** – Compassionate care / Teamworking & values / Vision / Quality & Innovation

The Big Ideas....

"Respectful and honest communication"

"To have someone that you could go to if you had a problem and needed to talk"

"A 'well done!' for a job well done"

"People to be more kind to you and give you a smile"

"Good attendance and good time keeping acknowledged"

"Protected time for team engagement"

"Encourage staff to enjoy health and wellbeing activity once per week during work- time to stop thinking of work"

"Keep good existing agency staff and explore their qualities and skills"

"Respect your colleagues"



It was really good to know that someone cared about us, and they really cared. You could see that straight away and the fact that they were there from the start made a difference. They came to us; we didn't have to look for them. They were always there.

At the start, I thought well this is good. They are here to help us get through to management'. I know they tried to say what it was like for us and what needed to be changed. Unfortunately, they weren't able to get the message through to the managers for us. Things didn't change or it took so long to get things changed the problems didn't change.



- FIT – Anon Whistleblowing Letter – keeping safe at work, H&WB, resilience, staff support, communication, staffing levels.....
- Estates
- Obs & Gyne
- Granville
- Microbiology
- SAI – ED case



What we will pay attention to



Our 3 priorities

Wellbeing

We will look after the wellbeing of our people

Belonging

Ensure people feel a sense of belonging in our Trust

Growing

Grow for our future



Wellbeing

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Growing

Creating the right culture and safe space for our people and our organisation to learn and grow together.

We will create a learning culture that drives engagement, improvement and innovation whilst inspiring, attracting and retaining the best talent.



So is our culture...?

A organisation that is **learning and continually improving** and where people feel **safe and supported** and **connected and cared for**.



Culture.....

I urge you to focus on the culture that you want to nurture: buoyant, curious, sharing, open-minded, and ambitious to do even better for patients, carers, communities, and staff pride and joy.

Berwick 2013



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Openness & Honesty



Compassion

Our culture

Take us forward to 2025... Marie Louise Connolly is talking to a few of our people who are describing what it is like to work here and what type of organisation we are.

What would you want to hear them saying?





Our culture? What is it? How do we describe it?

WIT-01610

A safe, high quality,
compassionate,
learning organisation

Consider.....does this describe what it feels like to work here or be treated here?



What we will get



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Compassion

3 Outcomes

What we will get:

1. We have a safe and healthy workforce
2. We have a workforce that feels connected, cared for, valued, respected and included
3. We have a reputation as an employer that people are proud to work, supporting them to thrive and be their best in order to support and care for our population

* *All 3 priorities are interconnected & need to be addressed to achieve these outcomes*



How will we know?

Safe and healthy workforce

- Staff staffing **WIT-01613**
- Sickness absence
- CMT compliance
- No of OH referrals
- Staff Survey

Workforce that feels connected, cared for, valued, respected and included

- Culture Assessment
- Staff engagement scores
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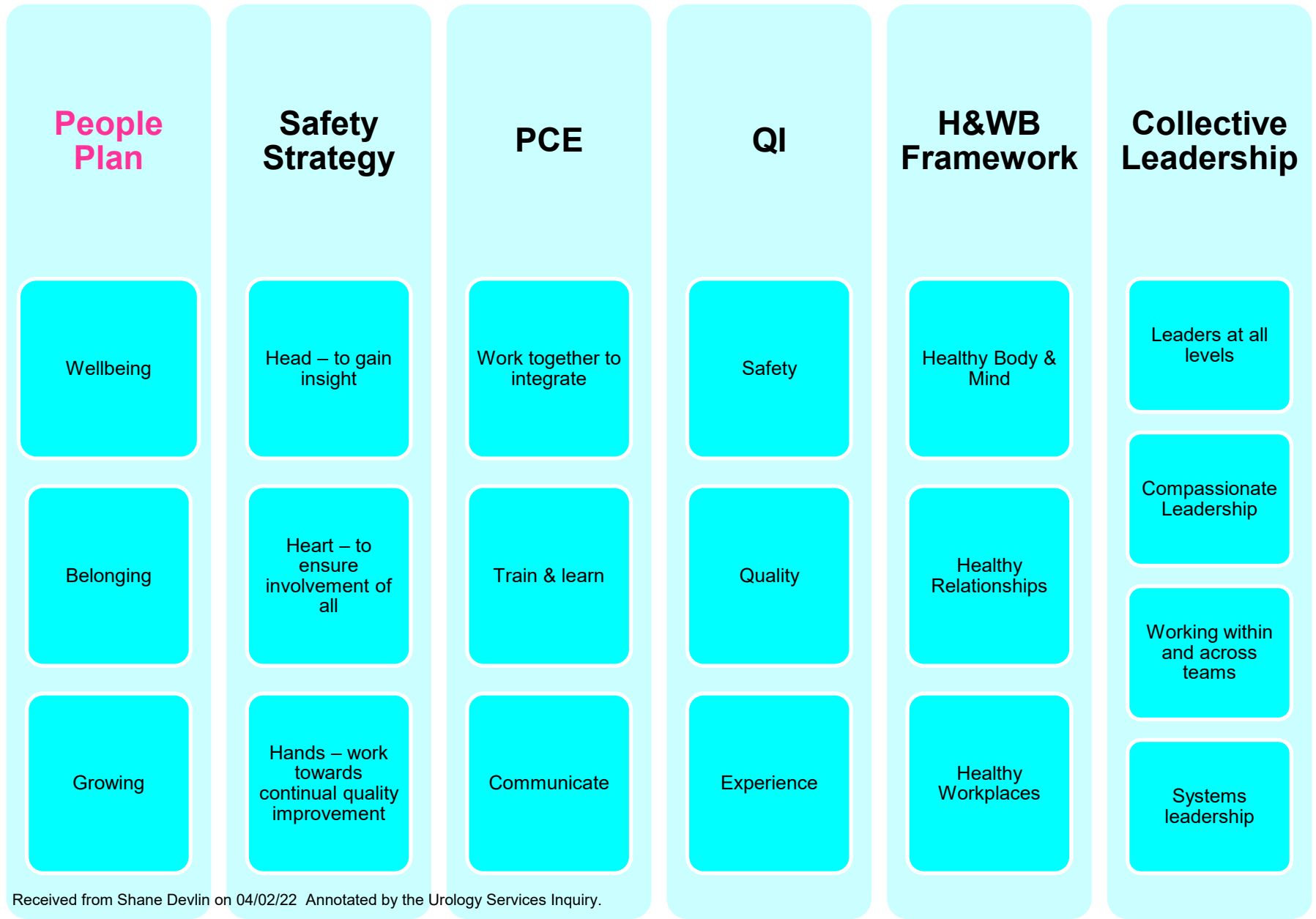
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Integration of our plans/strategies.....



Myron's maxims

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Thank You!





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WHY?



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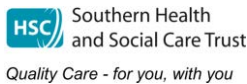


Working together Excellence Openness & Honesty Compassion

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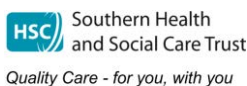
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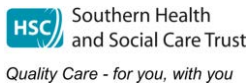
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- Looking after our people
- Belonging in the NHS
- New ways of working and delivering care
- Growing for our future



Culture

Organisational culture is 'how we do things round here'.

*It represents **the collective values and beliefs of the people who work in the organisation** and is influenced by its history, its primary task, key individuals, management strategy, external constraints and circumstances*



Culture.....

I urge you to focus on the culture that you want to nurture: buoyant, curious, sharing, open-minded, and ambitious to do even better for patients, carers, communities, and staff pride and joy.

Berwick 2013



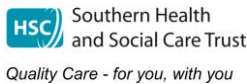
Our culture

Breakout Session

Take us forward to 2025... Marie Louise Connolly is talking to a few of our people who are describing what it is like to work here and what type of organisation we are.

What would you want to hear them saying?

What is the desired culture we want to create?



Staff experience – what they have told us....

- **Staff Survey – Mar / Apr 2019**
- **The ‘Big Coffee Conversations’ – Feb / Mar 2020**
- **COVID19 Lessons Learned – Jun – Aug 2020**
- **Culture Assessment Survey (CAT) – Oct / Nov 2020**

Regional HSC Staff Survey : March / April 2019	
What is working well ?	What do we need to focus on ?
Managers – supporting staff and encouraging team work. Engaging in and helping with difficult tasks	Staff Involvement & communication – need to involve staff in changes & improvements that affect them & update them on patient/service user feedback.
Health & Wellbeing - positive action being taken. Reduction in additional paid & unpaid hours, helping to achieve an more equitable work / home life balance	Recognition & Appreciation – staff want appropriate recognition, praise and to feel valued at work
Raising Concerns – staff are becoming increasingly secure & confident to raise concerns and are being encouraged to do so. Increasing awareness amongst staff of the responsibility to raise concerns	Senior Managers – managers need to improve the communications and engagement with staff to inform decision making and act on staff feedback
Training, Learning & Development – high levels received in last 12 mths which helps to do job more effectively and remain up to date with professional standards and requirements	Health & Wellbeing – address the increasing levels of musculoskeletal problems & work related stress
Performance Appraisals – high levels received in last 12 mths, helping to improve the job and staff feeling valued in the organisation	Violence, Harassment, Bullying & Abuse – Increasing experience of this from both patients/service users, relatives/public and managers/team leaders/colleagues

Coffee Conversations : Feb / March 2020
What do we need to focus on ?
Health & Wellbeing – individual and team support & initiatives, managers leading by example, create a culture of openness and support, health & wellbeing toolkit, support for aging workforce, adequate workforce to manage workloads
Leadership – role modelling values and behaviours, embed culture of collective leadership, improved communication & feedback, visibility of senior leaders, building relationships and trust
Recognising & Valuing our staff – be kind and show respect; recognise staff formally and informally ‘thank you’ ‘well done’, flexibility and discretion in decision making
Communication & Engagement – improved face to face communication between managers and staff, better use of technology, create psychological safety – openness to feedback and really listen to staff at all levels.
3 Areas of Focus in CAGPTW initiative : Health & Wellbeing / Behaviours / Relationships

The Big Ideas....

"Respectful and honest communication"

"To have someone that you could go to if you had a problem and needed to talk"

"A 'well done!' for a job well done"

"People to be more kind to you and give you a smile"

"Good attendance and good time keeping acknowledged"

"Protected time for team engagement"

"Less emails"

"Encourage staff to enjoy health and wellbeing activity once per week during work- time to stop thinking of work"

"Keep good existing agency staff and explore their qualities and skills"

"Respect your colleagues"

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



COVID-19 Lessons Learned : June / August 2020

What is working well ?	What do we need to focus on ?
New Partnerships & Team Working – more collaborative working across organisational boundaries, providing a real sense of 'we're in this together' and a willingness from everyone to go 'the extra mile'	Supporting Staff – staff concerned about 'burn-out' and indicated that they were unhappy with the working conditions (e.g. social distancing & PPE). Some felt isolated and unsupported.
Embracing New Ways of Working – staff embraced new ways of working, utilising working and meeting virtually therefore increasing productivity and reducing time spent travelling	Communication – staff indicated that at times they felt key information and regular updates were not reaching them and there were mixed messages and a lack of clear instruction
Digital Technology – enabled remote working, allowing for social distancing & childcare needs of staff to be supported	Leadership & Management – staff felt there had been a lack of direction & leadership and that leaders need to be more visible to staff

It was really good to know that someone cared about us, and they really cared. You could see that straight away and the fact that they were there from the start made a difference. They came to us; we didn't have to look for them. They were always there.

At the start, I thought well this is good. They are here to help us get through to management'. I know they tried to say what it was like for us and what needed to be changed. Unfortunately, they weren't able to get the message through to the managers for us. Things didn't change or it took so long to get things changed the problems didn't change.



Southern Health and Social Care Trust
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Working together



Excellence



Openness & Honesty



Compassion

Cultural Assessment Survey : Oct / Nov 2020	
What is working well ?	What do we need to focus on ?
Compassionate Care – belief that patients and service users are treated with compassion in order to implement effective, helpful actions.	Vision – how well the vision and future direction of the organisation are communicated and understood, providing clarity and a valued sense of
Team Working & Values – extent of authentic team-based working in the Trust both within and across teams. ??.	Quality & Innovation – the extent to which the Trust's culture promotes a focus on continually improving, high quality care and services, through support for innovation at all levels with a rapid response to changing circumstances
Goals & Performance – having clear, agreed, challenging objectives, ensuring the work is aligned to the vision and values of the organisation to provide effective performance management.	Collective Leadership – across different staff levels and service areas. Leaders promote leadership by all, irrespective of position, there is shared leadership in teams and leaders work together to priorities patient care and not just the success of their own immediate area.

- FIT – Anon Whistleblowing Letter – keeping safe at work, H&WB, resilience, staff support, communication, staffing levels.....
- Estates
- Obs & Gynae
- Granville
- Microbiology
- SAI – ED case

What we will pay attention to...

What we will get...

What we will do to make this happen...

Our 3 priorities

Wellbeing

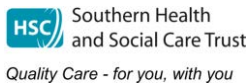
We will look after the wellbeing of our people

Belonging

Ensure people feel a sense of belonging in our Trust

Growing

Grow for our future



Wellbeing

Investing in creating a safe and healthy working environment for us all and promoting a culture of wellbeing, recognising the changing nature of work.

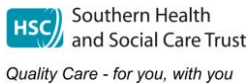
Through our behaviours we show we care about colleagues and ourselves, listening to needs and concerns so that together we can take action to create a safe and supportive environment, that becomes the best place to work for us all.



Belonging

Ensuring we all feel a sense of belonging by being connected to the core purpose of our organisation, each of us feeling valued, cared for, respected and supported.

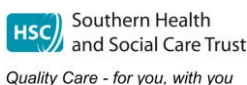
We are compassionate and inclusive, investing in our relationships with colleagues and appreciating the value of good team working.



Growing

Creating the right culture and safe space for us to learn and grow together.

We will create a learning culture that drives engagement, improvement and innovation whilst inspiring, attracting and retaining the best talent.



3 Outcomes

What we will get:

1. We have a safe and healthier workforce
2. We have a workforce that feels connected, cared for, valued, respected and included
3. We have a reputation as a employer that people are proud to work, supporting them to thrive and be their best in order to support and care for our population

* All 3 priorities are interconnected & need to be addressed to achieve these outcomes

HSC Southern Health
and Social Care Trust

Quality Care - for you, with you



How will we know?



HSC Southern Health
and Social Care Trust

Quality Care - for you, with you



Wellbeing – to achieve this we will focus on:

- Supporting staff to seek help and develop their skills in compassionate self care and other personal coping mechanisms
- Supporting and developing the capacity and capability of our managers to ensure their approach has a positive impact on the experience and wellbeing of their staff and themselves
- Promoting and nurturing a culture of compassionate leadership and teamwork as a way of ensuring our people feel cared for and supported
- Taking all necessary measures and efforts required to keep our people safe and well
- Continuing to promote, protect, and improve the health and wellbeing of our people
- Creating a safe, healthy and engaging workplace and environment to ensure the best possible experience for everyone

Belonging – to achieve this we will focus on:

- Ensuring a inclusive and diverse workforce
- Living our values and demonstrating associated behaviours
- Supporting development of teams where everyone can get involved, contribute and make a difference
- Recognising and appreciating our people for the work that they do and the contribution they make
- Taking time for sharing, laughter and chat
- Creating networks and communities that develop strong trusting relationships
- Nurturing a culture of collective leadership where everyone in the organisation recognises their role as a leader
- Ensuring everyone understands our vision and the future direction of our Trust

Growing – to achieve this we will focus on:

- Retaining our people by developing and training them so they can be the best they can be and fulfil their potential
- Inspiring, attracting and recruiting our future workforce to improve staffing levels
- Creating a culture of openness and candour to ensure the safety of care and practice
- Embracing new ways of working including the use of technology, automation, and digital transformation
- Supporting innovation and development of new ideas by everyone to improve the safety and quality of our services
- Taking time out to reflect, learn, create and innovate
- Creating a coaching culture which supports the wellbeing, development and career progression of our people
- Developing our 'SQE South' culture through our relentless focus on the safety, quality and experience for our staff, patients and service users

Our People Priorities

**Breakout
Session**

Discuss in groups:

What are your thoughts on these 3 priorities?

Will they help us create the desired culture?

Myron's maxims

1. People own what they help create
2. Real change happens in real work
3. Those who do the work do the change
4. Connect the system to more of itself
5. Start anywhere follow it anywhere
6. The process you use to get to the future is the future you get

Thank You!





Southern Health
and Social Care Trust

Quality Care - for you, with you



PEOPLE PLAN 2021 - 2024



Working together



Excellence



Openness & Honesty



Compassion

WHY?



What we know.....the case for

- ‘..cultures of engagement, positivity, caring, compassion and respect for all – staff, patients and the public - provide the ideal environment within which to care for the health of the nation. When we care for staff, they can fulfil their calling of providing outstanding professional care for patients.’

Prof Mike West



- **Francis Inquiry (2013)** - openness, transparency and candour & improved **support for compassionate, caring and committed care** and stronger health care leadership.
- **Berwick Report** – Recommendation 6: “The NHS should become a **learning organisation**. Its leaders should create and support the capability for learning, and therefore change, at scale within the NHS”.
- **H&WB Delivering Together 2026**: “We will be an **employer of choice**, leading by example and investing in the wellbeing of staff” “We must **invest in our staff and provide the environment to allow them to do what they do best** – provide excellent high quality care”

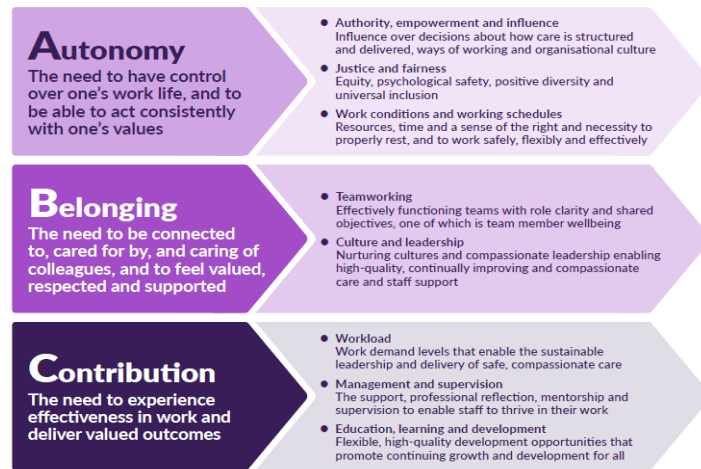


- **Workforce Strategy: Delivering For Our People:** The **workforce is the most valuable asset.....** in social care, and can, at its best, be at the forefront of empowering people's independence and choice and improving their social inclusion, participation and social wellbeing. Delivering this vision requires a confident, capable and well-trained workforce."
- **Collective Leadership Strategy** – Creating a culture where people deliver high quality, compassionate care and support. **Compassionate leadership.....**leadership is responsibility of all.....shared leadership within and across **teams...**



• The Courage of compassion: supporting nurses and midwives to deliver high quality care

Figure 1: The ABC framework of nurses' and midwives' core work needs



- **Covid-19: why compassionate leadership matters in a crisis** *Connection and compassion are certain, unchanging and provide a safe refuge in the face of this onslaught on health and care systems and our wider communities. Compassionate leadership is the most potent way people can deal with what feels frightening and overwhelming and leaders need to focus compassion on all those who provide health and care services whatever their role or grade. (Kings Fund:, Bailey and West)*

- **NHS People Plan – focuses on**

- Looking after our people
- Belonging in the NHS
- New ways of working and delivering care
- Growing for our future



Culture

Organisational culture is 'how we do things round here'.

*It represents **the collective values and beliefs of the people who work in the organisation** and is influenced by its history, its primary task, key individuals, management strategy, external constraints and circumstances*



Culture.....

I urge you to focus on the culture that you want to nurture: buoyant, curious, sharing, open-minded, and ambitious to do even better for patients, carers, communities, and staff pride and joy.

Berwick 2013



Working together



Excellence



Openness & Honesty



Compassion



Staff experience – what they have told us....

WIT-01648

- **Staff Survey – Mar / Apr 2019**
- **The ‘Big Coffee Conversations’ – Feb / Mar 2020**
- **COVID19 Lessons Learned – Jun – Aug 2020**
- **Culture Assessment Survey (CAT) – Oct / Nov 2020**

What is working well ?	What do we need to focus on ?
Managers – supporting staff and encouraging team work. Engaging in and helping with difficult tasks	Staff Involvement & communication – need to involve staff in changes & improvements that affect them & update them on patient/service user feedback.
Health & Wellbeing - positive action being taken. Reduction in additional paid & unpaid hours, helping to achieve an more equitable work / home life balance	Recognition & Appreciation – staff want appropriate recognition, praise and to feel valued at work
Raising Concerns – staff are becoming increasingly secure & confident to raise concerns and are being encouraged to do so. Increasing awareness amongst staff of the responsibility to raise concerns	Senior Managers – managers need to improve the communications and engagement with staff to inform decision making and act on staff feedback
Training, Learning & Development – high levels received in last 12 mths which helps to do job more effectively and remain up to date with professional standards and requirements	Health & Wellbeing – address the increasing levels of musculoskeletal problems & work related stress
Performance Appraisals – high levels received in last 12 mths, helping to improve the job and staff feeling valued in the organisation	Violence, Harassment, Bullying & Abuse – Increasing experience of this from both patients/service users, relatives/public and managers/team leaders/colleagues

What do we need to focus on ?

Health & Wellbeing – individual and team support & initiatives, managers leading by example, create a culture of openness and support, health & wellbeing toolkit, support for aging workforce, adequate workforce to manage workloads

Leadership – role modelling values and behaviours, embed culture of collective leadership, improved communication & feedback, visibility of senior leaders, building relationships and trust

Recognising & Valuing our staff – be kind and show respect; recognise staff formally and informally ‘thank you’ ‘well done’, flexibility and discretion in decision making

Communication & Engagement – improved face to face communication between managers and staff, better use of technology, create psychological safety – openness to feedback and really listen to staff at all levels.

3 Areas of Focus in CAGPTW initiative :

Health & Wellbeing / Behaviours / Relationships

The Big Ideas....

"Respectful and honest communication"

"To have someone that you could go to if you had a problem and needed to talk"

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What is working well ?

New Partnerships & Team Working – more collaborative working across organisational boundaries, providing a real sense of ‘we’re in this together’ and a willingness from everyone to go ‘the extra mile’

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Digital Technology – enabled remote working, allowing for social distancing & childcare needs of staff to be supported

What do we need to focus on ?

Supporting Staff – staff concerned about ‘burn-out’ and indicated that they were unhappy with the working conditions (e.g. social distancing & PPE). Some felt isolated and unsupported.

Communication – staff indicated that at times they felt key information and regular updates were not reaching them and there were mixed messages and a lack of clear instruction

Leadership & Management – staff felt there had been a lack of direction & leadership and that leaders need to be more visible to staff

It was really good to know that someone cared about us, and they really cared. You could see that straight away and the fact that they were there from the start made a difference. They came to us; we didn't have to look for them. They were always there.

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What is working well ?

Compassionate Care – belief that patients and service users are treated with compassion in order to implement effective, helpful actions.

Team Working & Values – extent of authentic team-based working in the Trust both within and across teams. ??.

Goals & Performance – having clear, agreed, challenging objectives, ensuring the work is aligned to the vision and values of the organisation to provide effective performance management.

What do we need to focus on ?

Vision – how well the vision and future direction of the organisation are communicated and understood, providing clarity and a valued sense of

Quality & Innovation – the extent to which the Trust's culture promotes a focus on continually improving, high quality care and services, through support for innovation at all levels with a rapid response to changing circumstances

Collective Leadership – across different staff levels and service areas. Leaders promote leadership by all, irrespective of position, there is shared leadership in teams and leaders work together to priorities patient care and not just the success of their own immediate area.

- FIT – Anon Whistleblowing Letter – keeping safe at work, H&WB, resilience, staff support, communication, staffing levels.....
- Estates
- Obs & Gynae
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- Microbiology
- SAI – ED case



What we will pay attention to...

What we will get...

What we will do to make this happen...



Our 3 priorities

Wellbeing

We will look after the wellbeing of our people

Belonging

Ensure people feel a sense of belonging in our Trust

Growing

Grow for our future



Wellbeing

Investing in creating a safe and healthy working environment for us all and promoting a culture of wellbeing, recognising the changing nature of work.

Through our behaviours we show we care about colleagues and ourselves, listening to needs and concerns so that together we can take action to create a safe and supportive environment, that becomes the best place to work for us all.



Belonging

Ensuring we all feel a sense of belonging by being connected to the core purpose of our organisation, each of us feeling valued, cared for, respected and supported.

We are compassionate and inclusive, investing in our relationships with colleagues and appreciating the value of good team working.



Growing

Creating the right culture and safe space for us to learn and grow together.

We will create a learning culture that drives engagement, improvement and innovation whilst inspiring, attracting and retaining the best talent.



3 Outcomes

What we will get:

1. We have a safe and healthier workforce
2. We have a workforce that feels connected, cared for, valued, respected and included
3. We have a reputation as an employer that people are proud to work, supporting them to thrive and be their best in order to support and care for our population

* *All 3 priorities are interconnected & need to be addressed to achieve these outcomes*



How will we know?

Safe and healthy workforce

- Safe staffing **WIT-01662**
- Sickness absence
- CMT compliance
- No of OH referrals
- Staff Survey

Workforce that feels connected, cared for, valued, respected and included

- Culture Assessment
- Staff engagement scores
- HR metrics
- Appraisal compliance

Reputation as an employer that supports our people to thrive & be their best

- Agency usage
- Turnover rates
- Vacancy rate
- Sickness absence figs
- Training activity



Wellbeing – to achieve this we will focus on:

- Supporting staff to seek help and develop their skills in compassionate self care and other personal coping mechanisms
- Supporting and developing the capacity and capability of our managers to ensure their approach has a positive impact on the experience and wellbeing of their staff and themselves
- Promoting and nurturing a culture of compassionate leadership and teamwork as a way of ensuring our people feel cared for and supported
- Taking all necessary measures and efforts required to keep our people safe and well
- Continuing to promote, protect, and improve the health and wellbeing of our people
- Creating a safe, healthy and engaging workplace and environment to ensure the best possible experience for everyone

Belonging – to achieve this we will focus on:

- Ensuring a inclusive and diverse workforce
- Living our values and demonstrating associated behaviours
- Supporting development of teams where everyone can get involved, contribute and make a difference
- Recognising and appreciating our people for the work that they do and the contribution they make
- Taking time for sharing, laughter and chat
- Creating networks and communities that develop strong trusting relationships
- Nurturing a culture of collective leadership where everyone in the organisation recognises their role as a leader
- Ensuring everyone understands our vision and the future direction of our Trust

Growing — to achieve this we will focus on:

- Retaining our people by developing and training them so they can be the best they can be and fulfil their potential
- Inspiring, attracting and recruiting our future workforce to improve staffing levels
- Creating a culture of openness and candour to ensure the safety of care and practice
- Embracing new ways of working including the use of technology, automation, and digital transformation
- Supporting innovation and development of new ideas by everyone to improve the safety and quality of our services
- Taking time out to reflect, learn, create and innovate
- Creating a coaching culture which supports the wellbeing, development and career progression of our people
- Developing our 'SQE South' culture through our relentless focus on the safety, quality and experience for our staff, patients and service users

Thank You!





Our People 2021-2024

A framework for
transforming our workplace...transforming our care



‘..cultures of engagement, positivity, caring, compassion and respect for all – staff, patients and the public - provide the ideal environment within which to care for the health of the nation. **When we care for staff, they can fulfil their calling of providing outstanding professional care for patients.**’

Prof Mike West



WHY?



What we know.....a reminder of the case for



- **Francis Inquiry (2013)** - openness, transparency and candour & improved **support for compassionate, caring and committed care** and stronger health care leadership.
- **Berwick Report (2013)** – Recommendation 6: “The NHS should become a **learning organisation**. Its leaders should create and support the capability for learning, and therefore change, at scale within the NHS”.
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- HSC Workforce Strategy 2026: Delivering For Our People (2018):** The **workforce is the most valuable asset**..... in social care, and can, at its best, be at the forefront of empowering people's independence and choice and improving their social inclusion, participation and social wellbeing. Delivering this vision requires a confident, capable and well-trained workforce."
- Collective Leadership Strategy (2017)** – Creating a culture where people deliver high quality, compassionate care and support. **Compassionate leadership**.....leadership is responsibility of all.....shared leadership within and across **teams**...



- **The Courage of compassion: supporting nurses and midwives to deliver high quality care (2020)** - The ABC Framework of nurses' and midwives core work needs: **Autonomy, Belonging & Contribution**
- **Covid-19: why compassionate leadership matters in a crisis (2020)** *Connection and compassion are certain, unchanging and provide a safe refuge in the face of this onslaught on health and care systems and our wider communities. **Compassionate leadership is the most potent way people can deal with what feels frightening and overwhelming** and leaders need to focus compassion on all those who provide health and care services whatever their role or grade. (Kings Fund:, Bailey and West)*

Our people priorities

- This document will set out what our people can expect – from their formal leaders and from each other.
- It has been informed by what our people have told us; what is important to them, what works well and how we can get better.
- It's a framework enabling our people to thrive and be their best to support the delivery of safe, high quality, compassionate care and support.
- It will outline what we will focus on to achieve a cultural shift in this Trust, supporting the transformation of our workplace to enable the transformation of our care.



- It focuses on **how** we must all continue to look after each other and foster a culture of inclusion and belonging, as well as actions to grow our workforce, train our people, and work together differently to deliver care to our patients and clients.
- Positivity, compassion, respect, dignity, engagement and high-quality care are key to creating the culture we need.
- And, just as importantly, we must deal decisively, consistently and quickly with behaviours inconsistent with our values, regardless of the seniority of people exhibiting them.



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



Working together



Excellence



Openness & Honesty



Compassion



What our people need

- Our people have been under increasing pressure since the response to the COVID-19 began, and there are on-going and further challenges ahead.
- Workload remains a pressing concern and we have all been reminded how critical it is to look after our people – and that we need to do more.
- Moral injury is real for many of our staff ...they need our support to minimise the risk
- We need more people, working differently, in a compassionate and inclusive culture.



Staff experience – what they have told us....

WIT-01679

- **Staff Survey – Mar / Apr 2019**
- **The ‘Big Coffee Conversations’ – Feb / Mar 2020**
- **COVID19 Lessons Learned – Jun – Aug 2020**
- **Culture Assessment Survey (CAT) – Oct / Nov 2020**

Key themes

- Health and Wellbeing
 - Recognition and appreciation
 - Engagement & communication
 - Relationships and behaviours
- 
- Leadership & management
 - Team Working
 - New ways of working
 - Quality and innovation



So what is culture?

- Organisational culture is '**how we do things round here**'. It represents **the collective values and beliefs of the people who work in the organisation** and is influenced by its history, its primary task, key individuals, management strategy, external constraints and circumstances
- A culture is not invented. A culture constantly evolves....which is why it needs to be nurtured. (Simon Sinek) – *or a beast of a thing that demands constant feeding?!*



Culture.....

I urge you to focus on the culture that you want to nurture:

- *buoyant, curious, sharing, open-minded, and ambitious to do even better for patients, carers, communities,*
- *and staff pride and joy.*

Berwick 2013



What we will pay attention to



Working together



Excellence



Openness & Honesty



Compassion

Our 3 priorities

Wellbeing

We will look after the **wellbeing** of our people

Belonging

We will ensure people feel a sense of **belonging** in our Trust

Growing

We will **grow** for our future



Wellbeing

Investing in creating a safe and healthy working environment for us all and promoting a culture of wellbeing, recognising the changing nature of work.

Through our behaviours we show we care about colleagues and ourselves, listening to needs and concerns so that together we can take action to create a safe and supportive environment, that becomes the best place to work for us all.



Belonging

Ensuring we all feel a sense of belonging by being connected to the core purpose of our organisation, each of us feeling valued, cared for, respected and supported.

We are compassionate and inclusive, investing in our relationships with colleagues and appreciating the value of good team working.



Growing

Creating the right culture and safe space for us to learn and grow together.

We will create a learning culture that drives engagement, improvement and innovation whilst inspiring, attracting and retaining the best talent.



Working together



Excellence



Openness & Honesty



Compassion

What we will get



3 Outcomes

What we will get:

1. We have a safe and healthier workforce
2. We have a workforce that feels connected, cared for, valued, respected and included
3. We have a reputation as an employer that people are proud to work for, supporting them to thrive and be their best in order to support and care for our population

* *All 3 priorities are interconnected & need to be addressed to achieve these outcomes*



How will we know?



Some metrics **WIT-01690**

- Safe staffing
- Agency usage
- Retention rates
- Vacancy rate
- Exit interviews
- Sickness absence figs
- CMT compliance
- No of OH referrals
- Staff Survey results
- Culture Assessment
- Staff engagement scores
- Appraisal compliance
- Training activity

**quantitative & qualitative data will be important*



What we will do to make this happen



Wellbeing – to achieve this we will focus on:

- Supporting staff to seek help and develop their skills in compassionate self care and other personal coping mechanisms
- Supporting and developing the capacity and capability of our managers to ensure their approach has a positive impact on the experience and wellbeing of their staff and themselves
- Promoting and nurturing a culture of compassionate leadership and teamwork as a way of ensuring our people feel cared for and supported
- Taking all necessary measures and efforts required to keep our people safe and well
- Continuing to promote, protect, and improve the health and wellbeing of our people
- Creating a safe, healthy and engaging workplace and environment to ensure the best possible experience for everyone

Belonging – to achieve this we will focus on:

- Ensuring everyone understands our vision and the future direction of our Trust
- Ensuring an inclusive and diverse workforce
- Living our values and demonstrating associated behaviours including dealing decisively and quickly with incivility and behaviours not in line with our values.
- Nurturing a culture of collective leadership where everyone in the organisation recognises their role as a leader
- Supporting development of teams where everyone can get involved, contribute and make a difference
- Recognising and appreciating our people for the work that they do and the contribution they make
- Taking time for sharing, laughter and chat
- Creating networks and communities that develop strong trusting relationships

Growing — to achieve this we will focus on: **WIT-01694**

- Developing and training our people so they can be the best they can be and fulfil their potential
- Inspiring, attracting and recruiting our future workforce to improve staffing levels
- Creating a culture of openness and candour where our people feel safe to raise concerns and take responsibility for their decisions and actions to ensure the safety of care
- Embracing new ways of working including the use of technology, automation, and digital transformation
- Being responsive and supporting innovation and development of new ideas by everyone to improve the safety and quality of our services
- Taking time out to reflect, learn, create and innovate
- Agreeing clear performance standards and supporting our people to recognise their responsibility to strive for excellence
- Creating a coaching culture which supports the wellbeing, development and career progression of our people
- Developing our 'SQE South' culture through our relentless focus on the safety, quality and experience of our staff, patients and service users

“Great leaders create movements that stick....Amazing is what spreads” D Nicholls

We need to create a movement to achieve irreversible change and lasting impact.

How can we do this and maintain momentum where this is seen as the responsibility of all?



Call to action



How can Trust Board be the first followers?



Man U OR Liverpool?



Bastian Schweinsteiger  @BSchweinsteiger · 4h

...

A devastating day for all @ManUtd supporters and the club but it didn't come out of nowhere. It was not a surprise.

@LFC showed them the difference, which is huge - having a philosophy & vision. Congrats, #LiverpoolFC.

Hopefully #ManchesterUnited will get back very soon. #MUNLIV



Southern Health
and Social Care Trust

Quality Care - for you, with you

Received from Shane Devlin on 04/02/22 Annotated by the Urology Services Inquiry.



Working together



Excellence



Openness & Honesty



Compassion

Let us...

- Believe in what is possible and what the future could be, and passionately communicate our vision for this organisation
- Avoid complexity – complexity kills movements, hence our 3 priorities
- ‘Get out of our cave’ and ‘invite people into the cave’ – different perspectives will help build momentum
- Use storytelling to emotionally connect and move people to action



What's next?



Working together



Excellence



Openness & Honesty



Compassion

Call to action

- Each of us has a part to play in making this a lasting change.
- This is an ask not just of HROD, but for everyone in the Trust – we need followers – leaders at all levels
- The way the plan is translated into action will likely differ for each directorate



Myron's maxims (simple rules for complex change) WIT-01701

1. People own what they help create
2. Real change happens in real work
3. Those who do the work do the change
4. Connect the system to more of itself
5. Start anywhere follow it everywhere
6. The process you use to get to the future is the future you get



What next?

- Trust Board commitment and visibility – start the movement...*how can you be our first followers?*
- Develop our community of leaders – *our second followers* – we need senior level commitment and buy-in
 - Facilitated monthly engagement sessions and quarterly face to face workshops
- Encouraging willing and interested champions –adding *more followers* across directorates to the movement



- Continual reinforcement through Trust wide communication from Chair, CX, SMT & Trust Board on all 3 integrated plans and our 3 people priorities
- Our storytelling - sharing examples of best practice relating to our people priorities and drawing out from these stories what we want to see more of
- Dealing decisively and quickly with behaviours and actions that don't align with our people priorities – making it clear what we don't want to see any of



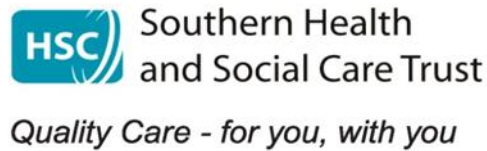
- HROD develop a corporate plan of key corporate actions and milestones
- Engagement sessions / discussion forums with staff as part of our call to action
- All directorate teams develop their people priorities
 - *The conversations that inform the local priorities will be as important as actions*



Thank you.

Discussion time.





SHSCT Clinical Audit Strategy

2022 - 2024

Draft V0.3 - December 2021

This document describes how SHSCT will implement it's clinical audit policy and increase the impact of clinical audit on the provision of safe, high quality care.

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Executive Statement

The Southern Health & Social Care Trust remains committed to delivering effective clinical audit in all the services it provides. The Trust sees clinical audit as essential to its ability to continually evolve, develop and maintain high quality patient and service user centred services.

When carried out in accordance with best practice standards, clinical audit:

- ✓ Provides assurance of compliance with clinical standards
- ✓ Identifies and minimises risk, waste and inefficiencies
- ✓ Improves quality of care and patient outcomes

The Trust is committed to ensuring that clinical audit delivers these benefits, and has developed a policy on the governance and practice of clinical audit, which applies to all staff (see draft clinical audit policy).

Achieving the objectives set out in this 2022 – 2024 strategy will ensure that the Trust policy is implemented and effective, resulting in sustained improvements and directly contributing to the Trust Vision of 'quality care – for you, with you'.

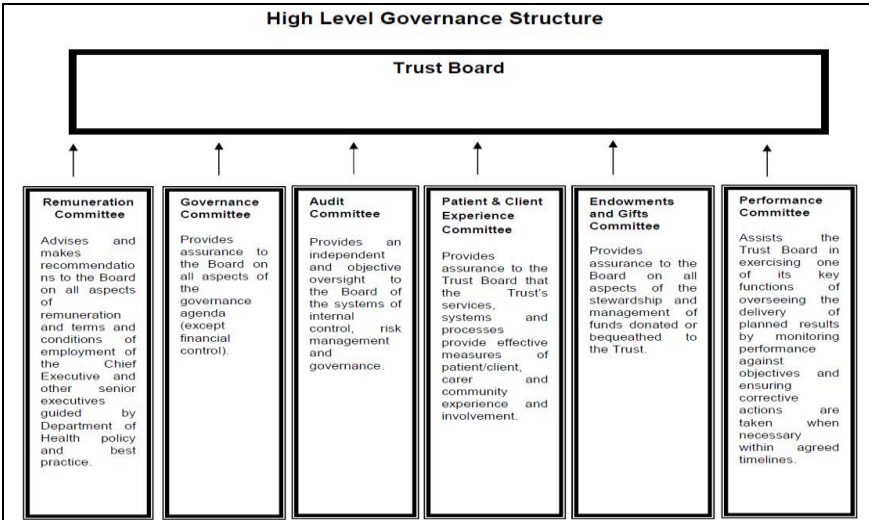
It is expected this three year clinical audit strategy, in line with the Trust's wider clinical and social care governance and corporate assurance mechanisms, will inform and enhance the process of learning and improving services.

Dr Maria O'Kane
Medical Director
December 2021

1.0 Organisational Context - Governance and Assurance Structures

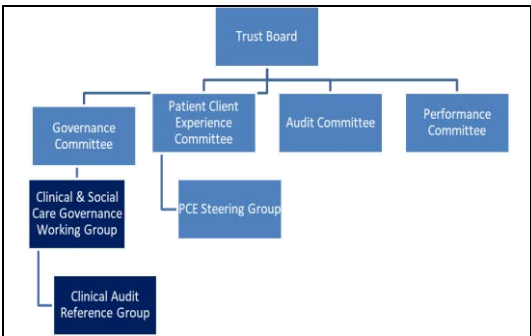
1.1 The role of clinical audit as a tool for **corporate assurance** sits within the: **Board Assurance framework¹ (June 2021)** where clinical audit has a key role to play across the three lines of defence at departmental, organisational oversight and independent external review levels. These three lines of defence provide assurance to Trust Board on the quality and safety of care. This assurance is provided through the Committee structure to Trust Board, primarily through the Governance Committee.

Figure 1 - High Level Governance Structure



The Medical Director as Executive Director with responsibility for Clinical and Social Care Governance sits on and reports to this committee along with other members of the Senior Management Team via quarterly meeting and reporting schedules. The reporting schedule provides information and assurance to support decision-making and effective operation of the Trust at all levels. In reviewing the Governance Committee sub structure a new CSCG working group (see Fig 1) is being established and a **(Clinical** reporting and accountability mechanisms are described in the Integrated Governance **Audit Reference Group)** will be one of 18 groups which will report to it.

Figure 2 - Proposed Trust Governance Structure



1.2 The role of clinical audit as a tool for **corporate governance** sits within the: **Integrated Governance Framework (2017/18 – 2020/2021)**. This framework incorporates arrangements for delivering clinical and social care governance, through which HSC organisations are accountable for continually improving the quality of their

¹ Pages 6 & 7

services and safeguarding high standards of care, by creating an environment in which excellence in care will flourish².

The integrated governance framework (ICF) designates the Medical Director as the Executive Director with responsibility for strategic leadership for risk management and clinical and social care governance. This includes the development of the strategic approach to patient client safety initiatives, patient client liaison (management of complaints and users views), litigation, **effectiveness and evaluation** (this includes standards, guidelines and **audit**) and risk management.

These corporate frameworks ensure SHSCT position's its clinical audit function to assist meeting its statutory, mandatory requirements for providing safe and effective care³. These 2006 Quality Standards and Quality 2020⁴, require all HSC organisations to have in place a comprehensive programme of evidence based practice, research, evaluation and quality improvement activities that includes healthcare professionals participating in regular clinical audit. This is reported on annually in the SHSCT Annual Quality Report.

- 1.3 The choice of national, regional and local clinical audit topics is central to supporting these key aspects of governance and quality reporting and in developing an annual clinical audit work programme that considers:
 - a) Clinical effectiveness: examining clinical outcomes and making improvements
 - b) Evidence-based practice: ensuring practice is based on current research findings
 - c) Clinical risk management/patient safety: auditing in response to concerns highlighted proactively by risk assessment and reactively by adverse incidents
 - d) Complaints and other forms of patient feedback: auditing in response to themes arising
 - e) Service improvement: involving transformation teams in discussions about clinical audit topic choice
 - f) Regulation: ensuring requirements such as the fundamental standards of the RQIA are being met.
- 1.4 Clinical audit also has role in supporting professional and other corporate governance functions:
 - a) Consultant appraisal, revalidation, and health professional registration: enabling clinicians to comply with their professional codes of conduct
 - b) Information governance: ensuring that clinical audit activity meets the requirements of information governance legislation
 - c) Patient and public involvement (PPI): ensuring that service user voices are central from planning to delivery, using insightful methods of listening and working in co-production with patients, families and carers to improve outcomes
 - d) National recommendations and guidance: issued by national bodies such as the National Institute for Health and Care Excellence (NICE), the Clinical Outcomes Review

² A First Class Service, DOH 1998

³ The Quality Standards for Health & Social Care, Supporting Good Governance and Best Practice in the HPSS (2006)

⁴ Quality 2020 - a ten year strategy to protect and improve quality in health and social care in Northern Ireland (Nov 2011)

Programme (CORP – covering National Confidential Enquiries and Inquiries), National Clinical Audit and Patient Outcomes Programme (NCAPOP), and national service reviews

- e) National Service Frameworks: defining standards of care, e.g. for cancer, coronary heart disease, chronic obstructive pulmonary disease, diabetes, kidney disease, long-term conditions, mental health, old age, and stroke care
- f) Litigation Services: clinical audit used to assure that care processes have improved.
- g) Research and development: mutually supportive of clinical audit
- h) Service evaluation: clinical audit may form a part of service evaluation projects
- i) Statements of Internal Control: clinical audit's contribution to the process by which an organisation gains assurances about the quality of its services and the effective management of risk.

- 1.5 This second SHSCT clinical audit strategy seeks to build on the work of the 2018 strategy, specifically addressing areas where the clinical audit function requires strengthening in providing a common framework for delivery across the whole organisation. This to ensure that the clinical audit activity delivered in each Directorate, Division or Service area:
- follows best practice guidance,
 - is rigorous and adequately supported and resourced and the
 - outcomes are utilised robustly to inform assurance processes as the foundation of our quality improvement efforts underpinning the **Trust's Patient Safety and Quality Improvement Strategy**.
- 1.6 The value of such a strategic audit approach across the organisation is realised within the clinical assurance process, when the improvements arising as result of audit recommendations are further measured and we demonstrate that improved practice has been sustained on an on-going basis.

2.0 Scope

This strategy is intended to inform, support and apply to all staff working in the SHSCT who have an interest in and responsibility for contributing to and overseeing the development, direction and delivery of national, regional and local clinical audit activity. This will includes clinicians and practitioners, clinical audit & QI leads, corporate clinical audit team, Medical, Nursing, AHP and Social Work leaders, Governance Teams, Service Managers, Senior Management Team and Trust Board committees and reference groups. The clinical audit policy contains a full description of roles and responsibilities of those involved in clinical audit in SHSCT.

3.0 Definition of Clinical Audit

The Healthcare Quality Improvement Partnership (HQIP) was established in April 2008 to promote quality in healthcare, and in particular to increase the impact that clinical audit has on healthcare quality improvement. They are an independent organisation led by the Academy of Medical Royal Colleges, The Royal College of Nursing and National Voices and are acknowledged as the leading voice on clinical audit.

HQIP's definition of clinical audit is used, as follows:

“clinical audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes”



4.0 Strategic Aim (Patient & Service User – Clinical & Social???)

The aim of this strategy is to use clinical audit as a process to assure clinical quality at all levels of the organisation over the next three years. The strategy focuses on **creating a culture** that is **committed to learning** and **continuous organisational development** through **measurement of evidence-based practice** to deliver **demonstrable improvements** in patient care.

5.0 Objectives

- 5.1 SHSCT is committed to developing a number of areas of clinical audit practice throughout the lifetime of this three year strategy to achieve the strategic aim. The action plan contains objectives supported by actions that are **Specific, Measurable, Achievable, Relevant, Time-based, Evaluated, Resourced** (SMARTER).
- 5.2 Explicit SMARTER objectives covering aims for improving clinical audit practice are:
- Strategic Aim 1** – Use clinical audit to assure clinical quality at all organisational levels
- To overcome barriers to healthcare staff participating in clinical audit
 - To develop a partnership approach to clinical audit within directorates and supported corporately
 - To ensure that staff have the necessary competency, support and time to participate in clinical audit
- Strategic Aim 2** – Create a culture committed to learning and continuous organisational development
- To link clinical audit to appraisal and revalidation
 - To demonstrate and celebrate the benefits of clinical audit
 - To ensure clinical audit activities are fully integrated with other quality improvement approaches and programmes
- Strategic Aim 3** - Measurement of evidence-based practice to deliver demonstrable improvements in patient care
- To establish a robust system for reporting the outcomes of clinical audit activity
 - To ensure that the Trust is fully compliant with the requirements of the National Clinical Audit and Patient Outcomes Programme (NCAPOP)
 - To ensure organisational compliance with regulatory standards

6.0. Operational Action Plan (SMARTER Objectives) - December 2021

Specific, Measurable, Achievable, Relevant, Time-bound, Evaluated and Resourced

Objective	Action	Responsible Person / Lead	Responsible Forum	Potential Barrier / Constraint	Expected Outcome	Monitoring Date / Completion
Strategic Aim 1 - To use clinical audit to assure clinical quality at all organisational levels						
Objective 1. To overcome barriers to health and social care staff participating in clinical audit	S - Delivery of a stakeholder engagement exercise to identify 'as is' position across Acute / CYP / MHD / OPPC. M – No. Surveys Requested & No. of Responses A – Dependent on level of stakeholder engagement R – First stage in any QI process is understand the current system T – Outcome by 31/12/2021 E – Results analysed for RAG rating and what works well / requires improvement R – Conducted by Head of Service	Head of Clinical Audit	DMD – Improvement Group MDO – Governance SMT	Priority for response during sustained C19 pandemic period Low response rate Low confidence of resulting in change Variation in how directorates engage	Analysis of surveys responses how CA is embedded in directorates (RAG Status) Qualitative information on what is working well and areas of improvement required.	31 December 2021

Objective	Action	Responsible Person / Lead	Responsible Forum	Potential Barrier / Constraint	Expected Outcome	Monitoring Date / Completion
Strategic Aim 1 - To use clinical audit to assure clinical quality at all organisational levels						
Objective 2. To develop a partnership approach to clinical audit	S – Produce updated strategy and develop policy document, SoPs and annual programme M – High level documents produced, consulted, uploaded to SharePoint and disseminated. A – Drafting completed January 2022 for consultation and dissemination by March 2022 R – Updated governing documents required ensuring partnership roles and responsibilities and aims of clinical audit programme are clear and understood. T – completed by 31/03/2022 E – Documents will be consulted upon and agreed. R – Head of Clinical Audit	Head of Clinical Audit	DMD – Improvement Group MDO – Governance SMT	Integration with other Corporate documents e.g. - Patient safety Strategy - QI Strategy - People Strategy Engagement with consultation / feedback / comments	2nd Clinical Audit Strategy New Clinical Audit Policy and Procedures Manual Annual Audit Programme	31 March 2022 To lead to establishment of the Clinical Audit Reference Group

Objective	Action	Responsible Person / Lead	Responsible Forum	Potential Barrier / Constraint	Expected Outcome	Monitoring Date / Completion
Strategic Aim 1 - To use clinical audit to assure clinical quality at all organisational levels						
Objective 3. To ensure that staff have the necessary competency, support and time to participate in clinical audit	S – To develop a resource plan that incorporates the staffing to deliver, to support the delivery, monitoring and reporting, as well as the training needed across the organisation. M – Staff identified, staff in post, roles identified, job planning, job descriptions, training plan and resources, corporate support and monitoring team. A – Phased approach to implementation dependent on funding, recruitment and training roll-out R – Progress monitoring across year 1, 2, and 3 T – Resource Plan submitted to SMT by 31/12/2021 E – External organisation resources used as benchmark R – Head of Clinical Audit	Head of Clinical Audit Head of Patient Safety Data & Improvement	DMD – Improvement Group MDO – Governance SMT Clinical Audit Reference Group	Separation of Patient Safety from Clinical Audit Function Recruitment of new staff posts Identification and delivery of training programmes	2 nd Clinical Audit Strategy New Clinical Audit Policy and Procedures Manual Annual Audit Programme Annual Analysis of participation including patients and service users and doctors in training and	Resource Plan by 31/12/2021 Annual Progress to: Clinical Audit Reference Group December 2022, 2023, 2024

Objective	Action	Responsible Person / Lead	Responsible Forum	Potential Barrier / Constraint	Expected Outcome	Monitoring Date / Completion
Strategic Aim 2 – Create a culture committed to learning and continuous organisational development						
Objective 4. To link clinical audit to appraisal and revalidation	S – Development of a robust system for linking information on clinical audit into individual appraisal of doctors. M – Annual no. of medical staff appraisals containing audit activity. A – Dependent on ‘searchable’ database functionality and central team capacity to deliver. R – Requirement of the supporting information needed for GMC re-validation Your supporting information - quality improvement activity - GMC (gmc-uk.org) T – First submissions - Autumn 2022 E – Annual Feedback from Appraisers and Appraisees of value added to Re-validation Process R – Part of the responsibility of a resourced corporate clinical audit team.	Clinical Audit Manager & Head of Clinical Audit	MDO – Governance SMT Clinical Audit Reference Group	Searchable central register Compliance with audit registration process Availability of Action plan / re-audit information	Clinical Audit re-validation scorecard for clinical audit / QI activity that will support the appraisee in demonstrating and reflecting on the quality of their work Annual feedback from Appraisers and appraisees	To be confirmed – entirely new process to be established. Autumn 2022, 2023, 2024

Objective	Action	Responsible Person / Lead	Responsible Forum	Potential Barrier / Constraint	Expected Outcome	Monitoring Date / Completion
Strategic Aim 2 – Create a culture committed to learning and continuous organisational development						
Objective 5 To ensure clinical audit activities are fully integrated with other quality improvement approaches and programmes	S – To ensure QI / Clinical Audit strategies are mutually supportive and complimentary M – Audit registration / QI plans note if another method of QI has been considered A – To be completed R – Clinical audit as a QI tool is used to check care meets defined quality standards and monitor improvements to address shortfalls identified. T – Strategies reviewed by 31/03/2022 E – A comparative analysis of both strategies. No. of CA and No. of QI projects R – Head of Clinical Audit / Head of Quality Improvement A guide to quality improvement tools – HQIP The tools described include clinical audit; Plan, Do, Study, Act; model for improvement; LEAN/Six Sigma; performance benchmarking, process mapping and statistical process control.	Head of Clinical Audit Head of Quality Improvement	MDO – Governance SMT Executive QI Steering Group	Prioritisation of work area Stakeholder engagement	Comparative analysis of both strategies Overarching CA / QI schedule Annual Quality Report to contain Clinical Audit section	To be agreed

Objective	Action	Responsible Person / Lead	Responsible Forum	Potential Barrier / Constraint	Expected Outcome	Monitoring Date / Completion
Strategic Aim 2 – Create a culture committed to learning and continuous organisational development						
Objective 6 To demonstrate and celebrate the benefits of clinical audit	S – Each Directorate establishes a dedicated forum for the presentation of clinical audits M – KPI reporting of meeting dates, agendas, minutes and outcomes. A - To be combined / incorporated within another forum if required to prevent duplication R – Service / Directorate CA / QI leads required to provide leadership, set agenda T – Monthly, Bi-monthly quarterly depending on directorate, volume of audit activity E – Monitor activity against the HQIP 4 stage cycle - Agenda, Attendance, Audits shared, Outcomes, Action Plans, Learning, Risk / Escalation, Celebration R – Each CA Forum supported by directorate or corporate audit facilitator	Clinical Audit Manager & Head of Clinical Audit	DMD – Improvement Group to establish forum network MDO – Governance SMT Clinical Audit Reference Group	CA /QI leads to be established Meeting overload Lack of engagement / non attendance	Regular scheduled annual timetable of meetings Use of Greatix to: - celebrate / acknowledge participation and - when 4 stage (HQIP) audit cycle has been completed	31 March 2022 Clinical Audit Reference Group from April 2022 - Updates on forum monitoring activity to each meeting

Objective	Action	Responsible Person / Lead	Responsible Forum	Potential Barrier / Constraint	Expected Outcome	Monitoring Date / Completion
Strategic Aim 3 - Measurement of evidence-based practice to deliver demonstrable improvements in patient care						
Objective 7 To establish a robust system for reporting the outcomes of clinical audit activity	S – Monitoring Schedule for Clinical Audit KPIs developed and contained in new clinical audit policy M – KPIs developed will measure the function A - Dependent on robust data flows from a central registry. R – Monitoring of clinical audit performance requirement T – Quarterly reporting to CARG & CSCG WG and 6 monthly reporting to CSCG E – Templated report developed for the CARG that will highlight performance, areas of non-compliance and escalation. CARG will report to the CSCG working group which in turn reports to Governance Committee R – Clinical Audit Manager	Clinical Audit Manager & Head of Clinical Audit	DMD – Improvement Group MDO – Governance SMT CARG CSCG WG GC	CA /QI leads to be established Forum	Quarterly monitoring reports on KPI compliance - Audits registered - Approved - In progress (HQIP Stages 1 – 4) - Action plan developed - Re-audits - Progress against directorate plans	31 March 2022 (Schedule developed) Quarterly reporting

Objective	Action	Responsible Person / Lead	Responsible Forum	Potential Barrier / Constraint	Expected Outcome	Monitoring Date / Completion
Strategic Aim 3 - Measurement of evidence-based practice to deliver demonstrable improvements in patient care						
Objective 8 To ensure that the Trust is fully compliant with the requirements of the National Clinical Audit and Patient Outcomes Programme	S – To provide an annual overview of the SHSCT's participation in the NHS England quality accounts list of national audits. M – Participated versus non participated audits, progress updates and nil returns A – Currently delivered on an annual basis. R - requirement to ensure that all relevant audits are participated T – annually to November Governance Committee E – Provides an updated SHSCT position on the progression of recommendations arising from participation in national audits, including those from previous years. R – Clinical Audit Manager National quality improvement programmes – HQIP	Head of Clinical Audit Clinical Audit Manager	DMD – Improvement Group MDO – Governance SMT CARG CSCGWG GC	Priority for response during sustained C19 pandemic period Information Governance Constraints preventing data sharing	Annual National Audit Assurance Report - ? 6 monthly progress Update	November 2022 ? update in May 2022

Objective 9 To ensure organisational compliance with regulatory standards	S – Develop the high level processes to link S&G implementation to requirement of audit for compliance M – S&G indicated audits included as part of directorate clinical audit plan, and enter the audit registration and KPI monitoring process A – Dependent on identifying S&G change leads and a CA lead R – Potential recommendation of S&G Internal Audit T – To be agreed E – Audit action plan, outcomes, learning & recommendations to be shared and implemented R – Part of the responsibility of a resourced corporate clinical audit team. Measuring the use of NICE guidance Into practice What we do About NICE	Head of Clinical Audit Senior Manager Risk & Learning	DMD – Improvement Group MDO – Governance SMT CARG CSCGWG GC	Difficulty identifying change leads and clinical audit leads during sustained C19 pandemic period	KPI – no. of audits registered linked to S&G Audits completed with action plan / learning outcomes linked to S&G Re-audits linked to S&G compliance.	To be agreed Entirely new system / process to be developed

Summary of Acute Revenue Pressure 2020/21 (AT RISK ONLY)

No	Service Area	Service Context	Categorisation	Staffing Requirement	Estimated Cost	Priority Ranking agreed by Acute SMT (March 2020)	Revenue Costing per Acute FM	Capital Costing per Acute FM	CYE cost pressure	FYE cost pressure	Prepared by	Comments	May-21
Medicine & Unscheduled Care													
1	Staffing Resource to support patients being sent to Belfast for clot retrieval CAH (AT RISK from 21/22)	Service Context Increase in nursing staff for ED/ 2 South Stroke to enable transfer of patients to RVH	At Risk	1.0wte Band 6 Stroke Nurse (FYE with unsocial hours allowance to reduce pressure on Band 6 Stroke Nurse rota)	£48,375		66,961.93			£31,875		LC	Costing completed as per IPT 20/21 (transformation funding NR). Approved NR 20/21
2	Staffing Resource to support patients being sent to Belfast for clot retrieval DHH (ASPIRATIONAL)	Additional resource is also required for DHH site	Aspirational	1.0wte Band 6 Stroke Nurse (FYE with unsocial hours allowance to reduce pressure on Band 6 Stroke Nurse rota)									To be costed
3	Emergency Department Additional Trainee (ST4) 5 th Post (AT RISK)	Service Context 4 ST4 posts in place in ED CAH – NIMDTA have offered a 5 th post to SHSCT but no funding available to progress	At Risk				96,998.13					LC	Costed at specialty registrar with 50% banding supplement. Check Mary
4	NEUROLOGY (ASPIRATIONAL)	Service Context Linked to the increase in referrals (particularly for MS) as a result of the review of neurology in BHSCT. DHH in particular needs more capacity to deliver an appropriate service to inpatients/unscheduled care patients. To support ambulatory / Hot clinic pathway in DHH / CAH, in reach to ED, Ward round support DHH, alongside increase Botox clinics due to increasing demand	Aspirational	• 4th Consultant Neurologist • 3rd Specialty Doctor • Physician Associate • 0.2wte Band 5 Nurse (to support Hot Clinics) • 0.2wte Band 3 HCA (to support Hot clinics) Domestic Services Band 2 0.40 WTE (15 hours M-F between 9-5)	£128k (based on most recent IPT @ 18/19 costs + 3%) £13k for Domestic Services							LC	T/C Andrea with Louise - Neurology service requirements include: 4th Consultant Neurologist, 3rd Specialty Doctor and Physician Associate. Nursing requirement for additional clinics = 0.2wte Band 5 Nurse and 0.2wte Band 3 HCA to provide DHH Hot clinic cover (originally set up during covid due to downturn in botox clinic) service would like to maintain going forward. Provisionally costed 1.4 with 6% allowances.
5	CAH Physician Associates (AT RISK)	To support improved flow. Currently 8.0wte funded but 10.0wte in post	At risk	2.0 wte - for medical wards			155,770.68					LC	To be costed Includes unsocial at 23.09% and no annual leave cover
6	DCC Medical Cover	Due to relocation of DCC to STH, medical cover is required to support staffing team. Recent SA's and risks have been highlighted.	At Risk	1.0wte Specialty Doctor			94,440.75					LC	To be costed Specialty Doctor costed at (1:5 rota to 1:8 rota - incl 4% allowance) excludes excess travel
7	Additional Staffing for Day Clinical Centre (ASPIRATIONAL)	Service Context CAH? Extend the day to swap less risky treatments to evenings and free up capacity during day Due to increasing volume of patients requiring supportive treatments such as blood transfusions, platelets, immunoglobulins etc. there is a need for increased capacity in DCC. The Service are experiencing lack of availability and consequently patients are being unnecessarily admitted for treatments which are suitable to delivered on an outpatient basis in DCC.	Aspirational	Additional space/ accommodation required along with more staff Alternatively need to consider opportunities to review service model to create more capacity within existing foot print albeit additional staffing resources would be required Domestic Services Band 2 0.4 WTE 6.30-9.30pm M-F	 £15k for Domestic Services		16,375.01					LC	Costed B2 Domestic with 25% annual leave cover and unsocial hours as detailed. T/C Andrea with Louise D 31/3/21 - a full review of DCC service is required in line with strategic direction of service and preferred location (following temp relocation to STH due to Covid - new location / accommodation to be identified to support growth in demand for DCC services plus new service model including venesection, mandeville treatments, medical cover etc. FULL IPT TO BE WORKED UP
8	CARDIOLOGY - Ambulatory model including Consultant Cardiologist No. 9 (AT RISK)	Service Context Directorate requests a further consultant (no 9) + specialty doctor + support costs. This will provide a 1:4 rota for covering DHH and provide a second person to do pacemakers. Directorate to explore potential to attract funding from DHHPF as a second phase.	At Risk	Domestic Services Band 2 0.40 WTE (15 hours M-F between 9-5)	£500k £13k for Domestic Services		905,873.00					LC	Costing per IPT developed July 2020 (costed) not submitted. Also links to NMS bids for ambulatory pathway development Costing consultant 1:1 rota to 1:4 rota - incl 8% allows, spec doctor 1:1 rota to 1:4 rota - incl 6% allowance and B4 secretary 18-Jan-21 Update IPT prepared in 2020 for Ambulatory Cardiology service. Includes 1 consultant & 2 specialty
9	1.5wte Specialist Nurse for Gastroenterology (AT RISK)	Service Context Posts are recruited and in place. No funding secured	At Risk	1.5wte Nurse Specialists (Gastro)	£81k Estimated cost for 1.5 wte band 7 posts only (@ 18/19 costs + 3%) – does not include any supporting infrastructure		112,568.66					LC	Costed B7 Nurse with 25% annual leave cover. 18-Jan-21 Update Relatively small wte included in the current biologics case - 0.1 Band 6
10	Stroke Middle Grade Doctor (ASPIRATIONAL)	Service Context Required for compliance with NICE NG 128 'Refer immediately people who have had a suspected TIA for specialist assessment and investigation, to be seen within 24 hours of symptoms.' There may be a requirement for other support staff e.g. stroke specialist nurse, imaging, admin etc. – need service to confirm.	Aspirational	1.0wte Middle Grade Doctor	£90k?		89,283.65					LC	Costed Specialty Registrar with 50% banding supplement. Stroke / Frailty Project Team established March 2021 to take forward review of funded baseline, gap analysis and development of stroke ambulatory model which will be subject to a separate paper.
11	Stroke Service Improvement Manager – uplift from Band 7 to Band 8A (AT RISK)	Service Context Post funded at Band 7 level however all other Trusts have appointed Band 8A – the post is now being replaced due to retirement and keen that the post is recruited at Band 8A level.	At Risk	Uplift from Band 7 – 8A			7,039.06					LC	1.0wte Band 8A post based in CAH - covering both sites
12	Stroke Services (AT RISK)		At Risk	3.0wte Band 7 Specialist Nurse (2.0wte for CAH and 1.0wte for DHH)			192,329.80					LC	To be costed Excludes unsocial hours/ annual leave cover
13	Dermatology (AT RISK)		At Risk	1.0 Clinical Nurse Specialist			64,109.93					LC	To be costed Excludes unsocial hours/ annual leave cover
14	Biologics (ASPIRATIONAL)	Additional funding required to support additional staffing and infrastructure costs	Aspirational	staffing requirements as per IPT completed March 2021			£748,877		£435,837	£748,877		LC	Detail as per IPT completed and costed March 2021. To be submitted to HSCB for recurrent funding allocation - currently - aspirational ask.
15	0.5 EBUS session (AT RISK)	Service Context We had bid to Southern Office of HSCB for this funding. Caroline Cullen thought it was being held for us but it wasn't. 0.5 session was funded from demography and this proposal was the balance to make up to a full weekly session.	At Risk		£30,154 (based on most recent IPT @ 19/20 costs)		£31,772			£30,154		LC	IPT costed and submitted to SLOG but unable to fund. £30k @ 2019/20 P & P. Inflationary uplift applied 20/21 and 21/22
16	Social Work (ASPIRATIONAL)	Service Context Acute demand exceeds current capacity. From this analysis it identifies that within the SHSCT the Acute Hospital Social work staffing levels are more than 60 percent lower than their colleagues in Mental Health and OPPC Non Acute Hospitals. The Head of Service has completed a detailed paper setting out the need and context for additional funding. 1wte Band 7 post was funded from 19/20 Demography funding. ~~Statutory Considerations~~ Current / Emerging Pressures Unscheduled care and Emergency Care NI Report: Recommendation 11 /Future Workforce Models/ Staffing levels must match the current level of business. This is not been currently achieved within Acute Hospital Social work. Current challenges include: - Constant cover of multiple wards rather than maintaining a consistent approach to wards / Impact on their performance and the development of collaborative working of the MDT - Limited ability to ensure early with patients and carers due to current staffing - Limited ability to spend adequate time with patients , carers to support and complete necessary assessments - Limited availability in identifying and signposting Young carers - Social work staff must prioritize Safeguarding referrals in respect of Child Protection and Adult Safeguarding / carers, this work is very complex and time consuming.	Aspirational							£587,609		LC	IPT Costed and held internally. 1wte Band 7 funded from Demography 19/20
17	Social Work (AT RISK)		At Risk	1.76wte Band 7 from Core Team 3.6wte Band 7 from project areas / patient flow 3.02wte Band 6 Core staff 2.0wte Band 6 Patient areas / Patient flow 2.0wte Band 4 Core staff 0.94 wte Band 7, 0.46wte Band 6 & 0.92wte Band 4 for 7 day working £31k associated with DASS Project (Domestic Violence)	£423,560 (inc G&S)		858,086.35					LC	To be costed Includes unsocial hours for 7 day working staff. No annual leave cover included. Band 4 includes No More Silos

	Falls (Aspirational)		Aspirational	1.0wte Band 7 Fall co-ordinator			64,109.93						to be costed	
19	Health Psychology Support for patients with IBD (AT RISK)	Service Context The service have had numerous requests from Consultants and Specialist Nurses to access medical psychology for patients with complex conditions that are impacting on their psychological wellbeing and if untreated are likely to lead to mental health issues in the future.	At Risk								LC	Part of SHSCT Psychology review and workforce requirements - MHD to take forward and seek demography funding - noted here for cross reference 18-Jan-21 Update This review does not seem to have moved forward. Intend adding 0.5 wte Psychologist in the Biologies IPT. Do we remove this as psychology is not within our gift to fix???	Need detail to cost (WTE and bandings)	
20	Additional ED Consultants for CAH (AT RISK)	Emails from Mary Burke and Gareth Hampton - Requirement to be established	At Risk				489,211.79				LC	Estimated 1.5 B4 WTE please advise if any other additional support costs. Costed 3 WTE Consultants per M McClements email to G Donaghy 29/06/2020 (4 Appointed 1 had funding therefore 3 at risk)		
21	Staffing to Support Frailty ward / service (AT RISK)	To be confirmed with service – Consultant Geriatrician posts	At Risk	Included on separate tab	??		2,923,320.11	80,000.00			LC	Staffing requirements are included on separate 'Frailty' tab. I am not aware if this was ever costed but I do recall that a bid was submitted under CAWT for Frailty so perhaps some costing by finance has happened. Consultant costed at (1:5 rota to 1:8 rota Cat A - incl 5% allows) and excess travel included. Specialty Doctor costed at (1:5 rota to 1:8 rota - incl 4% allowance) Nursing staff, Porters and Domestics costed with unsocial hour. No annual leave cover included.	Need breakdown of Lab Services B6 £130,023 FM have estimated this would equate to 2.39 WTE. What is included in Lab Goods and Services £65,011? Under catering equipment is it 1 x Burlodge trolley? If so this will need to be included in capital costs as >£10k	
22	Additional Medical Beds at CAH 'winter ward' (AT RISK)	18 additional medical beds	At Risk		£2.9m (£1.2m) funded from 19/20 winter resilience		1,233,000.00				LC	Is this a request for staffing need more information in order to cost? What bandings and WTEs? Need to consider this in the context of all unfunded and uncommissioned beds across Acute as a result of Covid and increasing demands. Anne advised 6 locum consultants and 13 SHO's currently in place to support uncommissioned beds Costed £2.9m less £1,667k funded.		
23	Overnight Cover on CAH Medical Wards (AT RISK)	Due to increasing pressures additional medical staff are in place overnight and at weekends	At Risk	2 Consultants and 2 SHOs - covering 7 nights per week and all weekend			438,051.38				LC	To be costed Consultant costed at (1:1 rota to 1:4 rota Cat A - incl 8% allows) and F2 costed including 50% banding supplements.	Need breakdown of WTE and bandings required in order to cost.	
24	Additional Medical Support DHH (AT RISK)	In response Covid additional medical staffing was put in place on Saturday and Sunday 9am - 2pm and Bank Holidays	At Risk									To be costed	Need breakdown of WTE and bandings required in order to cost.	
25	Haematology - uncommissioned beds (AT RISK)	currently the haematology service are commissioned for 8 beds, but are using on average 15 beds	At Risk									Not sure how we cost this one. Anne did not provide detail of additionality	Need breakdown of WTE and bandings required in order to cost.	
26	Haematology Band 7 Nurse Specialist		At Risk	Band 7 Specialist Nurse			64,109.93				LC	To be costed No unsocial hours/ annual leave cover included in costing		
27	Rota co-ordinator DHH (AT RISK)	0.5 WTE Band 3 Rota Co-ordinator who will be responsible for the FY1 and FY2 rotas in Medicine DHH	At Risk				18,639.82				LC	Costed 0.5WTE plus 25% annual leave cover. No unsocial hours.		
28	Emergency Department - 2nd Resus	As a result of Covid the Trust has implemented a second resus in the CAH ED to support segregation of patients	At Risk	Additional Registrar at night 7 days a week			91,822.18				LC	Costed 1.0 Specialist Registrar (includes 50% banding supplement and excludes excess travel)		
29	Acute Medical Unit		At Risk	6 SHO Locums			438,456.65				LC	to be costed Costed 6 x F2 M230 (includes 50% banding supplement and no excess travel)		
30	Unscheduled Care Admin Support		At Risk	2.0wte Band 4 ED Secretaries, 0.25wte Band 4 DAU Secretary, 1.6wte Band 2 Admin for MIU			120,510.50				LC	To be costed Excludes unsocial hours/ annual leave cover		
31	Chest Pain		At Risk	1.0wte Band 7 Nurse			64,109.93				LC	To be costed Excludes unsocial hours/ annual leave cover		
32	Echo Service		At Risk	1.0wte Band 7 Echo Support (NR funded ended March '21)	2.0wte Band 3		123,741.90				LC	To be costed Excludes unsocial hours/ annual leave cover		
33	Respiratory	Respiratory Investigations	At Risk	1.0 Band 7 1.0wte Band 5 BLS Backfill	6		119,196.94				LC	to be costed Includes unsocial but no annual leave cover		
NEW	Medical Assistants Uplift B3 to B4 (AT RISK)	Agreement to uplift the medical assistants in CAH Patient Flow from B3 to B4.	At Risk	7.07 WTE B4 Medical Assistants per CP M2 (May 21)			31,219.96				LC	Costed 7.07 WTE uplift from B3 to B4 at 21/22 with no unsocial or annual leave cover.		
NEW	Dementia Companion Uplift B2 to B3 (AT RISK)	Agreement internally to uplift the B2 Dementia Companions from B2 to B3	At Risk	2.0 WTE B3 Dementia Companions			5,299.48				LC	Costed 2.0 WTE uplift from B2 to B3 at 21/22 with no unsocial or annual leave cover.		
Integrated Women's and Maternity Services, Cancer, Clinical Services and AHPs														
34	Consultant Haematologist No. 5 & supporting staffing (AT RISK)	Service Context Transformation funding had initially been earmarked for this post but this has now been withdrawn. Directorate consider this to be a priority in order to stabilise the service and facilitate a 1:5 rota.	At Risk	1.0 wte Consultant Haematologist 1.0 wte Band 7 CNS 0.50 wte Band 4 Admin Support 0.28 wte Band 3 Admin support	£350k for Consultant, CNS, pharmacy & admin		233,411.00				OMC	IPT developed as part of TRF 19/20 Costing partially complete. Have costed 1 Consultant (1:5 rota to 1:8 rota Cat B - incl 2% allows and excess travel. 1.0 B7 CNS with 25% annual leave cover.	Consultant (1:5 rota to 1:8 rota Cat B - incl 2% allows and excess travel. 1.0 B7 CNS No unsocial. OMC	
35	Consultant Haematologist (No 6) (ASPIRATIONAL)	Due to service demands on ongoing requirement for oncology and haematology stabilisation	Aspirational									Full IPT work up required.		
36	3 rd Specialty Doctor Haematology (AT RISK)	Service Context Requirement for 3 rd Specialty Doctor for Haematology Benefits - Reduce ED referrals during working hours by seeing more emergency patients within haematology service - Provide extended day cover for ward patients to facilitate chemo and emergency admissions	At Risk	1.0wte Sepcialty Dr	c. £90k		96,441.00				OMC	Specialty doctor costed at (1:5 rota to 1:8 rota - incl 4% allowance) with excess travel allowance	Specialty Doctor (1:5 rota to 1:8 rota Cat B - incl 2% allows and excess travel. OMC	
	1.0wte Palliative Care Consultant (AT RISK)		At Risk	1.0wte Consultant			143,862.00				OMC	To be costed consultant (1:5 rota to 1:8 rota Cat B - incl 2% allows and excess travel.	consultant (1:5 rota to 1:8 rota Cat B - incl 2% allows and excess travel. OMC	
37	Consultant Clinical Scientist (ASPIRATIONAL)	Service Context BHSCCT have confirmed funding for SHSCT for clinical biochemistry for 3.5 years however BHSCCT will not be able to provide a substantive post at the end of the period. It is the service's experience that successful candidates tend to be more likely to accept the training post once they know there is a substantive post at the end of the training, therefore it would be useful if SHSCT could offer some assurance at the outset that they will have a post in place (2023) by the end of the training period.	Aspirational	1.0wte Consultant Clinical Scientist Band 8B (Band 8A initially for 4 years)							LC	Full IPT work up required. If progressed Band 8B required initially for 2 years and then converted to Consultant grade. Geoff confirmed no on call (29/4/21)		
38	Consultant Chemical Pathologist (ASPIRATIONAL)	Currently one consultant in post and indicating retirement plans in next few years. Opportunity to recruit an additional consultant post now to work alongside P Sharpe and then take over when he retires. Will be cost pressure in short term	Aspirational	1.0wte Consultant Chemical Pathologist			143,862.00				OMC		consultant (1:5 rota to 1:8 rota Cat B - incl 2% allows and excess travel. OMC	
39	Modular CT DHH (AT RISK)	Service Context Being funded at risk from Acute budget at present. Contract ends at end of January. Directorate would like to retain the modular to meet the increasing demand for CT. Current weekly rental cost is £9,950. 5 new CT sessions per week are proposed.	At Risk	1.57 wte Radiographer bd 6 0.63 wte bd 3 HCA 0.22 bd 3 Admin 0.65 wte band 2 admin 0.70 bd 2 Domestic Services 0.46 WTE Portering M-F (17.25 hrs p.w. M-F between 9-5)	£650k Portering £14k		610,480.00				OMC	24/7 service as part of lease agreement with provider. Consideration of IRFS change to capital requirement Have costed with 25% annual leave cover.	Rental Cost £7,950 per week currently = £413,400 per annum. The B6 Radiologist inc 23.09% allowance re weekends etc and cover plus 10% G&S. The remaining staff inc 25% Annual leave cover. Previously funded via £6.166m business case £415k provided Non Recurrently 20/21 OMC.	
40	RRO overnight reporting and 4Ways plain film pressure (AT RISK)	covered under return to balance	At Risk				435,968.30				OMC	What staff/ bandings and WTE required? Barry advised this was covered under return to balance and Finance would have a figure to put against this.		
41	Cellular Pathologist (ASPIRATIONAL)	Service Context Cellular pathology is the study of disease in organs, tissues and cells. Histopathology and cytopathology are key diagnostic tests in the initial detection and diagnosis of cancer and other diseases supported by modern molecular techniques. Consultant cellular pathologists are able to provide information on prognosis and help to appropriately direct therapies in post diagnostic treatment. Strategic Considerations	Aspirational	1 wte Consultant Cellular Pathologist Band 6 Biomedical Scientist	£300k		210,917.00				OMC	Full IPT Work Up Required. 6 PAs of a Cellular pathologist are required to make 1.0wte post (due to retirements and dropped PAs). This is due to demand in the system and associated impact from Urology Review / SAI. Band 6 Biomedical Scientist required to support Consultant	consultant (1:5 rota to 1:8 rota Cat B - incl 2% allows and excess travel. And the	
42	Additional AHP staffing (SLT and Physio) (ASPIRATIONAL)	Service Context (Text from demography list) Demand far exceeds current capacity across all disciplines. 1 wte band 7 physiotherapist needed for paediatrics alone. There is also an issue with availability of trained staff in some professions. Risks	Aspirational	Charlotte drafting paper for SIC outlining gaps and requirements			79,025.00				OMC	Are any additional staff required if so what bandings and WTE? What location will this be based costed 1.0 B7 WTE with 25% annual leave cover. Charlotte has drafted a high level paper to identify pressures and demands in AHP staffing. A full IPT is to be worked up.	1wte B7 Physio inc ludng 25% annual leave cover.	

65	Urology SAI Review		At Risk		At Risk		2,500,000					Costed as per workforce paper (Linda Jayne and Andrea)
Pharmacy Services												
66	Anti-coagulation Clinic (ASPIRATIONAL)	Service Context Through the return to balance process it was identified that the anticoagulant clinics are only funded to be covered for 46 weeks of the year, while in reality the service is operating 52 weeks of the year to maintain patient safety, consequently this is putting a considerable strain on staffing resources.	Aspirational			1					LC	Need WTE and banding information in order to cost. Any unsocial hours requirements Check Tracey
67	Peripetetic Pressures Pharmacy	To cover ongoing maternity leaves, the service are funding at risk in the region of 12wte bAnd 6 staff	At Risk	12wte Band 6 staff			816,031.00				MS	to be costed Costed 12 WTE Band 6 positions including 25% AL cover
68	Pharmacy Support for Critical Care	Funding will be at risk from March 22 - when regional funding ceases	At Risk	0.75wte Band 7 Pharmacist			60,103.00				MS	to be costed Costed 0.75 WTE Band 7 including 25% AL cover
69	Pharmacy Legislation - Falsified medicines Directive (FMD) (AT RISK) money will come if asked	New FMD legislation came into force across the UK in Feb 2019. Increased infrastructure required to ensure compliance.	Aspirational	2 wte Band 2 1 wte Band 3	E76k staffing + £12k licence + £5k equip	1	108,526.75				LC	Are any unsocial hours required? Costed with 25% annual leave cover. Salary costed only.
Functional Support Services												
70	Clanrye House	Change from office accommodation to paediatric outpatient accommodation has resulted in need for increased domestic services	At Risk	0.8wte Band 2			21,733.00				LC	To be costed Costed excluding any unsocial hours and annual leave cover
71	Waiting list Validation (ASPIRATIONAL)	Service Context This proposal is associated with the appointment of additional staffing resources to facilitate validation of waiting lists and improvements associated with data quality within the Trust. As agreed following the Performance Committee this has been developed into an IPT which is in the process of being finalised for SIC approval (albeit there is no identified revenue funding for it).	Aspirational	ACUTE 6 wte Band 4 2 wte Band 3 CYP (Community & Acute Paediatrics) 1 wte Band 3 MHLD 0.3 wte Band 4 2.5 wte Band 3 AHPs (Acute, CYP & OPCC) 1 wte Band 3	£364k	1	512,034.30				LC	Costed with 25% annual leave cover on all positions.
72	Admin Support for ED at DHH (ASPIRATIONAL)	Service Context Appointment of permanent administrative staff to support the increase in attendances at the Emergency Department at Daisy Hill Hospital and the additional duties associated with the establishment of the Decision to Admit Ward (DTA/Virtual Ward) at Daisy Hill Hospital.	At Risk	1.86 WTE Band 2 Administrative Assistants	E73,077 + £1,500 Capital cost - one Desktop computer		63,179.48				LC	Costed with 25% annual leave cover
73	Cleaning for Cardiac Investigations Level 4 and elective admissions dhh (AT RISK)	Cardiac Investigations have moved to level 4 and now occupy 10 rooms (previously 4). As this department was not previously funded there is nothing to transfer up. Also the 2 elective wards on level 4 and their associated rooms are not funded either and is frequently used for in-patients. It is becoming increasingly difficult to maintain a service on this floor. The requirement is as follows: Elective Wards - 1 x 35 hours Mon- Fri Cardiac Investigations - 1 x 10 hours Mon - Fri	At Risk	1.25 wte Band 2	£31k		42,499.33				LC	Costed with 25% annual leave cover
74	Portering / security staffing cah (AT RISK)	Service Context Investment required to fund Band 2 security Porter to cover Mon - Sun 7am - 11pm and also Band 4 security porter supervisor to cover Mon - Sun 11pm - 7am which would provide Band 4 cover to supervise the portering security team 24/7. There is currently a gap in supervision 11pm - 7am. (this is in a paper going to sig)	At Risk	1.75 wte Security Porter Band 2 (7am - 3pm) 1.75 wte Security Porter Band 2 (3pm - 11pm) 1.75 wte Security Porter Supervisor Band 4 (11pm - 7am)	£178,925	1	197,267.02				LC	Have included unsocial hours
75	Domestic Services (AT RISK) ED DHH CAH	Unfunded hours to support the ED service during high demand, to maintain standards of environmental cleanliness at behest of ipc etc Unfunded hours to support the ED service during high demand, to maintain standards of environmental cleanliness at behest of ipc etc	At Risk	48hrs Mon - Sun Band 2, 1.28 wte 101.5 Mon - Sun Band 2, 2.7 wte	£40K £120K	1	170,866.56				LC	Have included unsocial hours Please advise more detail on unsocial hours. Estimated unsocial hours.
76	Domestic Services Cataract Services STH	New service in STH, domestic services cost	At Risk	12.5 hpw Mon - Fri Band 2 0.33 wte	£10K		11,209.26				LC	Have included 25% annual leave cover and excluded any unsocial hours allowance
77	Elective Admissions CAH	Unfunded hours to support the Elective Admissions Unit, to maintain standards of environmental cleanliness as generally open 24/7	At Risk	45.Shpw Mon - Sun, Band 2 1.2 wte	£46K		52,771.30				LC	Have included 25% annual leave cover and unsocial hours enhancement for 24/7 cover.
78	Domestic Services Blossom	Original funding from main ward block transferred, however unit larger and requires additional hours have requested from financial management but still o/s .	At Risk	43.Shpw Mon - Sun, Band 2 1.6wte	£42K		48,231.22				LC	43.5 hrs is 1.16 not 1.6 which is it? I have costed at 1.16 WTE Have included 25% annual leave cover and estimated unsocial hours. Check business case
79	Domestic Services Winter Ward cah	Established for winter pressures 2018 but has remained open.	At Risk	129hpw Mon - Sun, Band 2 3.45wte	£120K		146,298.84				LC	Please advise more detail on unsocial hours. Have included 25% annual leave cover and estimated unsocial hours.
80	Domestic Services Transitional Ward cah	Opened for winter pressures 2019	At Risk	6Shpw Mon - Sun, Band 2 2wte	£36K		72,862.89				LC	2 WTE is 75 hours I have costed at 1.73 WTE, please advise more detail on any unsocial hours. Have included 25% annual leave cover and estimated unsocial hours.
81	Domestic Services Night Service cah	Additional activity and pressures at night.	At Risk	49hpw Mon - Sun, Unsocial Band 2 1.3wte	£57K		63,940.66				LC	Please advise more detail on unsocial hours. Have included 25% annual leave cover and estimated unsocial hours.
82	Domestic Services Discharge Lounge CAH	Open 2018 to assist patient flow and timely discharges, remains unfunded.	At Risk	17.Shpw Mon - Fri, Band 2 0.46wte	£15K		15,625.03				LC	Have included 25% annual leave cover and no unsocial hours.
83	Domestic Services Ramone Ward	Winter pressures opened for 3 months	At Risk	130hpw Mon - Sun, Band 2 3.46wte	£120K ly (£30K)		146,842.60				LC	Please advise more detail on unsocial hours. Have included 25% annual leave cover and estimated unsocial hours
84	Domestic Services Recovery CAH	Additional pressures and used as overflow for patients.	At Risk	25hrs Mon - Fri, Band 2 0.60wte	£20K		22,418.53				LC	0.66 WTE is 25 hours Costed at 0.66 WTE with an additional 25% annual leave cover and no unsocial hours
85	Domestic Services Day Surgery CAH	Additionality for weekend working.	At Risk	20hrs Mon - Sun, Band 2 0.53wte	£18K		18,002.76				LC	Please advise detail on unsocial hours. Have included 25% annual leave cover and no unsocial hours until advised.
86	Domestic Services DHH	Additionality to maintain environmental cleanliness standards.	At Risk	12hrs Sat - Sun, Band 2 0.29wte	£11k		15,523.32				LC	Have included 25% annual leave cover and unsocial hours
87	Health Records Pressures	Admin staff doing bloods in CAH and DHH - 2.09wte Band 3 ED Trackers - 3wte Band 4 Ward Clerk for Transition Ward - 1wte Band 3 Ward Clerk for Ramone Ward - 0.8wte Band 3 Ward Clerk for Winter Pressures Ward DHH - 0.8wte Band 3 Health Records member of staff to complete the work associated with SARS requests - 0.5wte Band 2	At Risk				320,261.74				LC	Have included 25% annual leave cover and unsocial hours Any unsocial hours required? Have included 25% annual leave cover no allowance for unsocial hours.
88	Referral & Booking Centre Pressures	Information & Data Quality Officer - 1wte Band 4 Mr McKay's Secretary - 0.5wte Band 4	At Risk									Any unsocial hours required? Are all of these posts for CAH? Have included 25% annual leave cover no allowance for unsocial hours.

		Reem Salman's Secretary – 0.5wte Band 4 IBD Nurse Specialist Secretary – 1wte Band 3 Dr Stewart (Rheumatology) Secretary – 0.25wte Band 4					106,885.61				LC		
89	Domestic Services Pressures	Neurology 3 rd Spec Dr – 0.4wte Band 2 Day Clinical Centre – 0.4wte Band 2 Consultant Cardiologist – 0.4wte Band 2 Chest Pain Pathway CAH – 1wte Band 2 Chest Pain Pathway DHH – 1wte Band 2 Discharge Lounge – 0.13wte Band 2	At Risk				113,111.66				LC	Any unsocial hours required? Are all of these posts for CAH? Have included 25% annual leave cover no allowane for unsocial hours.	Agreed
90	Portering Pressures	Modular CT DHH – 0.46wte Band 2	At Risk				15,625.03				LC	Any unsocial hours required? Is this required? Have included 25% annual leave cover with no allowane for unsocial hours	Agreed
91	Waiting for Funding for following posts (ASPIRATIONAL)	Transformation posts – 2wte Band 2 DAU funding – 1.66wte Funding associated with appointment of 4 th Dermatologist 2 Consultant Dermatologist Secretary's (McGrath & McIntyre) plus associated monies for RBC and audio typing Consultant Cardiologist Secretary (Artur) plus monies associated for RBC and audio typing Waiting list initiatives resulting in huge cost in the main for overtime	Aspirational								LC	Any unsocial hours? DAU which banding and any unsociable hours? What rota cover for dermatologist and WTE? Any support costs required? What bandings and WTE? Unsociable hours? What bandings and WTE? Unsociable hours? What bandings and WTE? Unsociable hours?	More detail required. Won't be cost of consultant - cost associated with support services.
	CAH ED Admin - Health Records (AT RISK)	0.40 WTE B3 Admin Health Records CAH ED (increase from position from 0.6 to 1.0 WTE)	At Risk				11,926.39				LC	Currently at risk.	
Corporate													
92	Acute Governance	Service Context Band 8A governance lead (with clinical skills) required to supplement the existing team. Greater stresses are placed on senior operational teams who do not have the capacity to develop targeted training and implement the learning fully from all clinical incidents and serious adverse incidences. The 8A Governance Lead would provide support to oversee and monitor all the SAI/ See investigation and provide the opportunity to challenge the report and recommendations. Also they would be required to implement learning from clinical incident and Mortality and Morbidity outcomes. One of the key elements would be to close the loop from presentation at screening/ M+M to the investigation and finally to implement learning and cascade to all appropriate teams. Risk The risk to the Trust if this post is not approved will be that the learning from Serious adverse incidents is not driven forward and cascaded to relevant teams. There would be limited assurance for the Trust about learning from SAI. Benefit The 8a governance lead would also be involved in the nurturing of an open and transparent culture within acute governance and would assist the 8B to deliver on the trusts ethos for learning / sharing and being open	At Risk		c. £60k	1	67,075.68				LC	Costed B8A only with no annual leave cover.	Agreed
93	Acute Governance – Band 7 post	Service Context Band 7 post for datix support required	At Risk	1 wte	£60k		60,036.62				LC	Costed with no annual leave cover. Are any unsocial hours/annual leave cover required?	Agreed
94	DHH Pathfinder Project	Funding required 20/21 and beyond to secure staffing in post			c.£3.2m in 20/21						LC	Need details of WTE and banding to cost.	
95	Normative Nursing	The shortfall between funding and staff in post @ 31 st March 2020 is £7.5m			£7.5m						LC	Need details of WTE and banding to cost.	

17,777,064.56

Minutes of a Trust Board meeting held in public on
Thursday, 26th September 2019 at 11.30 a.m.
in The Boardroom, Trust Headquarters, Craigavon

PRESENT

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

IN ATTENDANCE

Mr B McNeany, Director of Mental Health and Disability Services
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs J McConville, Acting Assistant Director of Corporate Planning (*for Mrs Magwood*)
Mr B Beattie, Acting Director of Older People and Primary Care (item 11 onwards) / Mrs M McAlister, Assistant Director of Older People (*for Mr Beattie items 1-10*)
Mr B Conway, Assistant Director of Cancer and Clinical Services and Integrated Maternity and Women's Health (*for Mrs McClements*)
Mrs J McKimm, Head of Communications
Mrs P Keenan, Boardroom Apprentice
Mrs S Judt, Board Assurance Manager
Mrs L Gribben, Committee Secretary (Minutes)

APOLOGIES

Mrs P Leeson, Non-Executive Director
Mrs E Gishkori, Director of Acute Services
Mrs A Magwood, Director of Performance and Reform
Mrs M McClements, Interim Director of Acute Services

REPRESENTATION FROM TRADE UNIONS IN REGARDS TO PAY PARITY

At the outset, the Chair welcomed members from NIPSA and Unison who had been granted speaking rights on the pay differential that currently exists within Agenda for Change across the National Health Service.

Speaking Rights

The Chair welcomed Ms Nuala Conlon and Ms Petra McCreesh from Unison. Ms Conlon thanked Trust Board for the opportunity to speak at the meeting today to highlight the challenge to establish pay parity across the 4 countries and the gaps that exist within Northern Ireland. She noted this issue has been discussed at the Joint Negotiation Consultation Forum (JNCF) every month. Ms Conlon referred to the leaflet that was circulated amongst members which illustrates the difference in pay parity between employees in Northern Ireland compared to the same banding and job roles for employees in England, Scotland and Wales. Ms Conlon spoke of the ongoing challenges in staffing levels and the effect this has on employees. She commented that when there are staff shortages, this is when mistakes are made. Ms Conlon stated that the situation has reached a crucial point and they are preparing for a ballot for industrial action of which the Department of Health has been informed. She asked that Trust Board support them in their campaign for pay parity by writing to the Department of Health.

Ms McCreesh stated a number of employees are accepting roles in the Republic of Ireland and on the mainland as their pay is higher for the same roles in Northern Ireland and this is a contributing factor to the challenge in retaining staff. She asked that Trust Board support the Trade Unions in this matter.

Speaking Rights

The Chair welcomed Mr Brian Smyth from NIPSA. Mr Smyth spoke of the crisis situation and asked Trust Board members to support and influence establishment of pay parity for its employees. Mr Smyth advised Trade Unions have resisted to strike, however if no progress is made on this issue NIPSA will have no other option but to progress further with the intention to ballot members on industrial action.

The Chair thanked Ms Conlon, Ms McCreesh, Mr Smyth and the Trade Union representatives for their comments and attendance. She noted the significant collaboration Trade Unions have with the Trust's Director of

Human Resources and other Directors and stated that they and the Chief Executive continue to work with the Department in relation to pay.

1. CHAIR'S WELCOME

The Chair welcomed everyone to the meeting. She particularly welcomed the Assistant Directors who were deputising, namely Mrs Janet McConville, Mr Barry Conway and Mrs Monica McAlister and welcomed back Mrs Paula Keenan, Boardroom Apprentice. The Chair advised Mr Brian Beattie, Acting Director of Older People and Primary Care will join the meeting at lunchtime. At this point members were reminded of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops / iPads are used for accessing Board papers only during the meeting.

The Chair was pleased to welcome four members of Trust staff from the Medical Directorate and stated that she would welcome their feedback in terms of what they will learn at today's meeting and how they take this learning back to their colleagues.

2. DECLARATION OF INTERESTS

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. In regards to first item on the agenda, the Trade Unions' speaking rights at Trust Board, Ms Mullan declared that her partner is an employee of Unison.

3. SERVICE IMPROVEMENT/LEARNING FROM SERVICE USER EXPERIENCE: ORGAN DONATION

The Chair welcomed Dr Claire Shevlin, Clinical Lead for Organ Donation. Mrs Rooney as the Chair of the Organ Donation Committee advised Organ Donation within the Trust is a service that is operated regionally through the Northern Ireland Blood and Transfusion Service and Dr Shevlin is contracted as the Clinical Lead for the Trust.

Dr Shevlin thanked the Chair for the opportunity to present to Trust Board on this important issue. She began by informing members there are approximately 140 people in NI are waiting for a transplant, 9 died last year while waiting for suitable organs. 43% people in NI are on the NHS Organ Donor Registry and a soft 'opt out' is still under discussion pending resumption of local government. Dr Shevlin explained the steps in process when a patient has been identified, usually in ICU.

Dr Shevlin presented the detailed report on Actual and Potential Deceased Organ Donation April 2018 to March 2019. In this time period the Trust had one deceased solid organ donation which resulted in 3 patients transplanted. She spoke of the significant role the SNOD (Specialist Nurse for Organ Donation) undertakes along with herself as the Clinical Lead in highlighting the importance of Organ Donation across the Trust.

Dr Shevlin spoke of the challenges namely the small donor pool in Northern Ireland and the need to maximise opportunities, the normalisation of organ donation as an end of life consideration and stated that this requires incorporation into culture of critical care and wider hospital. On the issue of consent, she advised that the first step is awareness of Organ Donation in the community and the need to discuss wishes with the family.

The Chief Executive asked what Trust Board can do to support and improve Organ Donation within the Trust. Dr Shevlin commented on the immense support from Mrs Rooney as Chair of the Trust's Organ Donation Committee and asked for Trust Board support in normalising organ donation into the culture of critical care and the wider hospital. Mrs Rooney reminded members art work was recently commissioned and is displayed in DHH and CAH in tribute to all those who have donated their organs. She mentioned work is underway with the local councils and schools to further promote organ donation.

The Chair assured Dr Shevlin of Trust Board's support and thanked her for her informative presentation

4i. CHAIR'S BUSINESS AND VISITS INCLUDING NON-EXECUTIVE DIRECTORS' BUSINESS AND VISITS

The Chair drew members' attention to her written report detailing events she had attended since the previous meeting, together with details of some good news stories and innovative work across the Trust. A list of Non-Executive Directors' business and visits was noted.

4ii. COMMISSIONER FOR PUBLIC APPOINTMENTS NORTHERN IRELAND (CPANI) BOARD MENTORING SCHEME

The Chair informed members the CPANI Public Board Mentoring Scheme is seeking expressions of interest from Board members who are willing to act as a mentor to a graduate student from Queens University

and Ulster Business School. She asked that those members who are interested to notify the Chair's Office at the earliest convenience.

Ms Mullan left the meeting at this point (12.15 p.m.)

5. CHIEF EXECUTIVE'S BUSINESS AND VISITS

The Chief Executive presented his summary report. He stated that he felt it was important to set this in the context of the current environment the Trust was working in, particularly the hospital environment, and he drew members' attention to the service challenges outlined in the report. In relation to the Trust's hospital performance for 2018/19, the Chief Executive highlighted the fact that the Trust is managing an increased demand for service with the highest rate of bed occupancy in Northern Ireland – 90.8% of all available beds occupied. Mrs McCartan stated the statistics demonstrate the volume of patients in the system and the challenge staff encounter on a daily basis.

The growing waiting lists were discussed. Mr McDonald referenced the Waiting List Validation Exercise within Acute and asked for an updated position. The Chief Executive advised an update on the exercise will be reported at the forthcoming Performance Committee meeting

Action: Mrs Magwood / Mrs McClements

The Chief Executive welcomed the Protect Life 2 Strategy that was recently launched by the Department of Health which outlines measures that will be taken to reduce suicide and self-harm in the next five years.

6. MINUTES OF MEETING HELD ON 29th AUGUST 2019

The minutes of the meeting held on 29th August 2019 were agreed as an accurate record and duly signed by the Chair.

The Board approved the minutes of the meeting held on 29th August 2019.

7. MATTERS ARISING FROM PREVIOUS MEETINGS

Members noted the progress updates from the relevant Directors to issues raised at the previous meetings.

8i. DRAFT TRUST DELIVERY PLAN (ST958/19)

The Chief Executive set the context of the TDP and reminded members the document sets out the actions the Trust will take in response to the Department of Health Commissioning Plan Direction and the commissioning priorities, objectives and goals for improvement included in the HSCB and PHA Commissioning Plan 2019/20.

Mrs McConville presented the TDP for approval. She noted an error on page 63 of the report for 5.3 and advised this should read AHP Referral and not Direct Payments; the report will be amended to reflect this.

Mrs McConville pointed out a significant number of targets (48%) are assessed as not achievable or partially achievable with additional resources in 2019/20. In the main this represents continued performance challenges from 2018/19 into 2019/20.

Members noted the main contributing factors limiting deliverability of commissioning plan targets and agreed volumes of activity included in the service and budget agreement relate to workforce challenges and insufficient financial resources.

Mrs McCartan referred to page 16, 2.2.3(d) where it reports on the lack of a Departmental Oral Health Strategy and asked if there was any indication of when a strategy would be available. Dr O’Kane agreed to raise this issue at the next regional Medical Directors’ Group meeting.

Action: Dr O’Kane

Ms Donaghy asked for clarification for 2.2.1 (b) elective / planned care where it states ‘the Trust will work with the regional elective care group to address longest waiters, however, this will be subject to additional funding and will address ‘new’ waits only’. Mr Conway clarified this is in relation to the elective care centres. The Chief Executive added that even if £100m was secured per annum it would still not take into account new waits.

In response to a query by Mrs McCartan on the achievement of break even at end of the financial year given the workforce shortages and the use of agency staff, Ms O’Neill advised that plans are underway across the Directorates to ensure that financial breakeven is achieved.

Mrs Keenan noted her concern for 3.3 ‘by September 2019, patients in all Trusts should have access to the Dementia portal’ that to date, no

service users have engaged in the pilot. This is due to a number of factors such as; the patient does not have good internet connectivity, lack of an email address and lack of consent due to the advanced dementia and asked how the Trust is addressing this. Mr McNeany recognised the issues reported and in relation to technology he advised the Trust is supporting individuals in this area to access the portal. The Trust will continue to contribute regionally to development and implementation of the Dementia Portal with the assistance of the Dementia Navigators who have recently taken up post.

Mrs McCartan noted overall 25% of OGIs are reported as green / achievable. She asked if the Trust benchmarks the data against the region. Mrs McConville confirmed the Trust has requested the other Trusts data and once that is received benchmarking will be undertaken.

The Chair welcomed the plan however she felt further narrative could be included in some areas as to why targets are unachievable. The Chief Executive assured members SMT review and discuss the red status OGIs and Trust Board will be kept to up to date with any changes.

The Board approved the Draft Trust Delivery Plan (ST958/19)

8ii. SUMMARY OF CAPITAL & REVENUE PROPOSALS IN EXCESS OF £300,000

Mrs McConville presented the summary of proposals with a capital/revenue value in excess of £300,000 that have been developed between 28th March 2019 and 26th September 2019. As in previous reports, she advised that each project has a risk management process in place to identify and seek to manage / mitigate any impact on successful delivery of the investments proposed.

The Board approved the Summary of Capital & Revenue Proposals in Excess of £300,000

9. SECTION 75 ANNUAL PROGRESS REPORT 2018/19 (ST960/19)

Mrs Toal presented the above named report for approval which presents the Trust's progress in fulfilling its Section 75 statutory equality and good relations duties, the Trust's Equality Scheme commitments and Disability Action Plan between April 2018 and March 2019. The Section 75 Annual Progress Report has been prepared using a template circulated by the Equality Commission for NI to all Public Authorities. The key issues and achievements have been

presented in accompanying newsletter format which is included in members' papers.

Mrs Toal highlighted the two new staff training modules for 'Making a Difference' which informs staff on the concepts of equality, good relations and human rights. She advised these modules are now mandatory, part 1 to be completed by all staff and part 2 to be completed by managers and will be rolled out corporately. Mrs Toal noted Mrs Lynda Gordon, Head of the Equality Unit can provide face to face training if required for certain areas. The Chair asked that members ensure their mandatory training is up to date and noted the importance for all staff to complete all relevant training.

Mrs Keenan referred to page 7 of the newsletter on the HSC Regional Interpreting Service and noted the Southern Trust has the highest number of requests received in the region and noted the number of people who were not provided for. Mrs Toal advised the demand for the interpreting service within the Trust is extremely high and it depends on the individual circumstances. Mr Morgan advised in some instances the community are providing interpreting services which is very resourceful and very beneficial to families. Ms O'Neill confirmed that this is a regionally funded service.

Mrs Toal commented the Trust will focus on disability employment over the next 12 months and a staff disability forum will be considered. She stated the Trust has signed up to the Mental Health Charter, the commitments of which will be taken forward by Dr Lorraine McGurk, Consultant Occupational Clinical Psychologist in her capacity as chair of the Trust's Psychological Wellbeing Workstream.

The Board approved the Section 75 Annual Progress Report 2018/19 (ST960/19)

10. OPERATIONAL PERFORMANCE

i) Finance Report (ST961/19)

Ms O'Neill spoke to the above named report and advised the cumulative outturn at month 5 is a deficit of £1.7m. She attributed this to two main causes: transformation funding, however work is ongoing with DoH, HSCB and project owners and the Trust is confident full funding will be secured and continued unscheduled care pressures which discussions have commenced with the Commissioner. Pay expenditure exceeds the budget by £2.5m and this largely due to

medical and nursing. Ms O'Neill spoke of the flexible payroll arrangements which are costing £27.6m, £6.7m more than the same period last financial year. In August the Trust employed a total of 1,166 Wte's on these flexible arrangements, an increase of 14 Wte's when compared to July.

Ms O'Neill advised the Trust has been notified of its indicative allocations for 2019/20 and a full assessment on the impact these will have on the financial position has been prepared.

Prompt payment was discussed. Ms O'Neill advised the prompt payment performance was 89.8% in month bringing the cumulative to 90.5%. She reminded members of the trend that occurs during the summer months where deterioration in performance occurs, due to annual leave. She commented as the number of agency staff has increased this has generated additional invoices for managers to process. This is having an impact on the prompt payment performance; however additional measures have been put in place to address this. The Chair spoke of the importance to pay suppliers and providers on time.

The Chair noted her concern at the unscheduled care pressures creating a budget overspend of £549k and asked for assurance on breaking even. The Chief Executive advised there is a monitoring round bid due on October 2019, which will not meet all of the demands, however it will help ease the financial situation. Ms O'Neill commented, the Trust has submitted a balance Trust Delivery Plan, but in doing so recognised that it was not going to be an easy task. Each Director is acutely aware of their responsibility in achieving break-even and they each continue to monitor their budgets, this will be closely monitored over the remaining months of the financial year.

The Board approved the Finance Report (ST961/19)

ii) Human Resources Report (ST962/19)

Mrs Toal presented the Human Resources Report for approval. The report provides a high level summary and update on some of the results and key themes from the regional 2019 HSC Staff Survey. The report also outlines key productivity information.

Mrs Toal advised at this stage the survey results have not been shared or publicised within HSC Organisations as the Department of Health have asked for the opportunity to share regional results first. The Trust

survey has only recently been issued and therefore further analysis is required. She advised the final Trust staff survey report will be shared with members when available.

The response rate from staff was 25% which was an improvement on 21% in 2015. The Trust overall staff engagement score was 3.78 which is same score as the HSCNI average, however it is slightly lower than the 2015 Trust score of 3.81. The Chair noted the low response rate and pointed out one of the themes was improvement on staff engagement and felt the response rate reflected this.

Mrs Toal commented on the number of positive results to recognise and build on which was outlined in the report. She referred to the opportunities for improvement within the workplace for areas: staff involvement, recognising and valuing staff, communication with senior managers, violence, harassment, bullying and abuse at work and communicate patient / service user experience feedback to staff. The Chair asked what measures are in place to address and reduce bullying and abuse in the workplace. Mrs Toal stated she was disappointed there is an increasing trend in the number of staff experiencing this and advised further analysis will be required to understand if this is occurring in certain areas. She informed members there is a new Conflict, Bullying and Harassment in the Workplace Policy which emphasises early intervention. Mrs Toal referenced the HSC Value 'Compassion' which will be a key focus going forward.

Mrs Toal advised SMT have dedicated a meeting in October to review the staff survey results to understand the themes that need focused on over the next two years in line with the development of the Workforce and Organisational Development Strategy.

A discussion ensued on staff not being valued and how this could be improved. Mr Wilkinson felt more engagement with frontline staff and their immediate line manager would make more of an impact on staff being valued and need to focus on the top down and leaders demonstrate the HSC values. Mrs McAlister spoke of the 'what matters to you' event which received good engagement from staff and they spoke of their ideas which management took on board. She noted the importance of listening and communicating to all staff. She did note the challenge in engagement with Domiciliary Care staff working in the community. Mrs McAlister advised a newsletter is issued to reach those Dom Care staff who work off site in the community.

In response to a question asked by Ms Donaghy, the Chief Executive advised it is the responsibility of SMT to ensure a plan is put in place to address all areas for improvements and to engage with staff on the results to collect their feedback and ideas going forward. He did note there were a number of external factors that impacts how staff feel at work e.g. pay, workforce pressures, vacancies etc. however this will be long term journey and the process is about building confidence throughout the workforce.

Mrs Toal moved onto workforce information and noted the cumulative sickness absence rate for 2019/20 year to date is 5%, which is slightly lower than the figure of 5.06% for the same period last year. Staff in post as at 31st July 2019 shows an increase of 17.13 wte since 31st March 2019. The flexible costs for 2019/20 have increased by an average of just over £2.1m per month compared to 2017/18 figures, and by over £850k per month when compared to 2018/19.

The Board approved the Human Resources Report (ST962/19)

Mr Beattie joined the meeting at this point

Mrs McAlister left the meeting at this point

11. PATIENT/CLIENT SAFETY AND QUALITY OF CARE

i) Executive Director of Social Work Report

Mr Morgan presented the Executive Director of Social Work report which provides a summary of activity and developments within the Social Work profession. Mr Morgan spoke of the Mental Capacity Act (MCA) which has been deferred to go live until 1st December 2019. The Trust is tasked with meeting the legislative requirements to implement part of the MCA. To enable the Trust to meet the legislative responsibilities, planning is underway to implement two main parts: Deprivation of Liberty Panels and Short Term Detention applications. Planning is also underway to strengthen the Approved Social Work (ASW) workforce. Mrs McCartan noted the already stretched social work workforce and asked how this additional responsibility will impact staff while delivering a service. Mr Morgan stated the Trust has the lowest ASW in the region and commented this will be a challenge for the Trust. He added 7 staff have enrolled for the ASW course commencing between September 2019 and January 2020 and funding has been made available to recruit 'short term detention' authorisers.

Mr Morgan moved onto Quality Improvement (QI) and noted the Social Work staff within the Trust continues to be developed in the field of QI and are core to the regional Staying Connected QI programme. He added funding was successful for the Scottish Leadership Programme and 7 Social Workers are undertaking the course where their projects have service user involvement. Mr Morgan spoke of the QI project that aims to appoint a hospital based Domestic Violence Advisor. He stated that Ms Flo Fegan, Head of Service for Acute Social Work is liaising with Clinical and Social Care Governance Teams on how best to support the victim. Mr Morgan informed members the Carers Conversation is currently being tested as an alternative to NISATS Assessment Tool through a QI project within Adults with Physical Disability Services. The compliance rate has improved and the QI project will be tested in Addictions Services and learning will be fed back to the DoH for a regional decision on the future use of NISATS.

Mr Morgan advised the Trust is involved in regional work progressing the development of a Professional Governance Practice Framework for line managers and professional leads supporting the safety and wellbeing of social work staff who are impacted by violence, threats and intimidation in the course of undertaking their professional roles and duties.

The Chair referred to workforce issues included in the report and the recent successful Social Work Job Fair. She noted out of the 138 people who were successful, of these 102 remain on the waiting list and asked for further explanation. Mrs Toal advised people who were successful but have not accepted posts remain on the waiting list due to a number of factors; primarily they would prefer posts in specific areas / teams / locality.

Mr Wilkinson noted the staffing issues in the Family Intervention Service (FIT) and asked what steps are being taken to address this. Mr Morgan advised a 'Grow our Own' initiative has been developed to support two social work assistants from the Gateway / FIT service through Open University Social Work Degree and on completion they have agreed to work in the FIT service for a minimum of 2 years.

Mr McDonald made reference to the Looked After Children Services (LAC) initiative and the development of a video which outlines the work that the team does. Members asked to see this video, once completed.

The Chair referred to the Regional Social Work Workforce Steering Group and asked how this is progressing. Mr Morgan advised the

group is lobbying for additional funding to train more social workers through Universities and highlight how rewarding social work is and ensure the posts are attractive to potential students. The Employment Based and Open University are also being explored as routes in to Social Work.

ii) Unallocated Child Care Cases

Mr Morgan spoke to the above named report and advised a total of 68 unallocated cases as at 31st July 2019, an increase on the previous reporting period (30 April), when 60 unallocated cases were reported. He advised Trust has the second lowest unallocated cases in the region.

iii) RQIA Review of Governance of Outpatients Services – Safeguarding Overview Report

Mr Morgan informed members the Department of Health undertook a RQIA Review of Governance of Outpatients Services – Early Findings on Safeguarding. The department of Health wrote to the Trusts on 5th February 2019 to advise that RQIA had conducted a Review of Governance of Outpatients Services – Early Findings on Safeguarding within the Belfast Trust. A number of key areas were highlighted and the Department of Health requested each Trust to review their current position of their outpatients services and provide a brief written report to Trust Board in advance of a RQIA inspection over the next 12 months. The report includes the internal preparation that was undertaken where a self-assessment template was developed to support teams to consider department compliance. Ad hoc walkabouts were completed in a sample of departments to support staff and identify gaps. The report also referenced the action plan that was developed and cascaded via Directorate's reporting lines.

Mr Morgan guided members through the summary of key findings for both adult and children. He noted the gaps identified through the review and the action that will be taken: up to date information / flow charts to be made available and displayed in public waiting areas, intranet / sharepoint to be cleansed and updated, remove out of date policies from staff areas, cascade pathways and aid memoirs for responding to concerns to all departments, access to posters and leaflets and ensure corporate mandatory safeguarding training is completed by all outpatient staff. The Chair welcomed the action to improve the information available to staff and patients.

Mr Morgan advised each Director is required to submit a composite report to the Head of Service for Safeguarding who will coordinate as a Trust report with regard to our state of preparedness.

iv) Executive Director of Nursing, Midwifery and AHPs Report

Mrs Trouton presented the above named report which focuses on education, development and quality of the Nursing, Midwifery and AHP workforce. She referred to the statistics for mentorship and advised out of 1444 mentor registered, 993 were available across the four directorates. In response to a question asked by Ms Donaghy, Mrs Trouton clarified that students have protected time to enable the mentor to support them.

Mrs Trouton guided members through the report which highlighted the ongoing work within Nursing, Midwifery and AHPs and provided information on quality improvement, bereavement, fitness to practice data and training. She reminded members the Chair asked for an update on the number of 3rd year students who were in post as at September 2019: out of the 88 that were offered a post, 39 accepted and were in post. Overall from the December 2018 nursing recruitment day, 159 posts were offered and 73 were accepted. She noted the work to be undertaken to increase the conversion rate from interview to post.

v) Inquiry Report into Hyponatraemia related Deaths Update

Dr O'Kane presented the above named report which provides an assurance the Trust is meeting the recommendations of the Inquiry Report. The oversight group have met on 5 occasions this year and regional workstreams are progressing. She noted there is an agreed communication strategy from the DoH which ensures all Trusts receive the information in the same way, which is tabled at the oversight group.

Mrs Trouton commented the initial focus was on the clinical recommendations; however as the Trust moves through the journey of implementing these recommendations the oversight group is reviewing and progressing work in other areas such as education, SAls and family engagement.

The Chief Executive added the challenge with achieving 100% in the auditing of fluid balance charts. The oversight group continues to work with operational directorates to improve compliance within Acute and CYP and progress will be monitored through SMT.

Dr O’Kane advised the oversight group plan to facilitate a workshop to review and update the Trust baseline assessment of all 96 recommendations.

12. BOARD COMMITTEES

i) Governance Committee

– Minutes of meeting held on 21st May 2019 (ST963/19)

In absence of Ms Mullan, Mrs Rooney presented the Minutes for approval and highlighted the key discussion points.

The Board approved the Minutes of the meeting held on 21st May 2019 (ST963/19)

– Summary of key issues from the meeting held on 5th September 2019

Mrs Rooney advised of the key issues raised at the meeting held on 5th September 2019.

13. BOARD REPORTS

i) Volunteer Annual Report (ST964/19)

Mr Beattie presented the above named report for approval. The report provides an update on the progress made by the Trust against the action plan under six key themes of the HSC Regional Plan for Volunteering in Health and Social Care 2015-2018. He was pleased to report the Trust is compliant with all 6 themes. Mr Beattie acknowledged the impact volunteering has for patients and the wider system and thanked the Chair and the Non-Executive Directors for their support and attendance at various events to recognise the important role played by Volunteers. Members agreed to continue to make staff aware of volunteering opportunities within the Trust.

The Board approved the Volunteer Annual Report (ST964/19)

ii) PPI Annual Report (ST965/19)

Mr Beattie presented the PPI Annual Report for approval. He advised the report outlines progress made during 2018/19 to further embed PPI, partnership working and co-production into the culture, ethos and

practice of the organisation. He assured members that the Trust is compliant with each of the standards and associated key performance indicators. Mr Beattie highlighted that Senior PPI Officer and Service User Consultants are funded via Transformation money, which is due to cease in March 2020.

The Board approved the PPI Annual Report (ST965/19)

14. APPLICATION OF TRUST SEAL (ST966/19)

Ms O'Neill sought approval for the Application of the Trust Seal to contract documentation as outlined in members' papers.

In response to a question asked by Ms Donaghy, Ms O'Neill clarified the contract for refurbishment of 3 North / Stroke Rehab was to deal with the service as it currently is and is completely separate to the Regional Stroke Consultation.

The Board approved the Application of the Trust Seal (ST966/19)

15. ANY OTHER BUSINESS

The Chair asked each of the Professional Lead Directors if they wished to bring any issues to the Board's attention in respect of their roles. There were none noted.

In conclusion, the Chair reminded Trust Board members to remain at the end of the meeting for a time of reflection on the proceedings of the day.

The meeting concluded at 3.00 p.m.

SIGNED: _____

DATED: _____



Southern Health & Social Care Trust

Risk Management 2020/21



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Acknowledgement

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

Control Log

Exit Meeting Held On:	30 September 2020
Working Draft Issued On:	03 December 2020
Management Actions Received:	21 January 2021
Final Report Issued On:	22 January 2021

Distribution List

Shane Devlin	Chief Executive (final report only)
Dr Maria O'Kane	Medical Director
Stephen Wallace	Interim Assistant Director of Clinical & Social Care Governance
Helen O'Neill	Director of Finance
Alison Rutherford	Assistant Director of Finance

Introduction

In accordance with the 2020/21 Annual Internal Audit Plan, BSO Internal Audit carried out an audit of Risk Management during September 2020. The last Internal Audit of this topic was performed during February 2020 when Satisfactory assurance was provided in relation to the Management of Corporate Risks and the management of risk within the Performance and Reform and the Finance, Procurement and Estates Directorates.

Risk Registers are developed at divisional, directorate and corporate level to record all forms of risk. The Corporate Risk Register records the most serious risks in terms of potential consequences for the Trust. The Corporate Risk Register (CRR) records the Trust's principal risks that have serious consequences for the organisation and threaten achievement of its' corporate objectives and the key controls to manage those risks. The Corporate Risk Register is reviewed by the Trust's Senior Management Team (SMT) on a monthly basis and, on behalf of the Trust Board, through the Trust Governance Committee on a quarterly basis.

Due to COVID19 and the unparalleled and rapidly changing environment the Trust was working in, these risk arrangements were replaced during the period March to June 2020, through the operation of twice weekly Trust SMT meetings and similar arrangements within Directorates at SMT level, to address the unprecedented operational risks which were appearing almost daily during this time. An updated Corporate Risk Register (CRR) was presented and discussed at Governance Committee in May 2020, including 3 corporate risk assessments for COVID19 rated as "Extreme". These were approved and presented to Trust Board in June 2020.

Governance structures show that the responsibility for the management of risk rests within operational directorates within their corresponding governance arrangements, and the corporate overview role is provided by the Medical Director and Corporate Governance Team.

While the Trust has a software system, Datix, which has the capability to support the management of risk at a corporate level and within each directorate, this has yet to be rolled out and risks continue to be recorded on a range of general software. The Trust plans to roll out Datix in Quarter 4 2020/21 or early 2021/22, SMT have recently approved the recruitment of a manager for this project and other corporate systems, as identified in the Review of Clinical and Social Care Governance.

Scope of Assignment

This audit focused on the Trust's Corporate, and 4 operational Directorate Risk Registers Acute Services, Older People and Primary Care, Mental Health and Disability, and Children and Young People Services. The audit was based on the risk that ineffective risk management processes will impact on the effectiveness of the organisation and its ability to deliver services.

The objectives of this audit were:

- To ensure there is an appropriate framework in place for Risk Management, including review of Strategy, Policy and Procedures; and
- To ensure the risk management system is operating effectively at Corporate and Directorate level.
- To ensure COVID19 risks were identified and assessed.

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

Level of Assurance

Satisfactory

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

Executive Summary

Internal Audit can provide Satisfactory assurance in relation to Risk Management. Satisfactory assurance is provided on the basis that key risks to the Trust in meeting its Corporate Objectives are considered in the Trust's Corporate Risk Register. During the past 6 months the Corporate Risk Register (CRR) has been subject to regular review by the Senior Management Team (SMT), and also by the Trust Board. Extreme risks such as those posed by COVID19 and the Mental Health Capacity Act have been assessed and added, while there is evidence of de-escalation of other risks between Corporate and Directorate Risk Registers during this period. Normal directorate governance / risk arrangements were replaced during the first surge COVID19 period March to June 2020 with twice weekly Trust SMT meetings and similar arrangements within each Directorate, to address the unprecedented operational risks which were appearing almost daily during this time.

There are no significant findings in this report that impact on the assurance provided.

The key findings of the audit are:

1. As previously reported, the Trust Risk Management Strategy refers to Risk Appetite and Tolerance. However, the Trust has not actually defined its Risk Appetite and it not utilising defined risk appetite in risk management processes.
2. The Risk Management Strategy remains in "Interim" status. The document was approved by Governance Committee in September 2019 and again in September 2020 however it has not received final approval from Trust Board. The Strategy had not been formally issued / made accessible to all Trust staff.
3. As reported in previous years, risk registers across the Trust continue to be held in different formats, i.e. Word, and Excel, with no standardised pro-forma leading to inconsistencies in the information recorded between what are controls/actions/progress.
Analysis of the most recent Corporate Risk Register and the operational directorates risk registers identified gaps in the completion of information on risk registers and an absence of timely review in some cases. Most significantly, whilst actions are identified to address corporate risks, responsible persons are not identified for implementation of the action and timescales for implementation of the action are not provided.
4. The Trust does not have a formal Risk Management training programme. Across operational directorates, the delivery of risk training tends to be ad-hoc with each directorate delivering training to staff in their own areas rather than through a centralised programme.

Other findings include:

5. The Trust's Risk Management Strategy states the Board Assurance Framework should be reviewed on a six-monthly basis" by Trust Board. This is actually happening on an annual basis.

Summary of Findings and Recommendations

Finding		Number of Recommendations		
		Priority 1	Priority 2	Priority 3
1.	Risk Appetite	-	1	-
2.	Risk Management Strategy	-	1	-
3.	Format and Population of Risk Registers	-	1	-
4.	Risk Management Training	-	1	-
5.	Review of Board Assurance Framework	-	-	1

Detailed Findings and Recommendations

1 Risk Appetite

Finding

The Trust Risk Management Strategy refers to Risk Appetite and Tolerance – the Trust has not actually defined its Risk Appetite.

A Directors Workshop was to be planned in relation to Risk Appetite however to date this has not taken place.

This finding was previously reported in the 2019/20 Risk Management Internal Audit report.

Implication(s)

Failure to identify the organisation's overall risk appetite increases the risk that the organisation will be exposed to unacceptable levels of risk and inconsistency/subjectivity across Managers when managing risk.

Recommendation 1.1	As previously reported in the Risk Management report 2019/20, the Trust's risk appetite should be clearly defined, documented in an annual risk appetite statement and communicated to all staff. The defined risk appetite should then be used throughout the Trust to assist in scoring and managing risk.
Priority	2
Management Action	ACCEPTED The Trust will define risk appetite, and document it in an annual risk appetite statement and communicated to all staff. The defined risk appetite will then be used throughout the Trust to assist in scoring and managing risk. Original Implementation Date: September 2020
Responsible Manager	Assistant Director Clinical & Social Care Governance (ADCSCG) / Interim (ADCSCG)
Revised Implementation Date	September 2021

2 Risk Management Strategy

Finding

The Risk Management Strategy is still held as "Interim". The document was approved by Governance Committee in September 2019 but release and finalisation of the document was delayed due to an internal review of Clinical and Social Care Governance arrangements within the Trust. The Risk Management Strategy was again presented to Governance Committee at its meeting in September 2020 and it is planned to presented to Trust Board for final approval in October 2020.

The Strategy has not been formally issued / made accessible to all Trust staff.

A similar finding was previously reported in the 2019/20 Risk Management Internal Audit report.

Implication

Risk Management guidance is not available to staff therefore staff may not be fully aware of their role in the risk management processes within the Trust.

Recommendation 2.1	The Risk Management Strategy should be finalised and approved by Trust Board. Once approved Directors, Corporate and Operational Governance Leads should draw the strategy to the attention of key staff in their directorates and ensure appropriate training is made available. The Risk Management Strategy should also be published on the Trust Sharepoint site so it is easily accessible for all staff.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Assistant Director Clinical & Social Care Governance (ADCSCG) / Interim (ADCSCG)
Implementation Date	February 2021

3 Format and Population of Risk Registers

Finding

As previously reported, risk registers across the Trust continue to be held in different formats, i.e. Word, and Excel, with no standardised pro-forma leading to inconsistencies in the information recorded between what are controls/actions/progress.

Internal Audit reviewed the most recent Corporate Risk Register, and the four operational directorates risk registers for - Acute Services (23 risks), Older People and Primary Care (6 risks), Children and Young People (8 risks) and Mental Health & Disability Directorates (9 Risks). Analysis identified the following gaps in information:

- The Corporate Risk Register has a section for Additional Actions Planned and Timescale. On review of these additional actions, a responsible person was not recorded for implementation of the action and timescales for implementation/completion of the action were not provided;
- 5 risks on the Acute Services Risk Register had not been reviewed/updated in the past year (1 - June 2019 and 4 - July 2019) – these were assessed as 2 High, 1 Moderate and 2 Low;
- 2 risks on the Acute Services Directorate Risk Register the Progress/Action Plan - were recorded as “*Added to Directorate Risk Register April 2018*” with no further details. Both these risks were graded as High;
- 1 risk on the Acute Services Risk Register had only one control listed as “*situation being monitored*”. This risk was assessed as High;
- A risk owner was not recorded against any of the 23 risks on the Acute Services Directorate Risk Register provided to Internal Audit.
- Across all 4 Directorate Risk Registers - whilst actions are recorded against each risk these tended to be retrospective actions or actions at a point in time – not future actions. Timeframes for completion of actions were not recorded and the person responsible for undertaking the action was not recorded.
- On the Children and Young People and Acute Services Directorate Risk Registers some risks were classified as ‘*moderate*’ as opposed to regionally agreed wording of ‘*medium*’ and colour coding of risk levels was not consistent with the regional model, e.g. risks rated ‘*high*’ per these directorates Risk Registers are highlighted in red as opposed to orange. Red denotes ‘*extreme*’ rating per the Corporate Risk Register and the regionally agreed model.
- While COVID19 risk was added to the Corporate Risk Register in May 2020, supported by 3 risk assessments and graded as “Extreme”, this was not always the case within directorates. It is recorded on CYP and OPPC directorates while within MHD it is a work in progress based on CRR, and Acute Services has nothing included. However we acknowledge that all directors were involved in assessing COVID19 risk corporately through SMT.

Internal Audit acknowledge that the Trust plan to roll out the DATIX system during quarter 4 / early 20/21 and are to recruit a system manager to assist in this process, which will help to address a number of the inconsistencies highlighted above.

A similar finding was previously reported in the 2019/20 Risk Management Internal Audit report.

Implication(s)

Inconsistencies in recording of risks may arise if there is no standardised risk register.

Risk registers may not capture all the required information to ensure that the risk is appropriately managed.

Recommendation 3.1	As previously recommended, the introduction of the Datix Risk Management module would ensure a standard pro-forma of a risk register is adopted throughout the Trust. All directorate risk registers should then be reviewed and gaps in information should be completed. Management should ensure that all relevant information is recorded in relation to risks identified and that a consistent approach is adopted using the regionally agreed scoring template / standards
Priority	2
Management Action	ACCEPTED The Trust plans to implement the DATIX risk management module for recording all risks throughout the Trust as part of a DATIX upgrade in 2020. This was planned for April 2020 however was postponed due to the impact of

	the coronavirus pandemic. Original Implementation Date: March 2016, June 2016, June 2017 & Sept 2018, January 2021
Responsible Manager	Assistant Director of Clinical and Social Care Governance
Revised Implementation Date	September 2021

Recommendation 3.2	All risks recorded on Directorate Risk Registers should be subject to timely review and update. Risk Register actions should be forward looking, include a timeframe for implementation and a responsible officer for implementation recorded against each action. In addition a risk owner should be identified for each individual risk.
Priority	2
Management Action	ACCEPTED
Responsible Manager	All Trust Directors
Implementation Date	June 2021

4 Risk Management Training

Finding

The Trust currently do not have a formal Risk Management training programme and across operational directorates the delivery of risk training tends to be ad-hoc with each directorate delivering training to staff in their own areas rather than through a centralised programme. MHD had no training, CYP had 58 trained and Acute and OPPC did not provide any information.

The review of Clinical and Social Governance within the Trust identified Risk Management training as a gap. On this basis SMT approved funding in September 2020 for the recruitment of a Corporate Head of Service for Standards and Guidelines, Risk Management and Learning – and also a Corporate Risk Management Training Officer.

Implication(s)

Without appropriate training, risk management processes may not be fully implemented and followed in all service and business areas.

Lack of corporate oversight of training and potential for inefficient delivery model.

Recommendation 4.1	On appointment of the 2 posts a scoping exercise should be conducted to establish what risk management training is required by staff at different bands and with varying degrees of responsibility for Risk Management. Consideration should be given to the introduction of e-learning for general Risk Management Awareness Training.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Assistant Director Clinical & Social Care Governance (ADCSCG) / Interim (ADCSCG)
Implementation Date	August 2021

5 Review of the Board Assurance Framework

Finding

The Trust's Risk Management Strategy states:-

Where the identified risks have the potential to threaten the achievement of the Trust's corporate objectives, they will be escalated by the SMT to the Board Assurance Framework. The Trust Board own the Board Assurance Framework and review it on a six-monthly basis.

On review of Trust Board Minutes Internal Audit noted that the Board Assurance Framework was presented to Trust Board on 30 June 2020. Internal Audit noted it was last presented to Trust Board at their meeting on the 12 June 2019 therefore annual presentation not six monthly. Internal Audit were advised by the Board Assurance Manager that the Board Assurance Framework is now only presented annually to Trust Board.

Implications

The Risk Management Strategy does not reflect current governance arrangements in relation to the Board Assurance Framework.

Recommendation 5.1	The Risk Management strategy should be updated to reflect that annual review of the Board Assurance Framework is performed by the Trust Board.
Priority	3
Management Action	ACCEPTED
Responsible Manager	Assistant Director Clinical & Social Care Governance (ADCSCG) / Interim (ADCSCG)
Implementation Date	June 2021

Appendix A - Definition of Levels of Assurance and Priorities

Level of Assurance

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

Recommendation Priorities

Priority 1	Failure to implement the recommendation is likely to result in a major failure of a key organisational objective, significant damage to the reputation of the organisation or the misuse of public funds.
Priority 2	Failure to implement the recommendation could result in the failure of an important organisational objective or could have some impact on a key organisational objective.
Priority 3	Failure to implement the recommendation could lead to an increased risk exposure.

Note to Report

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

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Serious Adverse Incident Panel & Chairperson Training



The HSC Leadership Centre is offering a 1.5 day virtual course for SAI panel and potential panel members with an additional half day (2 days in total) for Chairpersons.

Over the two days, we are delighted to have input from Mr Martin Dillon, Ms Patricia Gordon, Ms Vivian McConvey, Dr Gavin Lavery, the HSCB and PHA.

These sessions are funded by the Public Health Agency.

Course Objectives

To develop knowledge and skills on

- SAI process and impact
- SAI panel remit
- Roles and responsibilities
- The role of the HSC Board and Public Health Agency in the SAI process
- Family engagement
- Investigative methods

Dates

Wed 27 & Thurs 28 Jan 2021

Wed 24 & Thurs 25 Feb 2021

Wed 24 & Thurs 25 March 2021

Panel and Chair

Day 1 : 9.30am – 4.30pm

Day 2 : 9.30am – 12.30pm

1.30pm – 4.30pm (**Chair only**)

Apply Now

To book your place go to our website: www.leadership.hscni.net.

For further information contact: Irrelevant information redacted by the USI



1 Day Essentials of Effective Investigations

Workshop Programme

What you will learn

- The basic ABC's of how to conduct an effective investigation
- An insight into a range of tools and techniques that will assist you with this
- How to conduct a 'root causes analysis' and identify the 'right' root causes
- How to use the 'fisghbone' and human factors frameworks to help you identify 'root causes'

Workshop attendees

This workshop benefits staff who

- undertake local team based investigations
- undertake significant adverse incident reviews
- investigate non-complex complaints that do not constitute serious incident
- investigate professional performance concerns
- act as clinical/ specialist advisors to serious untoward incident investigation
- 'ask' others to investigate (i.e. commissioners of internal investigations)

Incidents covered/ tailored to organisation

Consequence UK work and provide training on RCA across acute, mental health, safeguarding, primary and community care, local authorities. We take care to tailor the training provided to suit the organisation, field of care and service remit.

1 Day RCA and Effective Investigations Workshop Root Cause Analysis and Incident Investigation

Note: This programme is a guide for the timing and order. Timings are rarely exact and change according to the needs of the workshop and the participants. **Please do not book meetings for the timetabled lunch recess as the timing can alter on the day.**

The Programme

08.45 Registration

09:00 Welcome and introduction - START

- General introduction and core objectives of the workshop
- Your range of experiences in the conduct of investigations to date
- Human and Systems Factors overview

09.45 The basics required to achieve an effective and proportionate investigation

- Determining what scope of investigation is required. Part A of the investigation process
- When is 'Part B' necessary?
- The terms of reference (TOR)
- Who should do the investigation?
- Your basic responsibilities as a team leader/manager/investigator

10.30 Refreshments

10.45 Analysing readily available documentation at an early stage

This session focuses on Timelining method as an easy to use safe and reliable tool for all staff required to conduct investigations where there is a period of time leading to an incident which must be understood.

- What is a Timeline?
- The difference between Timelining and narrative chronologies
- Incident types that suit Timelining
- Group activity – Creating a structured Timeline

12.00 Other tools for mapping information - OVERVIEW

- Control Analysis
- Person contact grids
- Pattern Analysis
- Participant / Non-participant observation

12.30 Lunch

13.00 Other tools for mapping information – Continued

13.30 Gathering information during the investigation process - OVERVIEW

It is not sufficient to rely on readily available documentation alone when conducting an investigation. Therefore some degree of additional information gathering is usually required. This session aims to expand your thinking beyond the face to face interview.

14.00 Analysing the information you have gathered

This session will address:

- Clarifying key care delivery and service delivery concerns and issues
- Conducting a contributory factors analysis
- Validation and Triangulation of data
- Agreeing root causes (the most significant influencing factors)

15.15 Refreshments

15.30 Identifying and devising recommendations to address 'root causes'

- What makes a good recommendation?
- From recommendations to the action plan

16.00 The investigation report - OVERVIEW

How you record the output of your investigation/review is important even if this is only appended to the incident report form. This session provides an overview of what elements are required for an effective and readable report.

16.30 Closing session

- Reflection on key learning points
- Reflection on 'what now' for the participants and how they are going to implement the learning from the programme

16.45 Close of workshop



2 Day RCA & Effective Investigations Workshop Programme

What you will learn

- The essential elements of a good quality investigation
- What it means to 'do' RCA or 'systems analysis'
- How to avoid the 'blame game'
- 'Being Open' with families following adverse incidents
- How and when to use specific investigation tools and techniques
- A robust approach to data analysis, and the formulation of robust recommendations
- What constitutes an good investigation report
- A range of methods to collect information to aide your undrstand of 'how and 'why' a system or process has underperformed

In short how to conduct a balanced, fair and robust investigation using an investigation process that enables you to write an investigation report that is 'evidenced' based and not simply 'opinion' based.

Incidents covered/ tailored to organisation

Consequence UK provides effective investigation training across a range of agencies. We take care to tailor the training provided to suit the organisation, field of care and service remit.

The case study we use for 'breakout' work has been chosen for its merits in enabling participants to best appreciate how effective investigation tools can work, rather than its allegiance to any particular health or social care professional group or domain.

WORKSHOP PROGRAMME

The Programme: Day 1

08.45 Registration

09:00 Welcome and introduction

- Overview of the purpose of the workshop
- Housekeeping and confidentiality
- Attendees share their range of investigation experience (Patient Safety, HR, H&S, complaint) and the type of events that led to the investigation
- Agree personal/ group learning objectives and needs
- The requirements of the different investigation you undertake:
 - Conduct and capability
 - Complaint
 - Health & Safety (RIDDOR)
 - Safeguarding (IMR)
 - Patient / client safety (medication error, pressure damage, falls management)

09.45 What does a good investigation look like, and what is required to achieve 'good'? - First Steps

- Early review and case assessment – asking the right questions
- Proportionality – get the focus right
- Retrospective record keeping; early memory capture; reflective practice documents; statements
- Knowing when 'RCA' is and is not necessary for 'this' investigation

10.45 Having the right mind set to deliver 'good'

- Understanding and avoiding counterfactual thinking
- Why we make the mistakes, 'we' do? – the basics of human error theory
- How the system contributes to the mistakes we make
- Separating out 'proximal' and 'root' causes to 'serious mistakes'
- Using a 'Culpability Framework' to assist determining, an HR or Learning from Experience Investigation
- Avoiding 'counterfactual thinking' (hindsight bias and judgmental thinking)

11.00 Refreshments

11.15 Having the right mind set to deliver 'good'- continued

11.45 Being Open and Duty of Candour - Meaningful Engagement with Families

- What are the rules
- What was the intent of 'D.O.C'
- Do families of patients, clients, service users and families of victims have rights in terms of information sharing
 - If yes to what extent
 - What if a Patient/ Service User says he/she doesn't want any information shared
- What does a true commitment to Duty of Candour and Being Open look like?

12.00 A detailed, and structured investigation is required – what now?**Getting on Track and Staying On Track**

- Terms of reference
- Getting the right mix of skills and knowledge in the investigator(s)
- The responsibility of the reviewers
- Managing the tasks required efficiently (project management)
- The importance of the initial case assessment

13.00 Lunch**13.40 Investigation Tools and Techniques:****The analytical timeline**

Participants will develop insight from a case study as to the use and benefits of an analytical timeline tool.

- What is a timeline?
- The difference between Timelining and narrative chronologies
- Incident types that suit Timelining
- How to create a structured chronological timeline
- Group activity – creating a structured timeline (between 30 – 40 minutes Inc. feedback)

Participants will be provided with a case study, however, the chronology will not be complete. Participants will create an analytical timeline in small groups (2-3 persons) to familiarise themselves with the methodology and to identify how it can assist in the delivery of a robust investigation.

14.40 Control Analysis (Barrier Analysis)

Not all adverse events lend themselves to the analytical Timelining method. This is a powerful approach for analysing incidents where there is no obvious antecedent chronology and where there are clearly established policies and procedures in place which if followed should result in incident avoidance.

- Control Analysis overview and how to
- Control Analysis – mini exercise
- Reflections on the pre-work exercise re – making an omelette etc....

Refreshments are taken during the above session at approximately 15.00hrs

14.40 Pattern Analysis A simple method of exploring patterns in information

16.00 Organisation own investigation report distributed.

Delegates will be asked to read and comment on this report using key questions set out in the workbook. It is strongly advised that delegates remain at the workshop venue for this as your observations will be required for the final report writing session on day two, and your facilitator may refer to the report at key stages of the programme on day two. (This work can be done individually or in pairs)

16.30 Close of Day 1

The Programme: Day 2

08.45 Registration

09.00 Start of workshop and recap of learnings on day 1

09.30 Achieving a 'deep' understanding of the System - Information gathering techniques

- Observation methods
- Surveys (market research; litmus test; on-line)
- Private post boxes
- The importance of face to face information gathering
- The Interview triangulation and validation map
- Effective questioning techniques – mini information gathering exercise
- The hallmarks of an effective 'investigative interview'?
- The 'round the table or reflective group meeting
- Making a good quality record of the meeting
- The importance of validating the records you take away from the meeting

In this session delegates will be asked to reflect on the pre-work observation 'coffee house' exercise.

10.45 / 11 am Refreshments

11.00 / 11.15 Analysing the information gathered

A core component that must be undertaken using an auditable and repeatable method. In this session participants will explore how they currently undertake this activity and learn about one approach that will assure consistency in practice as well as rigour in process.

- Clarifying those issues that constitute a significant / serious lapse in practice or service delivery
- One qualitative research technique – Content Analysis
- Affinity mapping and analysis using a human factors framework +/- 'The Fishbone'
- Validation and triangulation of data reiterated

Identifying the most significant influencing factors to significant/serious lapses in practice / service delivery i.e. 'Root Causes'

Once an investigation team has achieved clarity about the contributory factors to each individual significant lapse it is important that the 'root causes' to each is identified.

The Fishbone diagram c/w a human factors framework can be a helpful tool in achieving this and it is this tool that participants will work with at this stage.

12.15 – 12.30 ish Lunch

13.00 Recommendations and Action Plans

The design of your recommendations can directly impact on the quality and robustness of any improvement actions implemented.

- What makes a good recommendation?
- The nature of recommendations and their failsafe characteristics
- Who decides whether or not a recommendation is accepted and becomes an action plan?
- Designing action, and implementation, plans – how to increase the performance of low reliability solutions
- PDSA

14.00 The Investigation report – key pointers for success

Reflecting on key messages throughout the workshop:

- Open, honest, transparent, straightforward
- Answers family questions and the TOR
- Clarity of OK and not OK
- Evidence of understanding of 'not OK'
- Most significant contributory factors identified
- Recommendations that will deliver improvement
- Professionally produced and understandable
- Objective

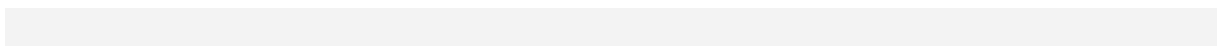
In this session delegates will be asked to reflect in their workgroups on the SI report provided. Each work group will be asked to provide feedback and ideas for how the report could have been enhanced (if at all)

14.30 / 14.45 Refreshments

15.30ish Closing session

- Reflection on key learning points
- Reflection on 'what now' for the participants and how learning can be implemented
- Collection of key messages for the hospital healthcare governance team

16.00 Close of workshop



Root Cause Analysis Masterclass

for Health and Social Care Professionals

Monday 1 March 2021
Wednesday 31 March 2021

Virtual Masterclass
Virtual Masterclass



Key Learning Points

- Managing an RCA investigation effectively
- Gathering, mapping and organising evidence
- Conducting interviews using the cognitive interviewing technique
- In-depth analysis: what tools are available?
- Identifying care and service delivery problems
- How to pin-point contributory factors and root causes
- Understanding the impact of human factors
- Strengthening/creating barriers to minimise future risk
- Agreed best practice in action planning and writing RCA reports
- The pitfalls of RCA: common failings and how to avoid these
- Understanding the future of RCA: what changes are in the pipeline?

Facilitated by:
Tracy Ruthven
*CASC Director, Magistrate and
Freedom to Speak Up Guardian*

Stephen Ashmore
*CASC Director
Patient Participation Group Chairman*

A Joint Healthcare Conferences UK
& CASC Masterclass

Root Cause Analysis Masterclass

for Health and Social Care Professionals

Monday 1 March 2021
Wednesday 31 March 2021

Virtual Masterclass
Virtual Masterclass

This one day intensive masterclass will provide Root Cause Analysis Training in line with the July 2019 Patient Safety Strategy. The course will offer a practical guide to RCA with a focus on systems-based patient safety investigation as proposed by the forthcoming National Patient Safety Incident Response Framework which emphasises the requirement for investigations to be led by those with safety investigation training and expertise, and with dedicated time and resource to complete the work.

"We think organisations should develop a patient safety incident review and investigation strategy to allow them to use a range of proportionate and effective learning responses to incidents. The proposal is to explore basing the selection of incidents for investigation on the opportunity they give for learning; and ensuring that providers allocate sufficient local resources to implement improvements that address investigation findings."

The NHS Patient Safety Strategy July 2019

This one-day course is designed to provide delegates with the key skills and knowledge that they will require to conduct RCA effectively. The course content walks learners through the seven-key stages to conducting a high-quality RCA investigation. We pay particular attention to planning and managing investigations, interviewing staff, mapping information, using appropriate analysis tools to establish contributory factors and creating fit-for-purpose action plans and final reports. We advocate RCA as a team-based approach and agree with NHS Improvement's 2018 statement 'investigations must be led by trained investigators with the support of an appropriately resourced investigation team'.

The course also focuses on the reality of conducting RCA. Indeed, recent publications such as The future of NHS patient safety investigations (2018) highlighted a number of potential weakness and flaws that can occur when healthcare teams conduct RCA. We explore these potential pitfalls and advise on what best practice in RCA delivery looks like.

Delivery is fast-paced and interactive with lots of practical guidance for learners. Attendees will receive lots of additional useful materials. All learners will receive a certificate of attendance.

The course is facilitated by Tracy Ruthven and Stephen Ashmore who have significant experience of undertaking patient safety reviews in healthcare. They also were commissioned by the Healthcare Quality Improvement Partnership to write a national RCA guide in 2016.

**A Joint Healthcare Conferences UK
& CASC Masterclass**

Root Cause Analysis Masterclass

for Health and Social Care Professionals

**Monday 1 March 2021
Wednesday 31 March 2021**

**Virtual Masterclass
Virtual Masterclass**

Virtual Training Timetable

- 09.45** Introduction to the day
Working with technology throughout the Masterclass. Objectives for the day
How information will be shared
How to undertake and gain the associated course accreditation
- 10.15** Introducing Root Cause Analysis. A brief history of RCA. Why is RCA important in 2020?
The 2019 Patient Safety Strategy and the future of RCA
- 10.45** Defining RCA. What is RCA? And what is not RCA!
Understanding the RCA process: seven-steps to success
- 11.15** Mid-morning screen break
- 11.30** Getting started with RCA: what are the initial steps?
Identifying the incident to investigate
Setting up your RCA team
Gathering information
Interviewing key stakeholders
- 12.20** Mapping the information, Narrative chronology, Tabular timelines, Time-person grids
- 13.00** Lunch break
- 13.30** Systematically analysing the information
Identifying what went wrong: contributory factors and the root cause
Understanding how to use key RCA tools: change analysis, the five-whys, fishbone diagram, process maps, run charts
A brief introduction to human factors
- 14.20** Barrier Analysis
Understanding why we fall over the edge
The Swiss-Cheese Model
- 14.40** Mid-afternoon screen break
- 14.50** Implementing changes, improvements and solutions
Understanding what needs to change
Guidance on effective action planning
- 15.30** Sharing feedback from your RCA investigation
Top tips in terms of writing your audit report
Methods for feeding back information to key stakeholders
- 15.50** Pitfalls to avoid when conducting RCA
- 16.00** End of formal teaching. We will remain online for 30 minutes if any learners wish to ask further questions

**A Joint Healthcare Conferences UK
& CASC Masterclass**

Root Cause Analysis Masterclass

for Health and Social Care Professionals

4th - 5th May 2021

Virtual Masterclass



Key Learning Points

- Managing an RCA investigation effectively
- Gathering mapping and organising evidence
- Conducting interviews using the cognitive interviewing technique
- In-depth analysis: what tools are available?
- Identifying care and service delivery problems
- How to pin-point contributory factors and root causes
- Understanding the impact of human factors
- Strengthening/creating barriers to minimise future risk
- Agreed best practice in action planning and writing RCA reports
- The pitfalls of RCA: common failings and how to avoid these
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4th - 5th May 2021

Virtual Masterclass

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“We think organisations should develop a patient safety incident review and investigation strategy to allow them to use a range of proportionate and effective learning responses to incidents. The proposal is to explore basing the selection of incidents for investigation on the opportunity they give for learning; and ensuring that providers allocate sufficient local resources to implement improvements that address investigation findings.”

The NHS Patient Safety Strategy July 2019

This two-day course is designed to provide delegates with the key skills and knowledge that they will require to conduct RCA effectively. The course content walks learners through the seven-key stages to conducting a high-quality RCA investigation. We pay particular attention to planning and managing investigations, interviewing staff, mapping information, using appropriate analysis tools to establish contributory factors and creating fit-for-purpose action plans and final reports. We advocate RCA as a team-based approach and agree with NHS Improvement's 2018 statement 'investigations must be led by trained investigators with the support of an appropriately resourced investigation team'.

The course also focuses on the reality of conducting RCA. Indeed, recent publications such as The future of NHS patient safety investigations (2018) highlighted a number of potential weakness and flaws that can occur when healthcare teams conduct RCA. We explore these potential pitfalls and advise on how best practice can be delivered in RCA.

Delivery is fast-paced and interactive with lots of practical guidance for learners. Attendees will receive many additional new practical resources. All learners will receive a certificate of attendance.

The course is facilitated by Tracy Ruthven and Stephen Ashmore (Directors of the Clinical Audit Support Centre) who have significant experience of undertaking patient safety reviews in healthcare. In 2016 they were commissioned by the Healthcare Quality Improvement Partnership to write a national guide for Root Cause Analysis.

Root Cause Analysis 2 Day Programme

Day 1 Programme

10.00 Why RCA is important in 2019

10.30 Commencing and planning the RCA process. What are the initial steps?
Setting up the RCA team, gathering information, interviewing key stakeholders

11.30 Comfort Break

11.45 Mapping the evidence. Sorting information by using narrative chronology, tabular timelines and time-person grids

13.00 Lunch Break

13.30 Systematically analysing the information using various tools. Identifying care & service delivery problems. Pin-pointing contributory factors

14.15 Barrier analysis. Why did we fall over the edge?

14.45 Comfort Break

15.00 Implementing improvements and solutions. What needs to change?
Key advice on effective action planning

15.30 Best practice in report writing and disseminating key learning from an RCA investigation

16.00 Summary & Close (for virtual the close time will be 15.30)

Day 2 Programme

10.00 Review of Day 1 learning and burning questions

10.30 Understanding Human Factors and ergonomics
Reducing human error in healthcare and the importance of focusing on the second victim

11.30 Comfort Break

11.45 Common RCA failings
What are the pitfalls to avoid
Best practice rules to follow when conducting RCA via our checklist

13.00 Lunch Break

13.30 RCA Case Study pt 1: Putting theory into practice

14.30 Comfort Break

14.45 RCA Case Study pt 2: Putting theory into practice

15.30 Summing up and final thoughts. A reminder of what is needed for the accreditation

16.00 Summary & Close (for virtual the close time will be 15.30)

PLEASE NOTE

The Zoom Link for the training will be open from 08:00am to allow for testing and troubleshooting. Training will commence at 09:00am

9:00 am Welcome

How to get on the Right Path - Investigation Approach

Phase 1 - Prepare

09:20 *Getting it Right from the Beginning* – Initiating the Investigation

The Right People, for the Right Job – Team Membership

Case Studies – Breakout Groups

Feedback Phase 1 – Prepare

10:25 **Comfort Break**

Phase 2 - Discover

10:30 *Failing to Prepare, Prepare to Fail* – Preparing for Analysis

Tell Me What Happened? - Incident Chronology

What exactly happened? – Fact Finding

Starting to Pull it all Together – Undertaking an initial analysis

11:10 **Comfort Break**

11:20 Case Studies – Breakout Groups

Feedback Phase 2 – Discover

12:30 [Lunch Break & Self-Directed Learning](#)

Phase 3 - Engage

13:10 *A Just Culture* - Engaging and Supporting Staff

To Interview or Not to Interview - Interviewing Approach

'I want to tell you how I feel' – Involvement of Patients, Services Users and their Carers and Families

14:10 [Comfort Break & Self-Directed Learning](#)

14:30 Case Studies – Breakout Groups

Feedback Phase 3 – Engage

15:45 [Self-Directed Learning](#)

9:00 am Reflection/Discussion Day 1

Phase 4 - Analysis

09:15 am *Find the Cause then Fix it - Causal Factors*

Change the Way you Look at Things - Contributory Factors

10:30 **Comfort Break & Self-Directed Learning**

10:50 **Case Studies – Breakout Groups**

Feedback Phase 4 – Causal Factors

11:50 **Comfort Break & Self-Directed Learning**

12:10 **Case Studies – Breakout Groups**

12:40 **Lunch Break & Self-Directed Learning**

13:20 **Feedback Phase 4 – Contributory Factors**

Phase 5 - Act

13:50 *What can we do to stop it happening again? – Recommendations, Action Planning & Lessons Learned*

14:20 **Comfort Break & Self-Directed Learning**

14:40 **Case Studies – Breakout Groups**

Phase 6- Evaluate

- 15:10 *If you can't explain it simply, you don't understand it well enough* – Report Compilation
- Take a Step Back* – Take Time to Evaluate
- Work Smart* – Running Effective Incident Investigation Team Meetings
- 15:30 **Feedback Phase 5 – Act**
- 16:00 **Question & Answer Session and Close**

Join Zoom Meeting

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9:00 am Welcome

How to get on the Right Path - Investigation Approach

Phase 1 – What Happened?

09:20 *The Right People, for the Right Job – Team Membership*

Tell Me What Happened? - Incident Chronology

Failing to Prepare, Prepare to Fail – Preparing for Analysis

Starting to Pull it all Together – Undertaking an initial analysis

What exactly happened? – Fact Finding

10:00 **Comfort Break**

A Just Culture - Engaging and Supporting Staff

To Interview or Not to Interview - Interviewing Approach

'I want to tell you how I feel' – Involvement of Patients, Services Users and their Carers and Families

10:55 **Comfort Break**

Case Studies – Breakout Groups

Feedback Phase 1 – What Happened?

Phase 2 – Why it happened?

12:00 pm *Find the Cause then Fix it - Causal Factors*

Change the Way you Look at Things - Contributory Factors

13:00 **Lunch Break & Self-Directed Learning**

Case Studies – Breakout Groups

Feedback Phase 2 – Why it Happened?

Phase 3 - What have we learned/What needs to change

14:35 *What can we do to stop it happening again? – Recommendations, Action Planning & “Lessons Learned”*

15:00 **Comfort Break & Self-Directed Learning**

Case Studies – Breakout Groups

Feedback Phase 2 – What have we learned/What needs to change

16:20 pm Question & Answer Session and Close

Zoom Details

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Southern Health & Social Care Trust

Board Effectiveness 2018/19



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Acknowledgement

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

Control Log

Exit Meeting Held On:	25 March 2019 (Chair)
First Draft Issued On:	1 April 2019
Management Meeting On:	3 June 2019
Management Actions Due By:	4 April 2019
Management Actions Received:	2 September 2019
Final Report Issued On:	3 September 2019

Distribution List

Roberta Brownlee	Chair (Final report only)
Shane Devlin	Chief Executive
Sandra Judt	Board Secretary
Helen O'Neill	Director of Finance, Procurement & Estates
Alison Rutherford	Assistant Director of Finance

Introduction

In accordance with the 2018/19 annual internal audit plan, BSO Internal Audit carried out an audit of Board Effectiveness during February/March 2019. The last Internal Audit of this topic was performed during February / March 2016 when satisfactory assurance was provided.

The Board Governance Self-Assessment Tool is intended to help Arm's Length Bodies (ALBs) improve the effectiveness of their Board and provide the Board members with assurance that it is conducting its business in accordance with best practice. Good governance best practice requires Boards to carry out a board effectiveness evaluation annually and with independent input at least once every three years. The Self-Assessment was completed by the Trust during March to June 2018 and was used to self-assess the Trust Board capacity and capability supported by appropriate evidence. This assignment reviewed the results of that self-assessment.

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

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

To ensure these functions are carried out effectively the SHSCT's governance structure is underpinned by a number of key documents including the Management Statement and Financial Memorandum and the Standing Orders (SOs), Standing Financial Instructions (SFIs), Integrated Governance Framework 2017/18 – 2020/21, Corporate and Annual Business plans. The Board, is supported by 5 Sub-Committees:

1. Governance Committee;
2. Audit Committee;
3. Remuneration Committee;
4. Endowments & Gifts Committee; and
5. Patient Client Experience Committee.

During 2018/19, a number of previously vacant or interim posts within the Executive SMT were filled on a permanent basis, and this improved stability has positively impacted the operation of the Trust Board. In addition to the board meetings, 4 board workshops have been held during the second half of 2018/19, to address the Trust vision, culture, planning etc and to help grow working relationships between the new SMT and NEDs.

Scope of Assignment

The NIAO Board effectiveness Good Practice Guide, was used as a basis on which to conduct this assignment through:

- Carrying out a survey of Non-Executive and Executive Directors;
- Using the results of the survey to interview 5 executives and non-executives.
- Attending / observing Board / Committee meetings;
- Reviewing minutes and papers of Board / Committee meetings; and
- Reviewing key strategic and operational documents.

The results of the survey were presented to the Board Workshop held on 21 February 2019.

The audit was based on the risk that the SHSCT Board may not be operating effectively.

The objectives of this audit were:

- To ensure that the Trust has appropriate processes to build / establish the Board;
- To ensure that there are appropriate arrangements in place to develop the Board;
- To ensure that there is clarity of roles, responsibilities and effective relationships among members;
- To ensure that Board meetings are conducted effectively;
- To ensure that appropriate information is received by the Board to discharge its responsibilities, including monitoring service performance and quality;
- To ensure that Board processes are effective;
- To ensure that the Board communicates effectively; and
- To ensure that the Board conducts adequate, regular assessments of its own effectiveness.

This assignment will exclude risk management, which has been the subject of a recent assignment, where satisfactory assurance has been provided

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

Level of Assurance

Satisfactory

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

Executive Summary

Internal Audit can provide Satisfactory assurance in relation to Board Effectiveness. The Trust Board is operating effectively and the recommendations in this report are aimed at enhancing an already effective Board. Satisfactory assurance has been provided on the basis that:

- The Board and its 5 Sub-committees have operated as required under their Standing Orders and respective terms of reference during 2018-19.
- From observation of the Trust Board meeting attended and review of Board minutes, there is evidence of effective challenge by Non Executive Directors.
- Papers to and minutes of Trust Board were found to be adequate.
- The survey of Executive and Non Executive Directors was largely positive (see Appendix A). The survey provided positive feedback in relation to the size of the board, engagement during board and committee meetings by both NEDs and Executives, and the skills and expertise of members. Other areas of positive feedback in the survey included: clarity of roles, effective discharge of responsibilities, objectivity of members, and the skills and experience of the Board Secretary.
- There is improved stability in the SMT membership during 2018/19 with several interim positions recruited to on a permanent basis;
- The Trust Board has conducted Board workshops in 2018/19 focusing on vision and culture.
- In line with best practice, after Board meetings there is now a short period of self-reflection by members to critically assess how well agenda items have been addressed and whether there is scope to improve future performance both individually and collectively.
- Internal Audit reviewed the Board's annual governance self-assessment which it completed in early 2018/19 and the subsequent action plan in place which had been reviewed / updated during the year by Trust Board. The 3 red flag areas identified – recruitment to vacant SMT posts, maximising attendance at Trust Board meetings and completion of directors' appraisals and objectives - have all been addressed during 2018/19. Internal Audit found the self assessment to be comprehensive and advise that the Board should incorporate the findings from this report into its new self-assessment due to be completed in early 2019/20.

There are no significant findings in this report, that impact on the assurance provided.

The key findings of the audit are:

1. Whilst no specific issues were identified with the adequacy of Performance Reporting to Board, the Trust are currently working to refine and improve their reporting. Executives and Non Executives identified a number of suggestions for improving the quality of board performance reporting including more integrated reporting across functions, focused on areas which can be actioned, and succinct reporting.
2. Board members highlighted that Board meetings are often part of a full day series of related meetings. There is an opportunity to review the Board agenda and the work of Committees to further refine and define what goes to Committee and the Board and for what purpose.
3. The main area for development that emerged from the survey of Executive and Non Executive Directors was Board Processes - specifically learning and involvement of the Board in planning/strategy. It is recognised that Trust Board are either working already or have planned work in these areas.

Other findings include:

4. There is a need to consider future proofing the Board against sudden loss of members and considering stakeholder representation (appreciating that the Trust is not in control of NED appointments). Executive Directors generally did not feel they had appropriate Board induction and annual assessment of performance on the Board. From discussions with NEDs, there is a need to review and refine HSC Board induction processes.
5. While attendance rates of NEDs and Directors at Trust Board and sub-committees has been excellent with attendance rates of 80-100%, this has not been the case for the Patient Client Experience (PCE) Committee, where average attendance rates have been 56% for directors and 60% for NEDs. Most NEDs are required to attend Governance, PCE and Audit committees. When considering their Board/Committee business, the Trust should review its committee terms of reference to assess whether it is most effectively utilising the limited time of its NEDs.
6. Internal Audit acknowledge the ongoing work of the Board Effectiveness workstream of the DoH led IHRD implementation project and the developments this workstream should bring to board effectiveness across the HSC, particularly around induction and other training.
7. Clinical Governance structures could be further developed and strengthened, as reflected in discussions with NEDs and recent Internal Audit reports.
8. During the 6 month period April to September 2018 there were 6 Leadership Walk-arounds. NEDs are expected to carry out 3 walk-around visits per year (24 in total). We are informed a further 5 visits have been conducted in October to March 2019.

Summary of Findings and Recommendations

Finding		Number of Recommendations		
		Priority 1	Priority 2	Priority 3
1.	Reporting Operational Performance to Trust Board	-	1	1
2.	Trust Board Meetings	-	1	-
3.	Board Processes	-	2	1
4.	Building and Developing the Board	-	2	-
5.	Attendance at Board / committees	-	2	-
6.	O'Hara and Board Effectiveness Recommendations	-	1	-
7.	Governance Structures	-	1	-
8.	Communication with Stakeholders	-	-	1

Detailed Findings and Recommendations

1 Reporting Operational Performance to Trust Board

Finding

There has been improvements in the quality of papers provided to Trust Board e.g. more succinct reports; use of trajectories to show changes in performance against OGLs; use of summary sheet to highlight key issues / points, etc. Internal Audit observed that the Trust has multi level reporting of performance against OGLs, highlighting key issues and summary data.

The Trust has expressed an intention to further develop their performance reporting to Board and in particular to explore a more integrated approach to reporting by directorate and division using integrated dashboards. This approach should address some members comments around the volume of statistical information provided and the need for summary information and appropriate analysis. Some members also highlighted the need to focus on what actions the Trust can take to improve performance.

When surveyed and through the interviews held with Executives and Non Executives, the following suggestions for improvement were made for how board performance reporting could be further improved:

- Use of comparative performance analysis with other Trusts/NHS and previous time periods within the Trust
- Development of Patient Safety Strategy with measurable outcomes and a governance assurance strategy driven by Quality Improvement
- Incorporating reporting on health of the population
- Review committee work and structure to consider what should go to Board and should go to a Committee.
- Increased use of exception reporting
- Chief Executive's report could include key risks/challenges, emerging issues, governance matters.

Implication(s)

Potential for loss of focus on key issues in performance reports, where these include too much detail / information.

Recommendation 1.1	Trust Board should consider the feedback on the current performance reporting from members, when shaping the intended reporting improvements.
Priority	2
Management Action	ACCEPTED Performance Committee to be established. Delegated powers and Terms of Reference approved by Trust Board on 29 th August 2019. First meeting of Committee agreed for 17 th October 2019
Responsible Manager	Chief Executive
Implementation Date	31 st August 2019

Recommendation 1.2	It is important that NEDs are comfortable with the complexity and understanding of performance data presented to them. As current reporting arrangements are changed, NEDs should be sufficiently trained.
Priority	3
Management Action	ACCEPTED • Function of Performance Committee is to ensure members are appropriately trained and understand the complexity of performance data • Training needs identified will be discussed and agreed at Performance Appraisal meeting with the Chair • Once Performance Committee is up and running for six months, any further

	trained needs will be considered
Responsible Manager	Chair and Chief Executive
Implementation Date	31 st March 2020

2 Trust Board Meetings

Finding

We observed that changes have been made to Trust Board agendas during 2018/19, including clarification of actions required by members against agenda items e.g. for noting, approval etc, times for each agenda item etc. We observed that agendas were appropriate and were sub-sectioned into normal business, strategic, operational performance, Board committees and Patient/Client Safety & Quality of Care, Additionally there was a Confidential Section agenda, 2 presentations by staff, and a short self assessment session at the end of the meeting.

Although Trust Board agendas were viewed as appropriate, some Board members commented that Board meetings are often part of a full day series of related meetings and commented on the potential to further refine the Board agenda. Inclusion of too many presentations, non-statutorily required items and extensive performance reporting were viewed by members as main contributors to long agendas.

Internal Audit attended the Board meeting in January 2019. An appropriate level of scrutiny and challenge was observed throughout the meeting. All members actively participated, and NEDs raised questions in a positive manner with Directors.

Implication(s)

Heavy Trust Board agendas and lengthy meetings could potentially impact on effectiveness. Absence of guidance on how to deal with members of the public / issues at Board Meetings creates uncertainty.

Recommendation 2.1	The Trust should review the content of Trust Board agendas to identify those items which are statutorily required and must be included and those items which are only for information / noting etc or e.g. could be better addressed through an appropriate board sub-committee. The scheduling of Board related meetings on the same day as the Board meeting should be reviewed with Board members.
Priority	2
Management Action	ACCEPTED New schedule of reporting approved by Trust Board on 29 th August 2019
Responsible Manager	Chair and Chief Executive
Implementation Date	31 st August 2019

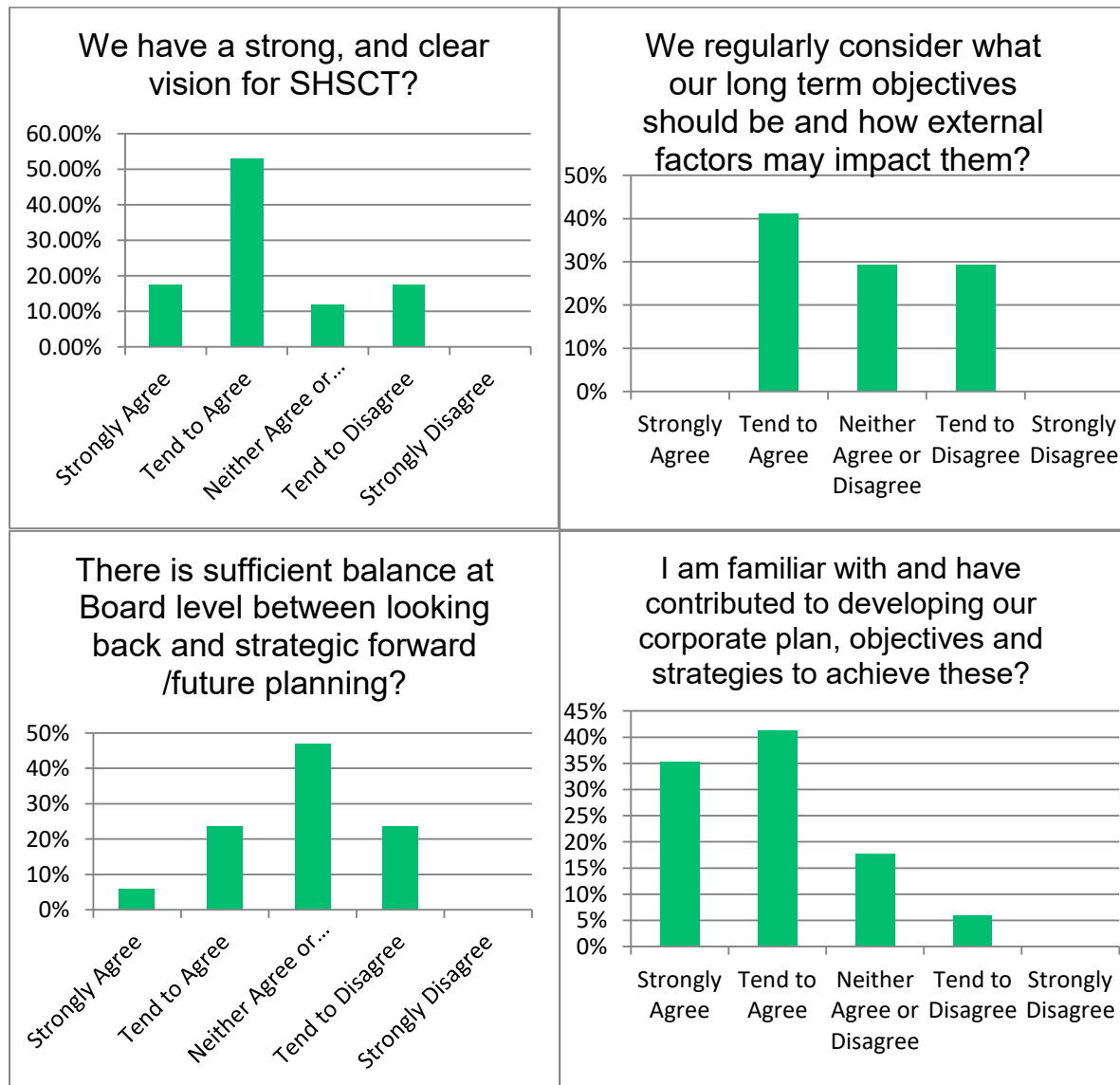
3 Board Processes

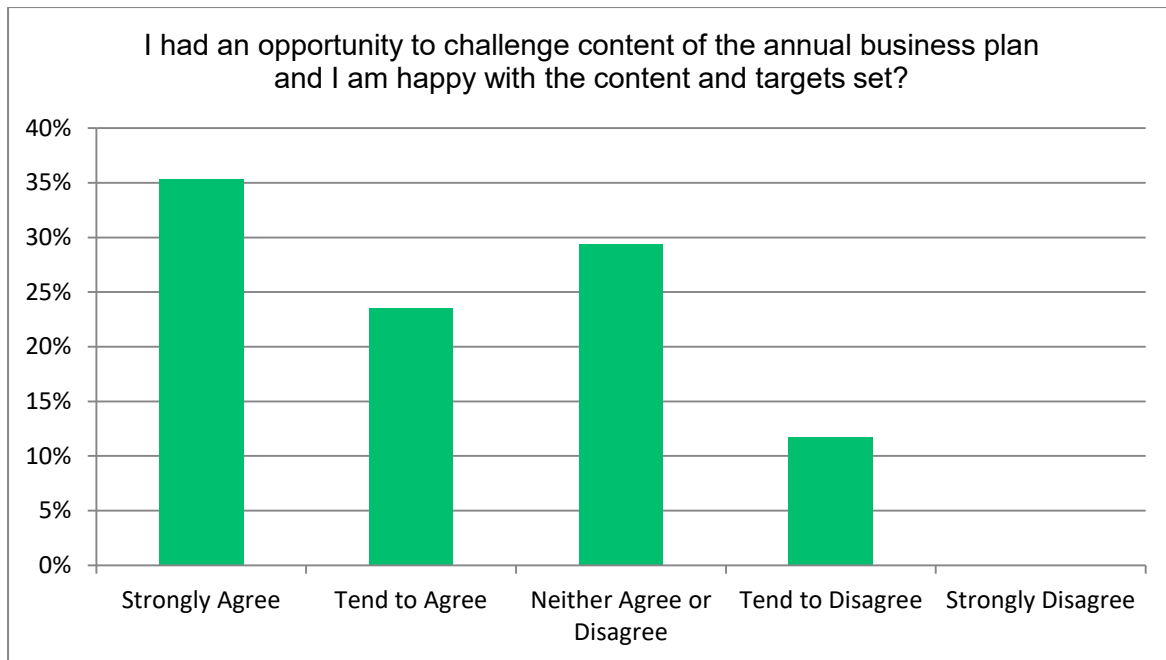
Finding

The main area for development that emerged from the survey of Executive and Non Executive Directors was Board Processes - specifically learning and involvement of the Board in planning/strategy.

Planning/Strategy:

There were mixed views in the survey to the following questions/statements, generally around planning/strategy:



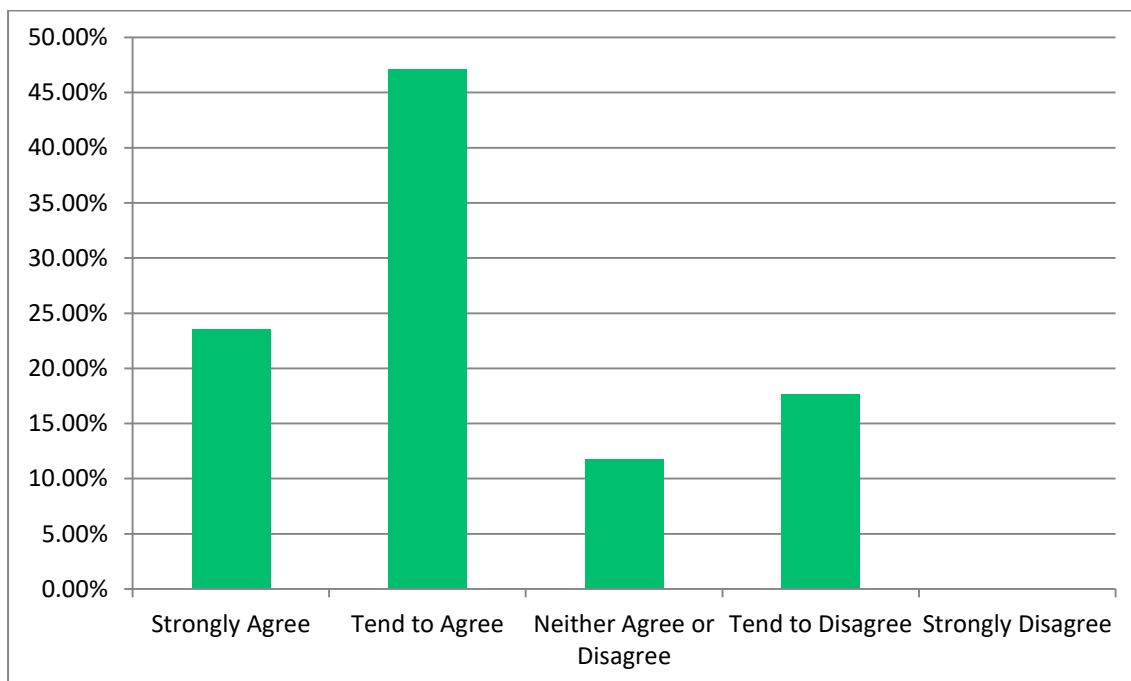


Learning:

Knowledge of other organisations and the potential to increase opportunities to work with and learn from other organisations regionally and nationally could be further developed. The survey showed 37% of respondents were neutral (31%) or negative (6%) around whether the Board has strong networks with other Trusts and support organisations. Discussion with the Chair indicated that the Trust has engaged with organisations such as the Kings Fund, and used contacts with former CEOs and Directors now working in English Trusts and Authorities to learn from their experiences.

Internal Audit appreciate this issue was recently raised at Governance Committee in December 2018 minutes and it is recognised as area for further development focussing on SAI and M&M outcomes.

Also there was mixed views in the survey of Executives and NEDS to the question 'The Board acknowledges instances where something went wrong and openly discusses how it should be addressed or missed opportunities and what should be done differently as a result?'



Implication(s)

Failure to develop a robust lessons learning culture across the Trust has potential to impact patient /client safety. Lost opportunity for joint working and shared learning with other organisations.
Insufficient clarity over Trust vision and corporate plans and how these will be achieved.

Recommendation 3.1	The Board should conclude their ongoing work on the Trust vision, culture and behaviours.
Priority	2
Management Action	ACCEPTED Work concluded with new set of Board Behaviours agreed at Board Workshop on 18 th April 2019
Responsible Manager	Chair and Chief Executive
Implementation Date	30 th June 2019

Recommendation 3.2	The Trust should seek to improve Trust Board's involvement in planning and strategy. We understand this is the intended focus of the Board in their next phase of development.
Priority	2
Management Action	ACCEPTED Use existing workshops to focus on strategic direction. This will be the focus of the workshop on 12 th December 2019
Responsible Manager	Chair and Chief Executive
Implementation Date	31 st March 2020

Recommendation 3.3	The Trust should explore opportunities for strengthening networks with other Trusts and sharing of learning.
Priority	3
Management Action	ACCEPTED Initiated agreement with the Northern HSC Trust to bring senior teams together to explore potential for sharing of learning.
Responsible Manager	Chief Executive
Implementation Date	31 st March 2020

4 Building and Developing the Board

Finding

In the survey of Executive and Non Executive Directors, 45% believed that Board membership is sufficiently diverse in terms of stakeholder representation.

22% of Executive and Non Executive Directors believe the Board is sufficiently future proofed against sudden loss of members. Internal Audit recognise that the Trust is not in control of the Non Executive Director appointment process.

Whilst NEDs were generally content with Board induction and annual performance assessment processes, Executive Directors generally did not feel they had appropriate Board induction and annual assessment of performance on the Board.

From discussions with NEDs, there is a need to review and refine HSC Board induction processes. *It is anticipated that the DoH-led IHRD implementation project will lead to improvements in current HSC Board induction processes, specifically in terms of training on statutory responsibilities and health-specific matters.*

Implication(s)

The stability and effectiveness of the Board is potentially at risk in the absence of future proofing, stakeholder diversity and suitable induction processes.

Recommendation 4.1	The Chair and Chief Executive should liaise with DoH to ensure an appropriate Chair / NED recruitment programme is introduced for the Trust, to assist in future proofing and improving stakeholder representation if possible.
Priority	2
Management Action	ACCEPTED The Chair and Chief Executive have and continue to liaise with the DoH, through the Accountability meeting process, to influence on this matter, most recently at meeting on 3 rd July 2019.
Responsible Manager	Chair and Chief Executive
Implementation Date	31st July 2019

Recommendation 4.2	The Trust should develop its induction programme for Executive Board members and specifically include Board performance in annual Director appraisals.
Priority	2
Management Action	ACCEPTED Induction programme in place for all Board members. During May and June 2019, the Chair completed a series of one to one meetings with Directors to assess their performance on the Board.
Responsible Manager	Chair
Implementation Date	30 th June 2019

Recommendation	See recommendation 6.1

5 Attendance at Board / Committees

Finding

While attendance rates of NEDs and Directors at Trust Board and sub-committees has been excellent with attendance rates of 80-100% during 2018/19, this has not been the case for the Patient Client Experience (PCE) Committee. Average attendance rates at the PCE Committee have been 56% for directors and 60% for NEDs as shown in the table below. The Chair of PCE Committee has raised this with committee members / Board and attendees in December 2018.

As can be seen from the table below and as per respective committee terms of reference, most NEDs are required to attend Governance, PCE and Audit committees.

Meeting No.	Board / Committee with Number & % Attendance (NEDs & Directors) 2018/19									
	Board (8 & 10)		Governance (7 & 10)		Audit (5 & 1)		E&G (3 & 3)		PCE* (5 & 6)	
	No.	%	No.	%	No.	%	No.	%	No.	%
1	7	87.5	6	86	4	80	3	100	3	60
	10	100	9	90	2	100	3	100	4	67
2	7	87.5	5	71	4	80	2	67	3	60
	10	100	9	90	1	100	3	100	3	50
3	8	100	7	100	4	80	3	100	3	60
	8**	80	10	100	1	100	2	67	3	50
4	8	100	N/A	N/A	4	80	3	100	N/A	N/A
	10	100			1	100	3	100		
5	8	100			4	80	N/A	N/A		
	10	100			1	100				
6	7	87.5								
	8**	80								
7	8	100								
	10	100								
8	N/A	N/A								
Average	7.6	95%	6	86%	4	80%	3	92%	3	60%
	9.4	94%	9.3	93%	1	100%	3	92%	3.33	56%

*PCEC also has 4 PPI representatives (service users) as members – they are not included in the table above. The average attendance of these members is 75%

** On these 2 occasions at Trust Board absent Directors sent another representative
N/A – not available yet

Implication(s)

Poor attendance by Directors and NEDs at the PCE committee creates a poor impression as to how valued users views are, or alternatively whether the PCE Committee is a valued means of assurance.

Recommendation 5.1	When considering their Board/Committee business, the Trust should review its committee terms of reference to assess whether it is most effectively utilising the limited time of its NEDs.
Priority	2
Management Action	ACCEPTED Committee Terms of Reference reviewed and approved on an annual basis.
Responsible Manager	Chair and Chief Executive
Implementation Date	31 st March 2020

Recommendation 5.2	The Trust should review the effectiveness of the Patient Client Experience Committee. The Chief Executive should re-enforce attendance at the Patient / Client Experience Committee with Directors and likewise the Chair with NEDs.
Priority	2
Management Action	ACCEPTED The Chair of the Patient and Client Experience Committee has addressed the issue of attendance and this will be kept under review during 2019/20
Responsible Manager	Chair and Chief Executive
Implementation Date	31 st March 2020

6 Inquiry into Hyponatremia Related Deaths (IHRD) Project

Finding

The IHRD inquiry produced a number of recommendations specifically targeted at improving board effectiveness as follows:

- i. The highest priority should be accorded the development and improvement of leadership skills at every level of the health service including both executive and non-executive board members.
- ii. Trust Chairs and Non-Executive Board Members should be trained to scrutinise the performance of Executive Directors in particular in relation to patient safety objectives.
- iii. All Trust Board members should receive induction training in their statutory duty.
- iv. Trusts should appoint and train Executive Directors with specific responsibility for Issues of Candour.
- v. Trusts should appoint and train Executive Directors with specific responsibility for Child Healthcare.
- vi. Trusts should appoint and train Executive Directors with specific responsibility for Learning from SAI related patient deaths.
- vii. Effective measures should be taken to ensure the minutes of Board and Committee meetings are preserved.
- viii. All Trust publications, media statements, and press releases should comply with the requirement for candour and be monitored for accuracy by a nominated Non Executive Director.
- ix. All Trust Boards should consider the findings and recommendations of this report and where appropriate amend practice and procedure.

Internal Audit acknowledge the ongoing work of the Board Effectiveness workstream of the DoH led IHRD implementation project and the developments this workstream should bring to board effectiveness across the HSC, particularly around Board Member induction and other training.

Implication(s)

Failure to address IHRD recommendations has potential to impact on patient safety and also potential for damage to public reputation of the Trust Board.

Recommendation 6.1	The Trust should continue to engage with the IHRD implementation project and work to implement the recommendations, in line with the work of the project.
Priority	2
Management Action	ACCEPTED IHRD implementation project is delivered through the local IHRD oversight group with progress reports to Trust Board three times per year.
Responsible Manager	Chief Executive
Implementation Date	Ongoing

7 Governance Structures

Finding

Clinical Governance structures could be further developed and strengthened, as reflected in discussions with NEDs and recent Internal Audit reports.

Implication(s)

Weaknesses in the assurance processes to Governance Committee and ultimately Trust Board.

Recommendation 7.1	The Trust should review its Clinical Governance structures, with a view to further developing and strengthening current arrangements.
Priority	2
Management Action	ACCEPTED Independent review of clinical and social care governance commissioned. Report to be available in October 2019.
Responsible Manager	Chief Executive
Implementation Date	31 st October 2019

8 NED Leadership Walkarounds

Finding

During the 6 month period April to September 2018 there were 6 Leadership Walk-arounds and 4 of these were conducted by the Chair. NEDs are expected to carry out 3 walk-around visits per year (24 in total). We have been informed a further 5 visits have been conducted during the second half of 2018/19, although not reported yet.

Implication(s)

Reduced Board presence to staff when NED walkarounds are not completed and reduced awareness of issues 'on the ground'.

Recommendation 7.1	The process around planning and scheduling NED leadership walkarounds should be strengthened to ensure the required number are scheduled and completed.
Priority	3
Management Action	ACCEPTED Work underway to ensure that each NED will carry out 3 walk-around visits in 2019/20.
Responsible Manager	Chair
Implementation Date	31 st March 2020

Appendix A – Results of Trust Board Survey

Board Governance and Effectiveness Survey

No	Question	Circle / highlight as appropriate					Comment
1	BUILDING THE BOARD						
1a	Are you a Director or Non-Executive Director	Director 10		Non-Executive Director 8			Total 18 responses
		Strongly Agree	Tend to Agree	Neither Agree or Disagree	Tend to Disagree	Strongly Disagree	
1b	The size of the Board is right in terms of the number of non-executive members, given the complexity of HSC provider environment.	33%	44%	17%	6%	0%	
1c	The work of the Board and its Committees does not overburden any individual members.	0%	65%	23%	12%	0%	
1d	The Board has an appropriate balance of professional expertise / functional skills, as well as strategic experience amongst its members.	33%	55%	6%	5%	0%	
1e	The Board has the specific skills needed for oversight of a HSC Trust.	17%	67%	5%	11%	0%	
1f	Board membership is sufficiently diverse in terms of stakeholder representation.	6%	39%	28%	22%	5%	
1g	All Board members are personally engaged and interested in the Trust's activities.	56%	33%	6%	5%	0%	
1h	Our Board is sufficiently future proofed against sudden loss of members.	0%	22%	28%	50%	0%	
2	DEVELOPING THE BOARD						
2a	Appropriate level of induction was available on joining the Board, including shadowing etc of previous incumbents where necessary or mentoring provided (e.g. committee chairs etc)	39%	11%	28%	22%	0%	
2b	I had an initial meeting with the chairman on appointment and was briefed on the organisation / personal induction assessment performed	72%	17%	0%	6%	5%	
2c	I receive regular updates on new developments / legislation etc in order to keep Board members' skills and knowledge up-to-date	22%	56%	11%	11%	0%	
2d	As part of my development I have visited departments in the organisation / directors & Heads of Service have presented work	65%	29%	0%	6%	0%	
2e	After a couple of months, I had a personal follow up meeting with the chair.	44%	28%	6%	17%	5%	
2f	I have an opportunity to meet informally with other board members or directors	44%	44%	6%	6%	0%	
2g	I routinely attend mandatory training and updates on new / emerging issues	39%	56%	6%	0%	0%	
2h	I have had an annual assessment of my performance on the board	50%	11%	17%	11%	11%	

No	Question	Circle / highlight as appropriate					Comment
3	ROLES, RESPONSIBILITIES AND RELATIONSHIPS	Strongly Agree	Tend to Agree	Neither Agree or Disagree	Tend to Disagree	Strongly Disagree	
3a	There is clarity around roles of a board member, chairperson and chief executive and their respective responsibilities	50%	33%	6%	11%	0%	
3b	The Management Statement and Standing Financial Instructions (SFIs) are accurate re roles and responsibilities	39%	50%	11%	0%	0%	
3c	Our Board is underpinned by a spirit of trust and professional respect.	17%	56%	22%	5%	0%	
3d	I am happy to challenge other members views and instigate constructive debate on difficult issues	35%	59%	0%	6%	0%	
3e	I can raise concerns with the Chair and / or Chief Executive, and know they will be addressed	39%	50%	11%	0%	0%	
3f	I feel my views are valued by the Chair, Chief Executive and other Board Members	33%	50%	11%	6%	0%	
3g	The Board is always objective and collectively acts in the best interests of the organisation	47%	53%	0%	0%	0%	
3h	I always declare any conflict of interests in a timely manner.	94%	6%	0%	0%	0%	
3i	This organisation has strong leadership and appropriate culture	22%	39%	28%	11%	0%	Discussion with NEDs indicated that this largely due to Trust having 4 interim CEOs and other acting directors for approx. 3 years and this weakened leadership and culture in the Trust. However felt that now CEO and director posts substantive there was clear evidence of improvements in this. Board Workshops on culture and vision in the current year were improving this aspect.
3j	The Chief Executive values the views of the Board, and seeks our views on important decisions	39%	50%	11%	0%	0%	
3k	I am happy to contact the chair, Chief Executive or Directors outside of board meetings, if I have concerns or require further information.	61%	33%	6%	0%	0%	
3l	There is positive interaction between board members, Chief Executive and directors in meetings.	44%	44%	11%	0%	0%	
3m	Directors speak openly and engage in issues within their remit.	28%	61%	11%	0%	0%	
3n	The Board meets as often as necessary without the Chief Executive and Directors present.	19%	19%	56%	6%	0%	Exceptions are mainly Executives
3o	The Board is a strong collaborative team.	11%	61%	22%	6%	0%	

No	Question	Circle / highlight as appropriate					Comment
3p	The Chair effectively discharges his/her responsibilities.	56%	44%	0%	0%	0%	
4	BOARD MEETINGS						
4a	A dedicated Board Secretary with appropriate skills and experience is in place.	82%	12%	6%	0%	0%	
4b	Sufficient time is made available to allow the Board to discharge its collective responsibility.	23%	71%	6%	0%	0%	
4c	The agenda for Board meetings is appropriate to ensure that all relevant items are brought to the Board's attention.	12%	70%	12%	6%	0%	
4d	The Board undertakes realistic self-reflection / self-evaluation	23%	71%	6%	0%	0%	
4e	There is annual timetable for board meetings and scheduling of recurrent / 'must do' agenda items.	82%	12%	0%	6%	0%	
5	BOARD INFORMATION	Strongly Agree	Tend to Agree	Neither Agree or Disagree	Tend to Disagree	Strongly Disagree	
5a	I receive appropriate information between meetings to keep abreast of significant issues, trends or developments.	47%	29%	18%	6%	0%	
5b	I often hear significant issues for the first time on the media.	0%	6%	25%	50%	19%	
5c	Papers for Board meetings contain relevant and appropriate material and are received sufficiently in advance of the meeting.	47%	53%	0%	0%	0%	
5d	Information is available to Board members in a form and of a quality and quantity that enables the Board to discharge duties effectively.	29%	59%	12%	0%	0%	
5e	There is appropriate consideration at Board level to service quality, patient safety and client experience.	47%	35%	12%	6%	0%	
5f	There is appropriate consideration at Board level given to performance against objectives.	29%	59%	12%	0%	0%	
5g	There is appropriate consideration at Board level given to financial position.	65%	29%	6%	0%	0%	
5h	There is a sufficient balance of consideration at the Board of competing pressures of performance, financial position and quality/safety and there is appropriate integration between these three competing areas.	17%	53%	18%	6%	6%	
6	BOARD PROCESSES						
6a	The Board acknowledges instances where something went wrong and openly discusses how it should be addressed or missed opportunities and what should be done differently as a result.	23%	47%	12%	18%	0%	
6b	We have a strong, and clear vision for SHSCT.	17%	53%	12%	18%	0%	
6c	We regularly consider what our long term	0%	41%	29%	29%	0%	

No	Question	Circle / highlight as appropriate					Comment
	objectives should be and how external factors may impact them.						
6d	I am familiar with and have contributed to developing our corporate plan, objectives and strategies to achieve these	35%	41%	18%	6%	0%	
6e	There is sufficient balance at Board level between looking back and strategic forward /future planning.	6%	24%	47%	23%	0%	
6f	I had an opportunity to challenge content of the annual business plan and I am happy with the content and targets set.	35%	24%	29%	12%	0%	
6g	At board, we regularly look at what is happening across HSC / NHS / HSE	13%	31%	19%	31%	6%	
6h	The Board receives regular updates on issues impacting other Trusts both regionally and nationally.	18%	12%	35%	35%	0%	
6i	The Board sub-committee structure is clear and the Board is adequately informed of each sub-committees' activities.	71%	23%	6%	0%	0%	
		Strongly Agree	Tend to Agree	Neither Agree or Disagree	Tend to Disagree	Strongly Disagree	
6j	I know the organisational / corporate risks and these are regularly discussed at Board meetings.	59%	18%	18%	6%	0%	
6k	I am content organisational / corporate risks are identified promptly by directors and escalated to the Board.	56%	25%	19%	0%	0%	
6l	Action plans to mitigate organisational / corporate risks are promptly implemented.	29%	53%	18%	0%	0%	
6m	We have a good balance between strategic and operational issues on our agenda.	25%	30%	13%	12%	0%	
7	COMMUNICATION						
7a	The Board is doing a good job of communicating effectively with stakeholders including DoH, staff, health professionals, volunteers, local community officials and leaders, patients and the public generally?	29%	47%	18%	6%	0%	
7b	The Board has strong networks with other HSC Trusts and support organisations.	19%	44%	31%	6%	0%	

Describe any positive changes over the past year to the way the Board functions.

Review of performance after each meeting. Clearer papers on presentation to Board. Summary sheets much better and succinct. More of a focus on questions rather than a presentation of the papers.

Significant work on Board development & the culture of how we do business has been undertaken. Better understanding and embracing by ED on the challenge role of NEDs.

The arrival of a new permanent CEO and the completion of a recruitment exercise for Directors/SMT. Stability has arrived. The introduction of a 15 minute reflection after each Board Meeting.

Changes in both the agenda items and the way Director workshops are structured and undertaken.

More time for evaluation at end of meetings. More emphasis on culture and how we can improve.

Formal time for reflection at the end of the board meeting.

We have started a journey in relation to reflecting on the HSC core values and the associated behaviours that we need to display as Board members. Open and honest conversations have been had amongst members. However, this needs to be able to conclude in the same open manner that it has started.

More workshops and indepth analysis and space to grow relationships.

Starting to get a better balance between the acute and community services.

During my time in the Southern Trust, I have seen many improvements / changes in how the Board functions. My response to this survey reflects this. How SMT functions is inextricably linked to this.

The Board Dev Workshop in Nov 18 facilitated by the Kings Fund was useful - the Trust is on a journey - it was an opportunity to build relationships between board members and to review Board practice. The self-evaluation session at the end of Board meetings is very useful. Improvements to the Corporate Risk Register template are welcomed - these discussions take place at Governance Cttee not at Board - also the deep dive of 1 corporate risk.

We have has Board Development days which have been very useful.

Permanent CEO, permanent Director team has had a significant positive change.

Annual Board Development Day each Nov. Self Assessment of the Boards effectiveness. Learning and sharing from a recent SAI event

Suggest any areas of Board performance which could still be improved upon.

Review of the nature of items which are statutory and those which are not. Which items demand significant debate and others only for information.

greater emphasis on the experience of the patient/ service user and how we support all clinicians to achieve best care. Greater awareness of the fundamental need for QI across Trust Board, SMT eg Scil training

More time for informal discussions

Reshaping of agenda items to allow for greater discussion on corporate performance and associated issues affecting performance.

acute directorate

Driving the culture change in the organization that is needed - more time needs to be spent on this. Also redefining the vision for the Trust - need to get on with doing this.

less meaty documents to allow more focused discussion and strategic considerations.

We regularly keep this under review and any proposed changes are considered

Informal conversations around certain topics can often produce very constructive ideas. I realize however that TB is for strategic, top line conversation and there is very little time.

Perhaps we do not give sufficient time to reflect on client experience and quality / safety at Board meetings. The Board sets the strategic direction and perhaps we need to set aside time - Board Strategy Day to contribute to the corporate plan, objs and strategies. Also we could allocate some time at a workshop reviewing the annual business plan outside of the formal board meetings.

work on behaviours and culture

Large complex agendas

As the Trust is currently considering how Performance Reporting to the Trust Board could be further developed, can you provide any specific views on existing reporting and how it could be improved and / or developed.

Review of performance against definitive timescales - long term and short term performance.

As above but recognize there has been some improvement in this area.

Some comparative performances analysis from other Trusts & NHS in general might serve to escalate discussion to a more strategic level insofar as many performance issues are systemic to the NHS as a whole & reflective of the lack of investment & need for improved processes & systems.

The development of a Trust Patient safety strategy with measurable outcomes and a governance assurance strategy driven by QI should improve this.

More reporting on the health of the population instead of missed targets

See above, information presented could perhaps be benchmarked against previous years, presented in graphical formats to give a visual picture of how over time performance in many specialities has greatly reduced / underperformed/ have been facing great difficulties in achieving performance. Qualitative information could be provided to provide assurances on actions taken.

Potentially having a performance sub committee to spend time getting a deeper understanding of performance in key areas

Leave the operational Directors to account for their areas of responsibility and to offer assurances for areas requiring attention or needing higher level assurance. highlight /exception reporting rather than all areas.

Again this is regularly reviewed and refined in terms of providing quality, meaningful information.

I like the current performance reporting template. It is clear and easy to understand. I do not have any suggestions for improvement. I am happy with how it is at the moment.

I think the CE's report could be improved to consider key risks/ challenges, emerging issues, governance matters with a focus on the Trust. The HR report is very long with lots of data - my preference would be for a shorter, sharper report. I think the clinical governance framework needs to be strengthened.

There needs to be a review of committees and how they deliver in line with the key roles of accountability, strategy and culture.

Appendix B - Definition of Levels of Assurance and Priorities

Level of Assurance

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

Recommendation Priorities

Priority 1	Failure to implement the recommendation is likely to result in a major failure of a key organisational objective, significant damage to the reputation of the organisation or the misuse of public funds.
Priority 2	Failure to implement the recommendation could result in the failure of an important organisational objective or could have some impact on a key organisational objective.
Priority 3	Failure to implement the recommendation could lead to an increased risk exposure.

Note to Report

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

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**Minutes of a meeting of the Audit Committee held on
Thursday, 10th October 2019 at 9.30 a.m. in the Boardroom,
Trust Headquarters**

PRESENT:

Mrs H McCartan, Non-Executive Director (Chair)
Mr M McDonald, Non-Executive Director
Ms E Mullan, Non-Executive Director
Mrs S Rooney, Non-Executive Director
Mr J Wilkinson, Non-Executive Director

IN ATTENDANCE:

Mr S Devlin, Chief Executive, SHSCT
Ms H O'Neill, Director of Finance, Procurement and Estates, SHSCT
Mr B Beattie, Acting Director of Older People and Primary Care, SHSCT *(Item 6i only)*
Mr B McNeany, Director of Mental Health and Disability Services, SHSCT *(Item 6i only)*
Mrs C Cassells, Assistant Director of Finance, Financial Management, SHSCT
Mrs A Rutherford, Assistant Director of Finance, SHSCT
Mrs F Jones, Corporate Financial Accountant/Fraud Liaison Officer, SHSCT
Ms B Bourke, Grant Thornton
Mrs C McKeown, Head of Internal Audit
Ms J McCaw, Internal Audit
Ms L Murphy, Northern Ireland Audit Office (NIAO)
Ms K Hudson, Sponsorship Branch, Department of Health (DOH)
Ms P Keenan, Boardroom Apprentice
Mrs S Judt, Board Assurance Manager, SHSCT
Mrs S McCormick, Committee Secretary, SHSCT (Minutes)

APOLOGIES

None

1) CHAIR'S WELCOME

Mrs McCartan welcomed everyone to the meeting and in particular she referred to Ms Murphy and Ms Hudson, attending Audit Committee on

behalf of the NIAO and DOH respectively. At this point, Mrs McCartan reminded members of their responsibilities in keeping with Board etiquette. She asked that mobile phones are turned to silent and laptops are to be used for accessing Audit papers only during the meeting.

2) DECLARATION OF INTERESTS

Mrs McCartan asked members to declare any potential conflict of interests in relation to items on the agenda. None were received and the business of the meeting proceeded.

6) INTERNAL AUDIT

Board Effectiveness 2018/19 – Satisfactory

A Satisfactory level of assurance was provided on the system of internal control in relation to Board Effectiveness. The report demonstrated evidence that the Trust Board is operating effectively. Ten Priority 2 and Three Priority 3 recommendations were identified. Mrs McKeown pointed out the recommendations contained within the report are aimed at enhancing an already effective Board. Members noted the finer detail around the recommendations, all of which have been accepted. The report contained no significant findings and members welcomed the outcome of the exercise. Mrs McCartan advised the report and action plan will be discussed at the next Directors' Workshop on 17th October 2019.



Southern Health & Social Care Trust

**Children & Young People Directorate
Risk Audit – Children with Disabilities
Service 2018/19**



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Acknowledgement

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

Control Log

Exit Meeting Held On:	29 March 2019
Working Draft Report Issued On:	26 March 2019
Management Meeting Held On:	8 & 25 April 2019
Management Actions Due By:	12 April 2019
Management Actions Received:	25 April 2019
First Draft Issued On:	25 April 2019
Final Report Issued On:	2 May 2019

Distribution List

Shane Devlin	Chief Executive (Final Report Only)
Paul Morgan	Director of Children & Young Peoples Services
Colm McCafferty	Assistant Director of Corporate Parenting & Disability Services
Lesley Waugh	Head of Children's Disability Services
Helen O'Neill	Director of Finance, Procurement & Estates
Alison Rutherford	Assistant Director of Finance

Introduction

In accordance with the 2018/19 annual Internal Audit Plan, BSO Internal Audit carried out a Directorate Risk Audit within the Children and Young Peoples Service during February and March 2019. This audit focussed on the Children with Disabilities Service. This audit has not previously been performed in the Trust.

Children with Disabilities (CwD) teams are organised across the Trust based on the three geographic areas, Armagh & Dungannon, Craigavon & Banbridge and Newry & Mourne,

Service configuration provided through these teams is based on a continuum of support through the following interventions:

- 'Light touch' – community based services through training, 'hand holding', summer schemes, youth clubs etc),
- Specialist services – specialist playgroup places, Early Years Contracts; Cedar, Enable, Mencap etc; and
- Highly specialist disability services – Short Breaks carer scheme, residential short breaks, specialist full time or shared care placements.

In recent years, the CwD service has re-focused its intervention strategy reducing the volume of residential short breaks provided in Oaklands and Willowgrove, (increasing day care provision simultaneously at these homes), and utilising Carrickore primarily for highly complex cases requiring longer and more intense interventions. However, the main shift has been towards increasing the use of Short Break Carers / foster care and more recently to develop a salaried specialist short breaks carer scheme.

A self-directed support (SDS) approach is applied now to all children and families who are assessed as requiring services, and an SDS Plan is in place for all as per departmental requirements. At 31 March 2018 there were 222 direct payments in place, an increase of 45% over the last 4 years.

The primary decision making forum in relation to allocation of resources and services to referred cases is the Children with Disabilities Family Support Forum Panel (FSFP). It is a multi-disciplinary body chaired by the Operational Manager that will consider support needs and authorise access to resources to meet the assessed needs of children and young people. It is also responsible for identifying any unmet needs to the Assistant Director.

Since January 2018, the CwD service use the PARIS system to record service user data and manage its caseload.

Understanding the Needs of Children in Northern Ireland (UNOCINI) is a framework to support professionals in assessment and planning to better meet the needs of children and their family. It should be considered whenever an individual practitioner identifies that a child may have needs that are additional to those of a similar aged child living in similar circumstances.

Once a referral has been received and assessed as appropriate by children's social services then an UNOCINI Initial Assessment will be completed by social services. This assessment is not designed to be in-depth but rather it is to provide a timely overview of current circumstances in order to take appropriate decisions about the future management and thresholds of intervention, for example provision of statutory social services, referral to another more appropriate agency or case closure. If the initial assessment indicates that children's social services should become involved then a more detailed and comprehensive UNOCINI Pathway Assessment will be completed. This will be tailored to the type of service most likely to meet the child or young person's needs.

Scope of Assignment

This audit focused on Service User Care Planning and application of UNOCINI within the 3 Children with Disabilities (CwD) Teams. A number of processes utilised by the service are identified on the Directorate risk register such as Self-Directed Support (SDS), shortage of specialised foster care services etc.

The audit was based on the risk that the assessed needs of Children's Disability Services users may not be met.

The objectives of this audit were:

- To ensure that appropriate governance and oversight arrangements are in place for Children's Disability Services.
- To ensure that services that are approved by the Family Support Forum Panel (FSFP) are received by service users on a regular basis and meet the service users' needs.
- To ensure that referrals to the Children with Disabilities (CwD) Services meet acceptance criteria, are promptly and fully assessed, an appropriate care plan is developed, implemented and subject to regular review.

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

Level of Assurance

Limited

There are significant weaknesses within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved.

Executive Summary

Internal Audit can provide Limited assurance in relation to the Management of Children with Disabilities Services. Limited assurance has been provided on the basis that there are significant delays in the processing of referrals to the service and there is no monitoring of unmet needs.

The significant findings in the audit, impacting on the assurance provided are:

1. UNOCINI Guidance details timelines for the completion of initial assessment, identification of need and action following the receipt of a referral. Testing of a sample of 30 referrals accepted by the Children with Disabilities Service identified significant delays in the various stages of the process.
2. Unmet needs whilst recorded locally in the service users case notes, are not formally collated / reported upwards to the Senior Management Team, Directorate level etc. to provide visibility over the issue and assurance that actions are being taken to address these unmet needs. In 16 from 30 (53%) sampled instances, some services approved could not be delivered i.e. unmet need resulted, for a variety of reasons.

Other key findings are:

3. The protocol for Family Support Forum Applications whilst followed has not been formally adopted; it does not have a version number, operational date and is not signed off.
4. The Trust does not have a Children with Disabilities Strategy.

Summary of Findings and Recommendations

Finding		Number of Recommendations		
		Priority 1	Priority 2	Priority 3
1.	UNOCINI Guiding Standards – Timeliness	-	1	-
2.	Unmet Need	-	1	-
3.	Policies and Procedures	-	-	1
4.	Children with Disabilities Service Strategy	-	-	1

Detailed Findings and Recommendations

1 UNOCINI Guiding Standards - Timeliness

Finding

UNOCINI (Understanding the Needs of Children in Northern Ireland) Guidance was developed by DoH in conjunction with all HSC Trusts. The guide is aimed at practitioners who provide services to children, young people and their families, whether they work in the statutory, voluntary, community or private sectors, who undertake or contribute to assessments under the UNOCINI Assessment Framework. The purpose of the document is to provide guidance to support staff to better meet the needs of children and their families through a comprehensive process for assessment leading to action. The guidance notes require that:

- UNOCINI initial assessments should be completed within 10 working days from the receipt of referral;
- UNOCINI Family Support Plans (FS1) should be completed within 20 working days from receipt of referral;
- The first review UNOCINI Family Support Plan (FS3) to be completed within 3 months of the initial plan; and
- Subsequent reviews six monthly.

A review of a sample of 30 referrals received by the 3 Children with Disability Services Teams highlighted the following:

- In 26 from 30 (87%) instances, initial assessments were not completed within 10 working days of referral. Delays in conducting the initial assessment ranged 6 to 158 working days after the 10 working day deadline;
- In 26 from 30 (87%) instances, the Family Support Plan had not been completed within 20 working days of referral. Delays in completing the Family Support Plan ranged 6 to 259 working days after the 20 working day deadline.
- In 14 from 30 (47%) instances, the first reviews of the Family Support Plan had not been completed within 3 months of the initial plan being developed. Delays ranged from 4 to 15 months after the 3 month deadline
- In 5 from 21 (24%) instances where a six monthly review was due at the date of audit fieldwork, this had not been completed within 6 months as required.

Implication

UNOCINI guidance is not being fully complied with, impacting on the timeliness of care/services.

Recommendation 1.1	The Trust should ensure that all initial assessments, Family Support Plans and reviews are completed in line with the time frames set out in the UNOCINI guidance. Reporting mechanisms should be put into place to monitor compliance with the guidance and corrective action taken as appropriate.
Priority	2
Management Action	ACCEPTED Contingent on adequate capacity being available to the service to deal with rising demand as evidenced through increased number of referrals.
Responsible Manager	Head of Children's Disability Services
Implementation Date	April 2020

2 Unmet Need

Finding

It is important that the Trust upon assessment and identification of need ensures that service provision is carried out in the most effective and timely manner. A service, in part or full that cannot be delivered is referred to as an 'unmet need'. Internal Audit notes that whilst unmet needs are recorded locally in the service users case notes neither these or actions taken are formally collated / reported upwards to senior management at Senior Management Team, Directorate level etc. to provide visibility over the issue and assurance that actions are being taken to address these unmet needs.

In 16 from 30 (53%) sampled instances, some services approved could not be delivered i.e. unmet need resulted, for a variety of reasons including:

- Inability to commission a domiciliary care package,
- Inability to identify a family to provide short breaks service,
- Inability to provide an overnight break at a Trust facility;
- Inability to source a place at a voluntary sector club etc.
- Inability to recruit support worker via Self Directed Support.

Implications

No visibility over unmet service needs preventing assurances from being sought that timely and proportionate actions have been taken as required.

Recommendation 2.1	The Trust should develop a process to collate and monitor unmet needs within the Children with Disability Teams on a regular basis. Monitoring information submitted should include details of actions taken / timeframes to address the gaps identified.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Head of Children's Disability Services
Implementation Date	September 2019

3 Family Support Forum Application Protocol

Finding

The Family Support Forum Protocol sets out how the Southern HSC Trust will address the needs of young people and their families known to the Children with Disabilities team and who:

- Require services to help support the child or young person at home or in the community
- Need community based or residential overnight short breaks

The protocol is in use but has not been formally adopted; it does not have a version number, operational date and is not signed off.

Implications

Staff may be unsure of processes to follow, in the absence of finalised detailed operational procedures.

Recommendation 3.1	The Family Support Forum Protocol should be formally adopted and signed off.
Priority	3
Management Action	ACCEPTED
Responsible Manager	Assistant Director of Corporate Parenting & Disability Services
Implementation Date	Already Achieved. April 2019

4 Children with Disabilities Strategy

Finding

The Trust does not have a Children with Disabilities Strategy although it is acknowledged that there are a number of externally / internally created documents upon which it relies to inform / advise of its vision, values and objectives and therefore expected outcomes. These include:

- Extracts from Corporate Themes / Outcomes & Overview of CYP Key Strategic Priorities,
- SHSCT carers action plan April 2018 – March 2020,
- SHSCT Action Plan to Enhance Personal and Public Involvement Within the Children and Young People Directorate 2018-2019,
- Southern Area Outcomes Group Children & Young People's Action Plan 2017 – 2020, and
- HSCB Children with Disability Social Work Service Criteria

Implication

The absence of a dedicated strategy may result in decisions being taken which are not aligned with expected outcomes.

Recommendation 4.1	The Trust should consider developing a Children with Disabilities Strategy for the provision of Children with Disability Services to clearly document the vision, values and outcomes of the service.
Priority	3
Management Action	ACCEPTED
Responsible Manager	Head of Children's Disability Services
Implementation Date	1 st October 2019

Appendix A - Definition of Levels of Assurance and Priorities

Level of Assurance

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

Recommendation Priorities

Priority 1	Failure to implement the recommendation is likely to result in a major failure of a key organisational objective, significant damage to the reputation of the organisation or the misuse of public funds.
Priority 2	Failure to implement the recommendation could result in the failure of an important organisational objective or could have some impact on a key organisational objective.
Priority 3	Failure to implement the recommendation could lead to an increased risk exposure.

Note to Report

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

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**Minutes of a meeting of the Audit Committee held on
Thursday, 9th May 2019 at 9.45 a.m. in the Boardroom,
Trust Headquarters**

PRESENT:

Mrs H McCartan, Non-Executive Director (Chair)
Mr M McDonald, Non-Executive Director
Ms E Mullan, Non-Executive Director
Mrs S Rooney, Non-Executive Director
Mr J Wilkinson, Non-Executive Director

IN ATTENDANCE:

Ms H O'Neill, Director of Finance, Procurement and Estates
Mrs C Cassells, Assistant Director of Finance, Financial Management, SHSCT
Mrs A Rutherford, Assistant Director of Finance, SHSCT
Mrs C Doyle, Corporate Financial Accountant
Mrs F Jones, Corporate Financial Accountant/Fraud Liaison Officer, SHSCT
Mrs A Magwood, Director of Performance and Reform *(Item 6i only)*
Mr P Morgan, Director of Children and Young People's Services/Executive
Director of Social Work, SHSCT *(Item 6i only)*
Mrs H Trouton, Interim Executive Director of Nursing & Allied Health
Professionals, SHSCT *(Item 6i only)*
Ms L Kelly, Grant Thornton
Mrs C McKeown, Head of Internal Audit, BSO
Mr J Murray, Internal Audit
Mr S Knox, Northern Ireland Audit Office
Mrs S Judt, Board Assurance Manager, SHSCT
Mrs S McCormick, Committee Secretary, SHSCT (Minutes)

APOLOGIES

None

1) CHAIR'S WELCOME

Mrs McCartan welcomed everyone to the meeting and reminded members of their responsibilities in keeping with Board etiquette. She asked that mobile phones are turned to silent and laptops are to be used for accessing Audit papers only during the meeting.

2) DECLARATION OF INTERESTS

Mrs McCartan asked members to declare any potential conflict of interests in relation to items on the agenda. None were received and the business of the meeting proceeded.

6i) INTERNAL AUDIT PROGRESS REPORT (5 REPORTS)**Children and Young People's Directorate Risk, Children with Disabilities - Limited**

Mrs McKeown advised that a Limited level of assurance was provided in relation to the Management of Children with Disabilities Services on the basis that there are significant delays in the timescales for processing of UNOCINI referrals to the service and there is no monitoring of unmet needs. Two Priority 2 and Two Priority 3 recommendations were identified.

At this point, Mrs McCartan welcomed Mr Morgan to the meeting to provide an update on progress post audit. Mrs McCartan raised the system gaps in complying with UNOCINI guidance and the associated impact on targets. At the outset of discussion, Mr Morgan acknowledged the disappointing audit findings. In relation to UNOCINI, he stated that recent feedback from staff had indicated the regional system is cumbersome and advised a system review led by the Department of Health (DOH) is currently underway. However, Mr Morgan acknowledged the Trust had underperformed in terms of achieving timeframes set out by UNOCINI guidance and he spoke to a number of contributing factors including workforce challenges, the complex assessment process, alongside an increase in the number of referrals. A working group is being established to take forward the audit recommendations, part of which will look at a triage/gateway system to filter all referrals in a timely way.

In responding to a question on the Children with Disabilities (CwD) Strategy, Mr Morgan advised that the Trust had accepted the

recommendation and would work with the HSCB to implement the development of a CwD Strategy. Mr Morgan went on to advise that he had been lobbying regionally for some time, in terms of the under investment within CwD and stated the HSCB had indicated their willingness to review the matter.

Mrs McCartan recorded disappointment at the poor monitoring identified within the Service in terms of 'unmet need'. Mr Morgan acknowledged the gap and stated the Service is open to improvement; however he assured members all referrals are screened on entry into the system, gateway processes are in place for main-stream referrals and waiting lists are reviewed every two weeks by a social worker. Mrs McCartan referred to the Delegated Statutory Functions Report and Mr Morgan reminded members 'unmet need' is captured within the monthly data return to the HSCB. Unmet need would also be reflected through to Trust Board.

In response to questions from Mr McDonald and Mr Wilkinson, Mr Morgan assured members that of the 30 referrals tested, lessons learned will be taken forward. A sample of other cases not in the audit will also be reviewed. He went on to state that an Action Plan is being developed to address the issues identified through the Audit and the possibility of enlisting the PARIS information tool to offer more functionality in terms of enhancing monitoring was also being looked into. Ms O'Neill reminded members of the funding and workforce challenges across CwD Services and both Ms O'Neill and Ms Mullan welcomed the development of a CwD Strategy to assist regional engagement around future investment.

On behalf of Audit Committee members, Mrs McCartan thanked Mr Morgan for attending the meeting to provide a clear update on progress despite the challenging environment.



Southern Health & Social Care Trust

**Specific Elements Of Infection
Prevention and Control (IPC)
Governance including Anti-Microbial
Stewardship 2018/19**



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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 audit engagement.

Control Log

Exit Meeting Held On:	25 February 2019
Working Draft Issued On:	11 March 2019
Management meeting Held On:	15 March 2019
Management Actions Due By:	25 March 2019
Management Actions Received:	8 April 2019
Final Report Issued On:	9 April 2019

Distribution List

Shane Devlin	Chief Executive (Final Report Only)
Dr Maria O’Kane	Medical Director
Helen O’Neill	Director of Finance, Procurement and Estates
Dr Martin Brown	Lead Infection Prevention and Control Doctor & Consultant Microbiologist
Dr Zara Hedderwick	Consultant Microbiologist
Simon Gibson	Assistant Director – Medical Directorate
Colin Clarke	Lead Infection Control Nurse
Alison Rutherford	Assistant Director of Finance

Introduction

In accordance with the 2018/19 Annual Plan, Internal Audit carried out an audit of Infection Prevention and Control including Anti-Microbial Stewardship (AMS) during January and February 2019. An audit of Infection Prevention and Control was last undertaken in November and December 2012 but AMS has not been audited by Internal Audit previously in this Trust. The objective of the audit was to assess the appropriateness and effectiveness of the processes in place to manage the prevention and control of infection including Anti-Microbial Stewardship within the Southern Trust.

The Trust has introduced an Infection Prevention and Control Strategy 2018-2021; it includes 10 elements which are designed to ensure excellence in IPC practice. The objectives of this strategy are:

- To deliver the highest safety standards for patients, visitors and staff.
- To become the best performing Trust in the UK for HCAI / IPC.
- To ensure IPC is embedded at every level from Board to Ward.

The Medical Director is the Lead Director responsible for Infection Prevention and Control (IPC) at Board level. The IPC Team (IPCT) is led by a Consultant Microbiologist and Lead IPC Nurse who are supported by a team of 8 IPC Nurses and 3 audit assistants. An Anti-Microbial Pharmacist also assists the Consultant Microbiologist in this area. A second Microbiologist has recently been appointed and three new Antimicrobial Pharmacists have been recruited and are due to start employment in Spring 2019. The governance arrangements include:

- HCAI Strategic Forum which is co-chaired by the CEO and Medical Director with membership from Operational Directors and IPC team, Pharmacy, Estates and Facilities. It meets bi-monthly and monitors infection rates, co-ordinating organisational responses to HCAI significant concerns and overseeing implementation, review and progress of IPC Strategy 2018-2021 and related initiatives.
- HCAI Clinical Forum which meets monthly, and is chaired by the Medical Director. It provides a platform to promote excellence, to ensure standards, guidelines and procedures and management of patients with HCAI are in place, adhered to and to discuss issues of clinical concern. It assesses, identifies and provides clinical and operational advice on IPC issues.
- The Medical Director reports weekly through SMT and monthly to Trust Board.

Commissioning Plan Objectives & Goals for Improvement (OGIs) for IPC for the 2018/19 year to date as reported to the Trust Board on 24 January 2019:

- OGI 2.3.2 - C.Diff infections in the Trust to date is 30 (target for year 50)
- OGI 2.3.1 - MRSA bloodstream infections in 2018/19 to date is 3 (target for year is 4),
- MSSA no longer a PfA target. There have been 38 cases to date in 2018/19 (internal target for the year is 34).

As per the National Institute for Health and Care Excellence (NICE) guidelines, the term 'antimicrobial stewardship' is defined as 'an organisational or healthcare-system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness'. Antimicrobial resistance (AMR) means that standard treatments become ineffective, infections persist and may spread to others. Resistance to antimicrobial drugs is a global threat to human health and wellbeing. The World Health Organisation (WHO) regards this as one of the top three such threats.

The Trust introduced The Antibiotic Review Kit (ARK project) in February 2019 and is targeted at 5 medical wards in CAH and DHH. This study aims to improve the review of antibiotics in all patients and stopping of antibiotics in patients who do not need them. Changes to the antibiotic section of the Acute Adult Kardex will be made to facilitate the intervention.

Governance arrangements for IPC include the Antimicrobial Management Team (AMT) which reports to the Drugs and Therapeutic (D&T) Committee and the Antimicrobial Stewardship Team (AST). Four targets have been set by the PHA in relation to Antimicrobial Stewardship, these are reduction in the monthly consumption of all antibiotics (1%), carbapenems (3%), piperacillin/tazobactam (3%) and increase in the proportion of all antibiotics within the WHO AWARE 'Access' category (over 55%).

Scope of Assignment

The scope of this audit included elements of Infection Prevention and Control (IPC) governance arrangements within the Trust (specifically oversight of compliance with Policies & Procedures, IPC Audit and training). Anti-microbial Stewardship was a particular focus of the audit.

Internal Audit reviewed results of audits carried out within the Trust over the past few months to assess compliance with IPC targets including hand hygiene and commode audits and also compliance with Trust Antibiotic guidelines. Internal Audit, accompanied the Trust IPC auditors, visited a sample of nine wards while they performed their hand hygiene and commode audits. Internal Audit, accompanied by an Antimicrobial Pharmacist, visited a sample of three wards and reviewed 44 patient charts for evidence of patients on antimicrobials to confirm if these were administered in line with Trust policy.

The audit was based on the risk that there may be an inability to meet and maintain externally and internally set infection prevention and control standards and the risk to patient safety if a patient is not treated effectively.

The objectives of this audit were:

- To ensure robust, effective governance procedures are in place within the Trust.
- To ensure adequate infection prevention & control training takes place for all staff.
- To ensure that there are infection prevention and control policies and procedures in place within the Trust.
- To ensure appropriate prevention and monitoring procedures are in place at ward level relating to infection prevention and control.
- To ensure the effectiveness of infection prevention and control improvement plans within the Trust.
- To ensure that there are appropriate procedures in place for anti-microbial stewardship in the Trust.
- To ensure there is appropriate governance oversight in respect of anti-microbial stewardship.
- To ensure relevant training takes place for appropriate staff.
- To ensure that there are anti-microbial stewardship policies and procedures in place within the Trust.
- To ensure there is an effective audit programme in place in respect of anti-microbial stewardship.
- To ensure that anti- microbial stewardship is operating effectively at ward level.

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

Level of Assurance

Specific elements of Infection Prevention and Control (IPC) governance - (oversight of compliance with Policies & Procedures, IPC Audit and training).

Satisfactory

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

Anti-Microbial Stewardship (AMS)

Limited

There are significant weaknesses within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved.

Executive Summary

Internal Audit can provide Satisfactory assurance in relation to specific elements of Infection Prevention and Control (IPC) governance (ie oversight of compliance with Policies & Procedures, IPC Audit and training). Throughout the course of the audit, there was generally good compliance with the sampled elements of IPC policies and procedures. Audit practices are well established as is training for IPC. There is timely communication of audit results to staff and regular reporting to the Trust Board.

Internal Audit can provide Limited assurance in relation to Antimicrobial Stewardship. Limited assurance has been provided on the basis that AMS monitoring of practice needs to be developed further and fully embedded in the Trust. A baseline position has been established for AMS but there is not yet a full complement of staff in the AMS team so regular testing on all wards is not currently taking place. Testing of 44 patient records with the Antimicrobial Pharmacist found an error rate of 9% and the Trust found an error rate of 16% in October 2018. Currently the Trust is meeting two of the four targets for AMS set by the PHA.

There are two significant findings in this audit, impacting on the assurance provided:

1. AMS practices need to be developed further and fully embedded into the organisation. The Antimicrobial Pharmacist has not been conducting all the planned monthly ward rounds and the Microbiologist ward rounds are ad hoc in nature. Internally, AMS reporting has fallen behind schedule with the most recent figures available from October 2018. In addition there is a need to ensure that there is an organisational wide approach to promoting and monitoring the use of antimicrobials this should include all medical, nursing and pharmacy staff.
2. Internal Audit accompanied by the Antimicrobial Pharmacist, carried out visits to three wards and reviewed a sample of 44 patient files. Testing of 44 patient records with the Antimicrobial Pharmacist found an error rate of 9% and the Trust found an error rate of 16% in October 2018.

The key findings of the audit are:

3. Attendance at Antimicrobial Team (AMT) meetings has been poor and there is limited buy-in from clinicians.
4. The Trust is not achieving 2 of the 4 AMS targets set by the Public Health Agency. The current carbapenem use and total antibiotic use are above the target levels.
5. There is no formal AMS training plan.
6. The Antimicrobial Stewardship policies and procedures require review and update. The platforms used for making these policies available to staff also need to be considered.
7. A number of exceptions around compliance with IPC procedures were observed during the IPC ward visits, in the areas of Hand Hygiene, Dress code and Commode audits on all nine wards.
8. Although the Trust is overall achieving its internal target of 60% for mandatory training in IPC, there are a number of areas where this is not being met and 'mandatory' training should be conducted by all relevant staff. Training for agency staff was at 30%, as at September 2018.

The other finding of the audit is:

9. The HCAI Strategic Forum Terms of Reference need to be updated. Frequency of the meetings and attendance at meetings does not currently reflect the Terms of Reference for the HCAI Clinical Forum.
10. On review of the main IPC policies Internal Audit found that for 6 of the 10 the review dates had passed.

Summary of Findings and Recommendations

Finding		Number of Recommendations		
		Priority 1	Priority 2	Priority 3
1.	AMS – Monitoring of Practice	-	3	-
2.	AMS – Compliance with Guidance	-	2	-
3.	AMS - Governance	-	2	-
4.	AMS - PHA Targets	-	2	-
5.	AMS - Training	-	2	-
6.	AMS - Policies and Procedures	-	1	-
7.	IPC - Ward Visits	-	2	-
8.	IPC - Training	-	1	1-
9.	IPC - Governance	-	3	-
10.	IPC - Policies and Procedures	-	-	1

Detailed Findings and Recommendations

1 AMS – Monitoring of Practice

Finding

NICE guidance states that Antimicrobial Stewardship is defined as an organisational or healthcare system wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness. This should include monitoring and evaluating antimicrobial prescribing and how this relates to local resistance patterns and feedback to individual prescribers about their antimicrobial prescribing.

There is currently no planned programme of Microbiologist ward rounds taking place. However, the Microbiologist may accompany the Antimicrobial Pharmacist on her ward rounds (approximately once per week). The Antimicrobial Pharmacist advised that monthly visits to each ward are not currently taking place. October 2018 was the last month a full programme of visits was carried out.

Internal Audit were advised that the current priority is taking part in the ARK (Antibiotic Review Kit) Public Health Study. This involves regularly visiting 5 wards (with high microbiotic usage) to compile data on their antibiotic usage. The study is ongoing until June 2019 and findings are yet to be reported.

Similarly there has been a delay in reporting of antibiotic ward round information within the Trust. The reports provided (up to October 2018) were the most up to date available at the time of audit. (February 2019).

Currently nursing or pharmacy staff do not receive a copy of the Antimicrobial Stewardship report and it is the responsibility of the Consultants who receive reports to feed back to these staff, there is no formal process in place to ensure that this happens. The Antimicrobial Pharmacist advised that going forward it would be useful for these staff to see a summary document / poster for their area.

Internal Audit appreciate that the Anti-Microbial Team has a number of vacant positions. The Trust has only recently recruited a second microbiologist and there are four anti-microbial pharmacists recruited and due to come into post in 2019.

Implications

The lack of Antimicrobial Stewardship at ward level increases the risk of misuse of antibiotics and increases the potential for Antimicrobial resistant organisms.

Without a full complement of ward rounds taking place (both Microbiologist and Antimicrobial Pharmacist) it is not possible ascertain the full extent of antimicrobial prescribing issues.

All ward staff are not aware of audit results for their area, this may impact the scope for improvements.

Recommendation 1.1	All clinical staff should be actively involved in the Antimicrobial Stewardship process. Additionally, Directors, Assistant Directors, medics, nursing and pharmacy staff must have ownership of AMS. Antimicrobial audit results should be discussed with the pharmacist, medical staff, nurses, and microbiologist at ward level.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Medical Director plus all Operational Directors
Implementation Date	1 st October 2019

Recommendation 1.2	A planned programme of both Microbiologist and Antimicrobial Pharmacist ward rounds should be promptly established and reported through the appropriate governance arrangements within directorates and action taken to rectify non-compliance and errors.
Priority	2
Management Action	PARTIALLY ACCEPTED (dependent upon recruitment of consultant staff)
Responsible Manager	Medical Director plus all Operational Directors
Implementation Date	1 st April 2020

Recommendation 1.3	Reports should be disseminated to the appropriate staff. Format and content should be considered for the target audience, specifically nursing, pharmacy and junior medical staff.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Medical Director plus all Operational Directors
Implementation Date	1 st June 2019

2 AMS – Compliance with Guidance

Finding

Internal Audit accompanied by an Antimicrobial Pharmacist, carried out visits to a sample of three wards (Daisy Hill Hospital, Male Medical and the High Dependency Unit and 4 North in Craigavon Area Hospital) and reviewed a sample of 44 patient files. There were a total of four exceptions recorded approximately 9% of the total sample;

- One patient had no documented signs of infection:
- One patient's antibiotics were switched from piperacillin/tazobactam to amoxicillin and gentamicin:
- Two patients' antibiotics (metronidazole) were to be stopped as they were not required.

Internal Audit reviewed the AMT Report October 2018 from the antibiotic ward round summary. In the report, there was an exception rate of 16%. The Antimicrobial Pharmacist advised that the 16% error rate was more representative of the overall exception rate.

Implication

Inappropriate use of antimicrobials increases the risk to patients of infection with resistant organisms.

Recommendation 2.1	Arrangements for addressing non-compliance with antibiotic policy and antimicrobial stewardship should be reviewed and strengthened.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Dr O'Kane
Implementation Date	1 st August 2019

Recommendation 2.2	Communication between the Clinical Pharmacists, the Antimicrobial Pharmacists, the Microbiologists and the Ward Team including the Ward Sister should be strengthened to ensure that there is regular and adequate discussion in relation to the use of antibiotics on all wards.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Dr O'Kane plus all Operational Directors
Implementation Date	1 st October 2019

3 AMS Governance

Finding

Internal Audit were provided with minutes of the last two Anti-Microbial Team meetings (September and December 2018). The following was noted:

- There were seven attendees at the September meeting and eight at the December meeting. Per the Terms of Reference there should be wide-ranging membership from across all operational directorates (minimum 15-20 members); There was discussion at both meetings re lack of clinical engagement with the AMT and how to increase this engagement such as targeted training for clinicians on specific wards, engagement through Mortality and Morbidity fora, and improved engagement with the Medical Director.

Implication

With limited attendance at AMT meetings, there is a lack of robust and formal oversight at management level of compliance with Antimicrobial Stewardship.

Recommendation 3.1	Management should strengthen the governance and corporate oversight arrangements in respect of compliance with Antimicrobial Stewardship, by ensuring that the AMT attendance is maximised and the Terms of Reference are appropriate.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Medical Director plus all Operational Directors
Implementation Date	1 st June 2019

Recommendation 3.2	The AMT should develop a formal Clinical Engagement Plan to include targeted training for clinicians on specific wards, engagement with clinicians through Mortality and Morbidity fora, and improved engagement on AMS issues with the Medical Director.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Medical Director
Implementation Date	1 st October 2019

4 AMS - PHA Targets

Finding

The Public Health Agency has issued targets to each of the Health Trusts to reduce their antibiotic use. These are as follows:

- 1% reduction in total antibiotic use compared to 17/18
- 3% reduction in piperacillin/tazobactam use, compared to 17/18
- 3% reduction in carbapenem use, compared to 17/18
- At least 55% of antibiotics from WHO AWARE category.

Details of what are issued by pharmacy in the Trust are used to populate the Antibiotic Dashboard for the PHA. Results for the period April to November 2018 show that two of the four targets were not being met:

- Failure to achieve 1% reduction in total antibiotic use; and
- Failure to achieve 3% reduction in carbapenem use.

The SHSCT do not know how they compare regionally in relation to the other Trusts in the area of AMS. Since the PHA took over responsibility for antibiotic consumption reporting, each Trust can only see its own results and has no access to information for any other Trust. This has been discussed at the regional group and reported to PHA.

Implications

There is non-compliance with regional and Trust policies in respect of AMS. Inappropriate use of antimicrobials increases the risk to patients of infection with resistant organisms. Lack of regionally accessible data means the Trust has no valid comparison, and is unable to assess their progress or otherwise in the area of AMS.

Recommendation 4.1	The Trust Senior Management should continue to monitor performance against the AMS targets. Increased Ward Rounds (see 1.2 above) will monitor usage and further training (see 5.1 and 5.2 below) should help achieve these targets.
Priority	2
Management Action	PARTIALLY ACCEPTED (dependent upon recruitment of consultant staff)
Responsible Manager	Medical Director
Implementation Date	1 st June 2019

Recommendation 4.2	The Trust should progress access to and sharing of comparative information re AMS for other Trusts with the PHA.
Priority	3
Management Action	ACCEPTED
Responsible Manager	Medical Director
Implementation Date	1 st June 2019

5 AMS Training

Finding

On the Corporate Risk Register (CRR) Healthcare Acquired Infection (HCAI) and emerging infections is recorded as a high risk. One of the key controls identified to mitigate the risk is training of staff in Antimicrobial Stewardship. Antimicrobial Stewardship training is not one of the Trusts mandatory training schemes. However there is AMS awareness within the mandatory IPC training for staff.

Adhoc training has been provided on Antimicrobial Stewardship, for example to F1 doctors, Neonatal ward and Surgical staff. This training has been provided at teaching sessions for medics but there is further scope to expand training across clinical staff and develop focused training for nursing staff.

Internal Audit noted that there is no corporate oversight for staff that have completed antimicrobial stewardship training. Attendance records are not kept for the teaching sessions detailed above.

Implications

In the absence of staff training there is an increased risk of inappropriate prescribing of antimicrobials. There is a risk that relevant staff may not receive the relevant and up to date training.

Recommendation 5.1	Training on antimicrobial prescribing and stewardship should be expanded across clinical staff groups /areas and focussed training for nursing staff should be introduced.
Priority	2
Management Action	PARTIALLY ACCEPTED (dependent upon recruitment of consultant staff)
Responsible Manager	Medical Director plus all Operational Directors
Implementation Date	1 st October 2019

Recommendation 5.2	The Antibiotic Stewardship e-learning package should be agreed and finalised, and an implementation plan put in place. This should identify staff to be trained and the timetable for roll out. Also the rate of uptake should be monitored.
Priority	2
Management Action	PARTIALLY ACCEPTED (dependent upon recruitment of consultant staff)
Responsible Manager	Medical Director plus all Operational Directors
Implementation Date	1 st October 2019

6 AMS Policies and Procedures

Finding

A number of the Antimicrobial Stewardship policies dated from October 2015, now require review. Internal Audit were advised that the AMT is in the process of reviewing all policies and procedures. Internal Audit met with the Consultant Microbiologist in the Trust who advised that currently the policies and procedures are available on various platforms:

- Intranet
- SHSCT website
- Sharepoint
- Microguide app

This has caused issues with version control and ensuring that the most up to date policies are on all platforms.

There was a general awareness among staff of AMS policies, however Internal Audit met with one Agency Doctor who was unaware of the Antimicrobial Stewardship policies and procedures.

Implications

Lack of direction in respect of Antimicrobial Stewardship in the absence of up to date policies. Roles and responsibilities may be unclear. Trust objectives in respect of Antimicrobial Stewardship may not be achieved.

Recommendation 6.1	AMT should review the Antimicrobial Stewardship policies. They should discuss and make a recommendation to the HCAI Strategic Forum as to the most appropriate platforms to make these policies and procedures available to staff.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Medical Director plus all Operational Directors
Implementation Date	1 st July 2019

7 IPC Ward Visits

Finding

Internal Audit accompanied the IPC Auditors while they performed Hand Hygiene, Dress code and Commode audits on nine wards, 5 in Craigavon Area Hospital and 4 in Daisy Hill Hospital. The following exceptions were noted:

Recovery CAH

- Environmental audit was not scored on the ward notice board;
- Internal audit observed that one nurse failed to comply with the Hand Hygiene policy, she missed moment 4.

AMU CAH

- There were no recent scores on the notice board for Hand Hygiene or Environmental audit;
- The Hand Hygiene score recorded for November 2018 was 88% (i.e. they did not achieve the 90% target)
- AMU recorded an independent audit fail for their Commode audit in November 2018.

3 South CAH

- Hand Hygiene was not scored on the ward notice board;
- The Deputy Sister was not aware of the new IPC Strategy, there is currently no link nurse for this ward;
- The Deputy Sister noted that Hand Hygiene audit results have not been as high recently. The ward is heavily reliant on agency staff and this can sometimes result in Infection Control issues;
- Hand Hygiene score recorded for November 2018 was 89% (i.e. did not achieve the 90% target);
- Internal audit observed one Health care assistant failed to comply with the Hand Hygiene policy, she missed moment 5;
- 3 south recorded an independent audit fail for their Commode audit in November 2018;
- One Health Care Assistant was wearing nail varnish and was not compliant with the Bare Below the Elbow Policy (BBE).

4 South CAH

- Independent Audit observed Commode audits, one of the five commodes in this ward failed;
- One pharmacist observed not BBE.

NNU CAH

- Internal audit observed one AHP (audiologist) failed to comply with the Hand Hygiene policy, she missed moment 1.

Renal DHH

- Neither hand hygiene nor environmental audit was scored on the ward notice board.

Stroke DHH

- Hand Hygiene score recorded for November 2018 was 89% (i.e. did not achieve the 90% target);
- Internal audit observed one nurse failed to comply with the Hand Hygiene policy, she missed moment 5;
- One nurse observed not BBE.

Female Medical DHH

- Hand Hygiene score recorded for November 2018 was 83% (i.e. did not achieve the 90% target)
- Female Medical recorded an independent audit fail for their Commode audit in November 2018,
- One medic observed not BBE.

Male Medical DHH

- Hand Hygiene score recorded for November 2018 was 89% (i.e. did not achieve the 90% target)
- Male Medical recorded a self-audit fail for their Commode audit in November 2018.

All observations noted during ward visits were reported to the appropriate level of staff at the time (ward sister, deputy sister), staff not meeting requirements were challenged and reminded of their responsibilities and findings were recorded in the monthly report by the independent auditors. The HCAI Strategic Forum regularly monitor audit results for these areas and re-audits take place where particular wards/facilities are found to be falling below the required standards.

Implication

All Trust staff are not all adhering to Trust guidance on hand hygiene, dress code policy and commode cleaning, increasing the risk of infection for patients.

Recommendation 7.1	Results of IPC audits should be displayed on all wards and good practice from high performing areas replicated in poor performing wards. Action plans to address wards who regularly perform poorly in audits should be developed, implemented and monitored.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Operational Directors
Implementation Date	1 st October 2019

Recommendation 7.2	The HCAI Clinical Forum should decide appropriate IPC information wards should display on their notice boards and ensure that all wards comply.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Operational Directors
Implementation Date	1 st October 2019

8 IPC Training

Finding

On the Corporate Risk Register (CRR) Healthcare Acquired Infection (HCAI) and emerging infections is recorded as a high risk. One of the key controls identified to mitigate the risk is training of staff in IPC and training re quality of completeness and quality of patient record keeping in Acute Services Risk Register.

Overall the Trust are meeting their internal target rate of 60% for mandatory training in Infection, Prevention and Control, however 'mandatory' training should be conducted by 100% of relevant staff. In Acute Medical Admissions at CAH only 29 of 50 (58%) staff are up to date with IPC training.

It is the responsibility of the contracted agency to ensure that all staff are adequately trained; at 30 September 2018 the Trust reported that only 461 of 1,526 agency staff i.e. only 30% have undertaken the required mandatory training. 1,065 agency staff had not been trained.

The IPC Team consists of 11 staff. The Lead Infection Prevention Control Nurse advised that a number of key staff in the IPC Team are due to retire within the next couple of years and adequate succession planning needs undertaken to ensure there are adequately trained staff to fill their roles.

Implication(s)

In the absence of staff training there is a risk of increasing infection rates. There is a need to ensure that training is kept up to date as infection control requirements and guidance is a constantly changing area with new challenges.

Recommendation 8.1	An increased focus should be placed on improving mandatory IPC training rates. Additional training should be re-enforced with staff in high risk wards in relation to isolation of patients and use of the IPC checklist, as these are listed as key controls and practice on the CRR, as well as patient record keeping by both medical and nursing staff.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Operational Directors
Implementation Date	1 st October 2019

Recommendation 8.2	Appropriate succession planning should be put in place to ensure that all mandatory training can be provided by the IPC Team.
Priority	3
Management Action	ACCEPTED
Responsible Manager	Medical Director
Implementation Date	1 st June 2019

9 IPC Governance

Finding

The following governance issues were noted during the audit:

- HCAI Strategic Forum Terms of Reference need to be updated. They were dated 2014 and are due for review.
- In recent months the Lead IPC nurse has chaired the HCAI Clinical Forum; however per the Terms of Reference the Medical Director should chair this group with the vice-chair the Senior Manager - Medical Directorate. The membership is wide reaching and includes Directors, IPC staff, Clinical Directors and AMD's, OPPC Heads of Service and Ward Managers (among others). Meetings have not been well attended recently, and a larger cross section of staff needs to be represented as is intended with the wide-ranging membership listed in the Terms of Reference.
- The HCAI Clinical Forum was scheduled to meet 12 times in 2018. It actually met 10 times; two meetings were cancelled (January and June).
- On the Acute Risk Register there are 4 risks related to Healthcare Acquired Infection (HCAI) recorded as a high risk. However there was limited evidence of discussion of IPC issues at directorate level governance meetings during 2018. There was no record of discussion of IPC issues at Acute Clinical Governance meetings.

Implication

Weak governance function due to lack of support from key clinicians and managers to ensure that all aspects of IPC are promoted, managed and that IPC risks are routinely considered at appropriate fora.

Recommendation 9.1	HCAI Strategic Forum Terms of Reference should be reviewed and updated.
Priority	3
Management Action	ACCEPTED
Responsible Manager	Chief Executive/Medical Director
Implementation Date	1 st July 2019

Recommendation 9.2	HCAI Clinical Forum should consider attendance at and frequency of meetings to ensure that their Terms of Reference are being achieved and that all IPC issues are being appropriately dealt with.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Medical Director
Implementation Date	1 st August 2019

Recommendation 9.3	HCAI Strategic Forum should discuss how IPC issues are dealt with at directorate level and make clear which committees are to have IPC issues appear as standing agenda items.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Chief Executive/Medical Director
Implementation Date	1 st August 2019

10 IPC Policies and Procedures

Finding

On review of the main IPC policies Internal Audit found that for 6 of the 10 the review dates had passed.

Implication(s)

Policies and Procedures not regularly reviewed will not be reflective of the current arrangements for infection control. This can lead to confusion over responsibilities etc.

Recommendation 10.1	The IPC policies and procedures should be updated and amended to reflect recent changes.
Priority	3
Management Action	ACCEPTED
Responsible Manager	Medical Director
Implementation Date	1 st October 2019

Appendix A - Definition of Levels of Assurance and Priorities

Level of Assurance

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

Recommendation Priorities

Priority 1	Failure to implement the recommendation is likely to result in a major failure of a key organisational objective, significant damage to the reputation of the organisation or the misuse of public funds.
Priority 2	Failure to implement the recommendation could result in the failure of an important organisational objective or could have some impact on a key organisational objective.
Priority 3	Failure to implement the recommendation could lead to an increased risk exposure.

Note to Report

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

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**Minutes of a meeting of the Audit Committee held on
Thursday, 11th April 2019 at 9.30 a.m. in the Boardroom,
Trust Headquarters**

PRESENT:

Mrs H McCartan, Non-Executive Director (Chair)
Mr M McDonald, Non-Executive Director
Ms E Mullan, Non-Executive Director
Mrs S Rooney, Non-Executive Director
Mr J Wilkinson, Non-Executive Director

IN ATTENDANCE:

Ms H O'Neill, Director of Finance, Procurement and Estates
Mrs C Cassells, Assistant Director of Finance, Financial Management, SHSCT
Mrs A Rutherford, Assistant Director of Finance, SHSCT
Mrs F Jones, Corporate Financial Accountant/Fraud Liaison Officer, SHSCT
Mrs M McClements, Director of Older People and Primary Care, SHSCT *(Item 6i only)*
Dr M O'Kane, Medical Director, SHSCT *(Item 6i only)*
Mr S Gibson, Assistant Director – Medical Directorate, SHSCT *(Item 6i only)*
Mrs V Toal, Director of Human Resources and Organisational Development *(Item 6i only)*
Mrs H Trouton, Interim Executive Director of Nursing & Allied Health Professionals, SHSCT *(Item 6i only)*
Ms L Kelly, Grant Thornton
Ms J McCaw, Assistant Head of Internal Audit, BSO
Mr J Murray, Internal Audit
Mr D Lynn, Northern Ireland Audit Office
Mrs S Judt, Board Assurance Manager, SHSCT
Mrs S McCormick, Committee Secretary, SHSCT (Minutes)

APOLOGIES

None

1) CHAIR'S WELCOME

Mrs McCartan welcomed everyone to the meeting and reminded members of their responsibilities in keeping with Board etiquette. She asked that mobile phones are turned to silent and laptops are to be used for accessing Audit papers only during the meeting.

2) DECLARATION OF INTERESTS

Mrs McCartan asked members to declare any potential conflict of interests in relation to items on the agenda. None were received and the business of the meeting proceeded.

6i) INTERNAL AUDIT PROGRESS REPORT (5 REPORTS)**Specific Elements of Infection Prevention and Control (IPC) Governance including Anti-Microbial Stewardship – Limited**

Ms McCaw was please to advise a Satisfactory level of assurance in relation to specific elements of IPC governance, namely (oversight of compliance with policies and procedures, IPC Audit and training). She stated that the audit exercise had identified generally good compliance with the sampled elements of IPC policies and procedures. Furthermore audit practices were well established in terms of IPC training and timely communication of audit results to staff and regular reporting to the Trust Board evidenced. However, members noted a Limited level of assurance was provided in relation to Antimicrobial Stewardship (AMS), on the basis that AMS monitoring of practice requires further development and embedding across the Trust. Currently the Organization is meeting two of the four targets for AMS set by the Public Health Agency (PHA). Eighteen Priority 2 and two Priority 3 recommendations were identified. Ms McCaw advised that all recommendations have been accepted by Trust management.

At this point, Mrs McCartan welcomed Mrs Trouton to the meeting to provide an update on progress alongside, Dr O'Kane and Mr Gibson. Dr O'Kane acknowledged it was disappointing to see Limited assurance in terms of AMS however, she assured members the Trust have taken a collective leadership approach to the issues raised. Dr O'Kane referred to a number of issues including, the recently publicized overuse of antibiotics and workforce challenges. She stated that the Trust currently has two Microbiologists in post

however further Microbiologists have been recruited and all envisaged to be in post by the end of 2019 and this will assist higher AMS at ward level. Dr O'Kane referred to Anti-Microbial Team meetings and advised that in order to improve clinical engagement, Mrs Trouton and herself have undertaken some work around reporting structures along with Mrs Gishkori.

Members welcomed the proactive work undertaken post audit. Mrs McCartan suggested the matter required further discussion through the remit of the Trust Governance Committee. Ms Mullan agreed to take this forward.

Action – Ms Mullan

Mrs Rooney referred to page 60, AMS training and suggested there would be benefit in including this under mandatory training for F1 doctors. Dr O'Kane agreed to liaise with Queens University and the Northern Ireland Medical and Dental Training Agency (NIMDTA) on the matter to ascertain at what stage training/teaching on Antimicrobial Stewardship is provided. Members were advised that Mr Martin Brown, Consultant Microbiologist speaks to junior doctors on AMS as part of their induction training.

Action – Dr O'Kane

In conclusion, Mrs McCartan thanked Dr O'Kane, Mrs Trouton and Mr Gibson for attending the meeting. She emphasized this was an important area of Governance for the Organisation and stated further discussion on the issue would be taken forward via the Trust Governance Committee.



Southern Health & Social Care Trust

Management of Standards & Guidelines – 2018/19



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Acknowledgement

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

Control Log

Working Draft Issued On:	31 October 2018
Exit Meeting Held On:	02 October 2018
Management Meeting Held On:	20 November 2018
First Draft Issued On:	21 November 2018
Management Actions Due By:	5 December 2018
Management Actions Received:	29 November 2018
Final Draft Issued On:	29 November 2018
Final Report Issued On:	30 November 2018

Distribution List

Shane Devlin	Chief Executive (final report only)
Dr Ahmed Khan	Acting Medical Director
Margaret Marshall	Assistant Director Clinical and Social Care Governance
Helen O'Neill	Acting Director of Finance
Alison Rutherford	Assistant Director of Finance

Introduction

In accordance with the 2017/18 Annual Internal Audit Plan, BSO Internal Audit carried out an audit of Management of Standards and Guidelines during September 2018. The last Internal Audit of this topic was performed during May 2015 when Satisfactory assurance was provided.

This audit reviewed corporate and directorate processes for the dissemination, prioritisation/risk assessment (where appropriate) and implementation of standards and guidelines.

Standards and Guidelines (S&G) upon receipt are initially logged onto the Trust Standards and Guidelines database by the Corporate Governance Team. On a weekly basis the Corporate Governance Team forward the Standards and Guidelines received to Directorate Governance Officers, Pharmacy Governance and Medical Directors Office. In addition S&Gs received are logged on the Trust Sharepoint site. Responsibility for identifying applicability, risk assessment and subsequent implementation of Standards and Guidelines within the Trust resides within the Operational Directorates. Each of the operational directorates has developed their own processes as to how Standards and Guidelines will be managed through Operational Directorate Governance structures, so for example the Acute Services Directorate has established a Standards and Guidelines Review Group which meets on a bi-weekly basis due to the high volume of applicable standards and guidelines. The role of this and similar groups in other directorates is to undertake a risk review of each clinical standard and guideline received and the identification of a change lead to take forward the required actions. These directorate groups are also responsible for the ongoing monitoring and progressing those clinical standards and guidelines where full compliance has not yet been met.

Standards and Guidelines come from a variety of sources and are received by a number of regional bodies for regional endorsement. Such external agencies include the HSC Board, Public Health Agency (PHA) and Safety & Quality Unit at the DoH. These agencies disseminate the Standards and Guidelines to the HSC Trusts for action and in some instances, there is a requirement that an assurance will be provided to confirm that the required recommendations have been embedded within local practice. Standards and Guidelines are increasingly challenging for providers and commissioners to manage due to their increasing numbers and variety of sources involved.

There were 360 Standards and Guidelines received from January 2017 to August 2018 and of these 156 (43%) had been received from NICE and a further 76 (21%) from the Chief Medical Officer. In line with NICE Circular HSC (SQSD) 2/13 and Circular HSC (SQSD) 3/13, the HSCB seeks a positive assurance report on NICE Guidance issued from September 2011 on a bi monthly basis. This assurance includes confirmation the Trust has completed the initial actions of targeted dissemination, identification of a clinical/management lead and implementation planning within 3 months of issue and that the Trust has fully implemented all guidance within the required timescale. Where NICE Clinical Guidelines are not implemented or not on track for implementation within 12 months of issue, the Trust is required to complete a Section E template which sets out the major barrier/s to implementation, any specific requirements to address the major barriers and any immediate patient safety concerns if the clinical guideline is not implemented within the 12 month timescale. The HSCB requires the Trust to monitor and keep under review the Section E documents which are in place and provide updates on implementation. The Trust currently has 55 NICE guidelines within Acute Services where a Section E template is in place and notified to the HSCB.

The breakdown of Standards and Guidelines received are as follows:-

Issuing Organisation	Number of Standards and Guidelines (Issued January 2017 to August 2018)
NICE Technology Appraisal	93
CMO Letter	76
NICE Clinical Guideline	27
NICE Clinical Guideline Update	23
Safety & Quality Reminder of Best Practice Guidance	20
HSCB/PHA Letter	17
Medical Device Alert	17
HSCB Letter	16

Issuing Organisation	Number of Standards and Guidelines (Issued January 2017 to August 2018)
PHA Letter	15
DOH Letter	10
NICE Public Health Guidance	8
Drug Safety Update	5
NICE Interventional Procedures	5
Public Health Guideline	5
Various Others	23
TOTAL	360

Scope of Assignment

This assignment reviewed the processes in place for receipt, dissemination, implementation and corporate oversight for standards and guidelines received. It also reviewed processes in place for ensuring that systems were in place for reporting compliance to issuing organisations.

The audit was based on the risk that standards and guidelines may not be adhered to and required actions implemented in the absence of a robust process for recording, dissemination, monitoring compliance, and providing assurance.

The objectives of this audit were:

- To ensure that there is an appropriate system in place for coordinating, disseminating and overseeing standards and guidelines.
- To ensure that Standards and Guidelines are appropriately disseminated and implemented in the Trust.
- To ensure that changes to practice/procedure following receipt of Standards and Guidelines is effectively communicated and implemented.
- To ensure that there are reporting arrangements in place in respect of guidance and circulars.

This audit did not include NIAIC or Drug Alerts received directly into Estates and Pharmacy

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

Level of Assurance

Limited

There are significant weaknesses within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved.

Executive Summary

Internal Audit can provide Limited assurance in relation to the Management of Standards and Guidelines within the Trust. While the Trust has in place good controls to record corporately the receipt and subsequent dissemination of all Standards and Guidelines to directorates, there is no corporate overview and reporting of the Trust's overall compliance against standards and guidelines. Weaknesses were also found in relation to completeness of data held on the Trust Standards and Guidelines register and there is limited ongoing audit / follow up of compliance. There was evidence within the operational directorates of ongoing review, implementation and management of standards and guidelines, through Operational Directorate Governance processes.

A satisfactory assurance was given in our previous audit of Standards and Guidelines in 2015/16. Since then there has been a reduction in the extent of corporate reporting e.g. previously the Accountability Report on compliance and implementation of Standards and Guidelines went to Governance Committee twice a year – during the period tested there was no reporting through Governance committee on compliance with extant Standards and Guidelines.

There are two significant findings in this report that impacts on the assurance provided.

1. During the period September 2017 to September 2018, there had been no reporting of compliance with Standards and Guidelines presented to the Board Governance Committee. Consequently the Trust Board has not received assurance that all Standards and Guidelines are implemented on a timely basis and are subsequently being complied with. Previously the Trust prepared an Accountability Report for Standards and Guidelines which was presented to the Trust Governance Committee on a six monthly basis which detailed the Trust's compliance against each standard and guideline received. This Accountability Report is no longer compiled.
2. Review of the Trust Standards and Guidelines register (spreadsheet) found that there are significant gaps in the information held. In particular updates on actions taken by directorates are not recorded on the register by directorate governance teams to enable compliance progress against individual standards and guidelines to be fully tracked and reported.

The other key findings of the audit are:-

3. When a Standard or Guideline is viewed as fully implemented, there is no formal audit or follow-up process in place to ensure ongoing compliance. Where a Standard and Guideline is for dissemination only, the operational directorates governance teams do not have a process in place to ensure that this has been disseminated to all relevant staff.
4. In review of the corporate process map, Internal Audit noted that whilst the process for dissemination and review of the Standards and Guidelines is outlined, it does not refer to how responses should be managed and collated via the Corporate Governance team. Responses to the issuing organisation are agreed at Directorate level but there is no corporate overview or reporting of these responses.
5. To ensure compliance with issuing organisations timescales for responses to individual standards and guidelines, the Corporate Governance Team regularly review the Trust Standards and Guidelines register and issue email reminders to prompt directorate operational governance teams when actions are due. This process is dependent on manual interventions as the system cannot automatically generate reminders, which would improve efficiency and effectiveness. Testing found 24 of the 40 Standards and Guidelines reviewed had a response timeframe:
 - The Positive Assurance report for July 2018 had not been submitted to the HSCB at the date of audit fieldwork in September 2018.
 - In 2 out of 24 cases, the response date as per the Standard & Guideline had not been achieved, the Trust submitted responses 2, and 7 weeks after the required submission date.
 - In 2 cases, the response was for a nomination from the Trust to attend a regional group – in these 2 cases the request for a nomination was made directly through the relevant Director by the issuing organisation.
6. Upon receipt Standards & Guidelines are issued weekly by the Corporate Governance Team to Operational Governance Teams in the relevant Directorates. In review of 40 Standards and Guidelines the following exceptions were noted:-
 - 3 had not been issued to 8-9 working days after receipt from issuing organisation.
 - 1 had not been issued to 13 working days after receipt from issuing organisation.
 - 1 case where the S&G had been issued from the source organisation on 24 May 2018 but was not emailed to operational governance leads until 20 July 2018, a delay of 42 working days. 1 had been issued by the source organisation on 25 September 2017 but was only issued on 9 March 2018 by the corporate team – this S&G had not been received by the corporate team and had been issued directly to the Medical Directors office. The Corporate team picked this up as part of a compliance audit completed in March 2018. There was a delay of 120 days between receipt and dissemination to Governance Leads.

There are no other observations in this report.

Summary of Findings and Recommendations

Finding		Number of Recommendations		
		Priority 1	Priority 2	Priority 3
1.	Corporate Oversight and Reporting	1	-	-
2.	Register of Standards and Guidelines	-	1	-
3.	Follow-Up and Audit of Implemented Actions	-	1	1
4.	Corporate Process Map for Standards and Guidelines	-	1	-
5.	Performance Management – Meeting Target Responses Dates	-	2	1
6.	Compliance with Processes	-	1	-

Detailed Findings and Recommendations

1 Corporate Oversight and Reporting

Finding

There was evidence within the operational directorates of ongoing review, implementation and management of standards and guidelines, through Directorate Governance processes.

However, during the period September 2017 to September 2018 there had been no reporting of compliance with Standards and Guidelines received to the Board Governance Committee, either as a stand-alone item or as part of a broader Clinical Governance report or quality improvement report. The Trust Board are not receiving assurances that Standards and Guidelines are being appropriately managed. Internal Audit acknowledges that at the Governance Committee meeting held on 11 May 2018, a report was presented in relation to the logging and dissemination of Standards and Guidelines. However this did not report on the extent of Trust compliance with standards and guidelines.

Previously the Trust prepared an Accountability Report for Standards and Guidelines which was presented to the Trust Governance Committee on a six monthly basis which detailed the Trust's compliance against each standard and guideline received. This Accountability Report is no longer compiled.

Implications

There is a lack of robust and formal oversight at a corporate level of the overall Trust compliance with Standards and Guidelines issued. Trust Board may not receive the necessary assurances that actions required in relation to Standards and Guidelines are being progressed and implemented.

Recommendation 1.1	Management should strengthen the governance and corporate oversight arrangements in respect of compliance with Standards and Guidelines. A report should be regularly presented to Governance Committee in relation to compliance with Standards and Guidelines and the corresponding risk rating. This assurance report should be presented to the Governance Committee at its meeting in December.
Priority	1
Management Action	ACCEPTED
Responsible Manager	Assistant Director of Clinical and Social Care Governance Operational Directors and Directorate Governance Leads.
Implementation Date	December 2018

2 Register of Standards and Guidelines (Data Quality and Completeness)

Findings

Currently the Trust's Standards and Guidelines Register is held on an excel spreadsheet by the Medical Directorate. The purpose of the register is to provide a central record of all standards and guidelines received by the Trust, who they were disseminated to, risk rating and to monitor progress re implementation within designated timescales where applicable. Review of the corporate register found that updates on actions taken by directorates to address requirements contained in standards and guidelines are not recorded on the register by directorate governance teams. Also there were gaps in the information completed e.g. Lead Directorate not always completed, applicable directorates not always completed.

Consequently the Standards and Guidelines Register will not facilitate reporting on the Trust's actual compliance and progress against actions.

Implication

The current register may not be fit for purpose due to incomplete data and absence of directorate actions to address requirements contained in standards and guidelines. Trust is unable to use the register to report corporately on the implementation status of standards and guidelines.

Recommendation 2.1	The Trust Standards and Guidelines spreadsheet should be fully populated by all directorates, and processes introduced to ensure it is properly managed and timely updated both by Corporate and Directorate Teams. Additional fields should be added to the Trust Standards and Guidelines spreadsheet to record directorate data regarding actions taken to comply with standards is recorded on a timely basis, and to enable accurate reporting of compliance on a standard by standard basis.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Assistant Director of Clinical and Social Care Governance Operational Directorate Governance Leads
Implementation Date	September 2019

3 Follow-Up and Audit of Implemented Actions

Finding

Each Directorate manages standards and guidelines through their directorate governance processes this includes ensuring dissemination to appropriate staff, were applicable identifying change leads. Where responses are required to issuing organisations these must be agreed by the Director in advance of submission to the corporate team who are responsible for forwarding these responses to the issuing organisation, including where applicable any barriers to implementation within the agreed timeframes etc.

However when a Standard or Guideline is deemed to be fully implemented, there is no formal audit process in place to ensure ongoing compliance. In addition where a Standard and Guideline is for dissemination only, the operational directorates governance teams do not have a process in place to ensure that this has been disseminated to all relevant staff.

Implications

On an on-going basis the Trust does not have assurance that they continue to be compliant with Standards and Guidelines received.

Not all relevant staff may receive the standards and guidelines.

Recommendation 3.1	Internal Audit acknowledges that due to the volume of standards and guidelines received it would not be feasible to audit compliance for all. However based on the overall risk rating or profile of the standard or guideline, management should include audits of compliance with high risk Standards and Guidelines within directorate clinical audit plans from 2018/19, taking into consideration the Trust Clinical Governance Strategy.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Assistant Director of Clinical and Social Care Governance Directorate Clinical Governance Leads
Implementation Date	June 2019

Recommendation 3.2	Where a Standard and Guideline only requires dissemination, governance teams in operational directorates should build into their initial email a request from Heads of Service to confirm dissemination of the Standard and Guideline to relevant staff in operational teams.
Priority	3
Management Action	ACCEPTED
Responsible Manager	Operational Directorate Governance Leads
Implementation Date	January 2019

4 Corporate Process Map for Standards and Guidelines

Finding

There is a process map in place which details the dissemination of Standards and Guidelines from the corporate team to the operational directorates. However, whilst this corporate process map outlines the process for dissemination and review of the S&Gs, it does not refer to how responses should be returned centrally via the corporate team. Each directorate compiles their own response and agree this through their governance processes before forwarding to the Corporate Governance team who are responsible for forwarding this to the issuing organisation.

Implication

The process map does not reflect all processes which are undertaken by the Corporate Standards and Guidelines team.

Recommendation 4.1	The corporate process map should be reviewed, amended, updated and approved to reflect the complete process for the management of Standards and Guidelines within the Trust. • This should include the process in relation to NICE positive assurance. • The corporate co-ordination or submission of responses to the issuing organisation.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Assistant Director of Clinical and Social Care Governance
Implementation Date	December 2018

5 Performance Management – Meeting Target Responses Dates

Finding

To ensure compliance with issuing organisations timescales for responses to individual standards and guidelines, the Corporate Governance Team regularly review the Trust Standards and Guidelines register and issue email reminders, to prompt directorate operational governance teams when actions are due. This process is dependent on manual interventions as the system cannot automatically generate reminders, which would improve efficiency and effectiveness. Testing found 24 of the 40 Standards and Guidelines reviewed had a specific response timeframe stated.

15 of the 24 were in relation to NICE guidelines or technology appraisals. On a bi-monthly basis the Trust are asked to provide a Positive Assurance to the HSCB in relation to NICE guidelines and Technology appraisals at the date of audit fieldwork the Positive Assurance report for July 2018 had not been submitted to the HSCB.

In the remaining 9 cases which had designated response dates, Internal Audit noted the following exceptions:-

- In 2 cases the response date as per the Standard & Guideline had not been achieved, the Trust submitted responses 2 and 7 weeks after the required submission date.
- In 2 cases the response was for a nomination from the Trust to attend a regional group – in these 2 cases the nomination had been submitted directly in one case by the Executive Director of Nursing (this was recorded as overdue on the central register) and in one case by the Medical Director.

A similar finding was previously reported in the 2015/16 Standards and Guidelines report.

Implication

Failure to comply with issuing organisation response timeframes.
Use of manual reminder systems is inefficient and less effective.

Recommendation 5.1	As previously recommended, the Trust should ensure that response to standards and guidelines are made by the designated response date. Where response timeframes are not achieved this should be included in the report to Governance Committee and reasons for non-compliance or barriers to implementation.
Priority	2 (<i>Priority 2 under previous audit classifications</i>)
Management Action	ACCEPTED Responsible Officer: - Assistant Director of Clinical and Social Care Governance Original Implementation Date: - 28 February 2016
Responsible Manager	Assistant Director of Clinical and Social Care Governance
Revised Implementation Date	March 2019

Recommendation 5.2	Management should consider further development of its systems to introduce automated mailing of timely reminders to prompt directorate operational governance teams when actions are due.
Priority	2
Management Action	ACCEPTED

Responsible Manager	Assistant Director of Clinical and Social Care Governance
Revised Implementation Date	September 2019

Recommendation 5.3	Where a Standard and Guideline requires a nomination and these are submitted by the professional lead i.e. Medical Director, Executive Director of Nursing etc this updated action should be recorded on the Trust Standards and Guidelines register.
Priority	3
Management Action	ACCEPTED
Responsible Manager	Assistant Director of Clinical and Social Care Governance Operational Directorate Governance Leads
Implementation Date	January 2019

6 Compliance with Processes

Finding

Standards & Guidelines as per the corporate process map should be issued every week by the Corporate Team to Governance Teams in the operational directorates. In review of 40 S&Gs received in the period 1 January 2017 to 31 August 2018 Internal Audit Noted the following issues:-

- 3 took 8-9 working days to issue after receipt from the issuing organisation
- 1 took 13 working days to issue after receipt from the issuing organisation
- 1 took 25 working days to issue after receipt from the issuing organisation.
- 1 case where the S&G "**Resources to support the safe adoption of the revised National Early Warning Score NEWS 2**" had been issued from the source organisation on 24 May 2018 but was not emailed to the operational governance leads until 20 July 2018 a delay of 42 working days. This S&G had been issued directly to the Medical Director by the issuing organisation.
- 1 case where the S&G "**Flexible Scopes requiring a Sterile Status: Establishment of short life Task and Finish Group to develop reprocessing Best Practice**" had been issued by the source organisation on 25 September 2017 but was not identified by Corporate Team until 9 March 2018. The S&G had not been received into the corporate team and had been dealt with at the issue date through the Medical Directors office. The Corporate team picked this up as part of a compliance audit completed in March 2018. There was a delay of 120 days between receipt and dissemination to Governance Leads however the action required had been completed as it was Trust nomination to sit on the Task and Finish Group. Both these latter 2 cases were categorised as low risk.

Implications

Non-compliance with procedures.

Potential for delays in issue of standards and guidelines to impact upon patient safety issues.

Recommendation 6.1	All standards and guidelines should be issued to the relevant governance staff in operational directorates within 1 week of receipt as per the process map. Where standards and guidelines are not received by the corporate team these should be forwarded by the receiving officer as a matter of priority to allow the S&G to be logged on the Trust S&G register.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Assistant Director of Clinical and Social Care Governance
Implementation Date	March 2019

Appendix A - Definition of Levels of Assurance and Priorities

Level of Assurance

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

Recommendation Priorities

Priority 1	Failure to implement the recommendation is likely to result in a major failure of a key organisational objective, significant damage to the reputation of the organisation or the misuse of public funds.
Priority 2	Failure to implement the recommendation could result in the failure of an important organisational objective or could have some impact on a key organisational objective.
Priority 3	Failure to implement the recommendation could lead to an increased risk exposure.

Note to Report

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

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**Minutes of a meeting of the Audit Committee held on
Thursday, 14th February 2019 at 9.30 a.m. in the Boardroom,
Trust Headquarters**

PRESENT:

Mrs H McCartan, Non-Executive Director (Chair)
Mr M McDonald, Non-Executive Director
Mrs S Rooney, Non-Executive Director
Mr J Wilkinson, Non-Executive Director

IN ATTENDANCE:

Ms H O'Neill, Director of Finance, Procurement and Estates
Mrs C Cassells, Assistant Director of Finance, Financial Management, SHSCT
Mrs F Jones, Corporate Financial Accountant/Fraud Liaison Officer, SHSCT
Mr P Morgan, Director for Children & Young People's Services, SHSCT *(Item 6i only)*
Mrs M McClements, Director of Older People and Primary Care, SHSCT *(Item 6i only)*
Mr B McNeany, Director for Mental Health & Disability Services, SHSCT *(Item 6i only)*
Dr M O'Kane, Medical Director, SHSCT *(Item 6i only)*
Mrs L Leeman, Assistant Director of Performance Improvement, SHSCT *(Item 6i only)*
Mrs T Reid, Assistant Director of Clinical & Social Care Governance, SHSCT *(Item 6i only)*
Ms B Bourke, Grant Thornton
Ms J McCaw, Assistant Head of Internal Audit, BSO
Mr J Murray, Internal Audit
Mr D Lynn, Northern Ireland Audit Office
Mrs S Judt, Board Assurance Manager, SHSCT
Mrs S McCormick, Committee Secretary, SHSCT (Minutes)

APOLOGIES

Ms E Mullan, Non-Executive Director
Mrs A Rutherford, Assistant Director of Finance, SHSCT

1) CHAIR'S WELCOME

Mrs McCartan welcomed everyone to the meeting and in particular Mrs Rooney, Non-Executive Director. She advised that following the recent review of Committee membership of Non-Executive Directors conducted by the Trust Chair, Mrs Rooney has replaced Mrs P Lesson on the Committee with effect from 1 January 2019. Mrs McCartan also welcomed Mrs Cassells following her recent appointment to the post of Assistant Director of Finance - Financial Management and wished her well in the future.

Mrs McCartan reminded members of their responsibilities in keeping with Board etiquette. She asked that mobile phones are turned to silent and laptops are to be used for accessing Audit papers only during the meeting.

2) DECLARATION OF INTERESTS

Mrs McCartan asked members to declare any potential conflict of interests in relation to items on the agenda. None were received and the business of the meeting proceeded.

3) CHAIR'S BUSINESS

None.

Mrs McCartan requested that Item 6i, IA Report on the Management of Standards and Guidelines would be discussed next on the agenda.

Management of Standards and Guidelines (S&G) - Limited

At the outset Ms McCaw pointed out an audit exercise of the Management of S&G had previously been undertaken in 2015/16 and Satisfactory assurance provided, however in terms of this audit, Ms McCaw advised that a Limited level of assurance was provided in that while the Trust has good controls in place to record corporately the receipt and subsequent dissemination of S&G to Directorates, there is no corporate overview and reporting of the Trust's overall compliance. Gaps were also identified in terms of completeness of data on the Trust S&G register and auditing/follow up of compliance; however, Ms McCaw welcomed evidence within the Operational Directorates of ongoing review, implementation and management of S&G through

operational directorate governance processes. One Priority 1 and 6 Priority 2 recommendations were identified.

On behalf of members, Mrs McCartan recorded disappointment at the Limited level of assurance provided and highlighted in particular concern around the lack of corporate oversight and the potential for risk to patient safety if standards and guidelines are not disseminated and actioned in a timely fashion.

At this point, Mrs McCartan welcomed Dr O’Kane, Medical Director and Mrs Reid, Interim Assistant Director of Clinical and Social Care Governance to the meeting to provide a progress update post audit. Dr O’Kane thanked IA for their recent work and stated the report provides a strong baseline from which the Trust needs to improve. She referred members to her written update on progress, outlining actions being taken forward to address the weaknesses identified including strengthening corporate reporting of S&G to the Trust Governance Committee. Mrs Reid acknowledged further work was required in terms of the completeness of the S&G database and advised regarding ongoing work at Directorate level in conjunction with the Trust IT Department to review the current systems in order to ensure the availability of more meaningful information and assist the implementation of more robust S&G.

Mrs McCartan asked about audits of compliance with high risk S&G. Mrs Reid advised that clinical audits are undertaken across the operational teams and work is progressing on an audit schedule to include S&G compliance. Dr O’Kane pointed out that a recent appointment to the post of Head of Patient Safety Data and Audit will help to strengthen this area. Mrs McCartan emphasized the importance of achieving compliance and ensuring same was maintained. Dr O’Kane concurred with this point and assured members that this was one of the challenges being considered through the lessons learned group. She also advised of the introduction of a weekly governance debrief reporting to the Trust Senior Management Team (SMT). Mrs McCartan asked if there was a model for comparison used elsewhere. In responding Dr O’Kane advised this was a challenging area across the piece, however some consideration was being given to models in England where performance is better. Mr Lynn welcomed this approach. Dr O’Kane also advised that work had started on a Trust Clinical and Social Care Governance Strategy which will be widely consulted.

Mrs Rooney welcomed the update on progress and pointed out the report highlights the need to review reporting of S&G to Governance Committee and review the Governance Committee agenda. She continued by asking in terms of patient safety, how Pharmacy is linked into the management of S&G to which Dr O’Kane advised that Dr Boyce, Head of Pharmacy is contributing to the overall Clinical & Social Care Governance Framework which will be very helpful.

In concluding Mrs McCartan thanked Dr O’Kane and Mrs Reid for their attendance and reiterated this was a high risk area in terms of patient safety and pointed out the importance of ensuring recommendations are addressed within the agreed timescales.



Southern Health & Social Care Trust

Risk Management 2018/19



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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 audit engagement.

Control Log

Exit Meeting Held On:	18 December 2018
Working Draft Issued On:	20 December 2018
Management Meeting Held On:	10 January 2019
Management Actions Due By:	10 January 2019
Management Actions Received:	10 January 2019
Final Report Issued On:	11 January 2019

Distribution List

Shane Devlin	Chief Executive (Final Report Only)
Dr Maria O'Kane	Medical Director
Helen O'Neil	Director of Finance, Procurement and Estates
Margaret Marshall	Assistant Director of Clinical & Social Care Governance
Alison Rutherford	Assistant Director of Finance
Fiona Jones	Fraud Liaison Officer

Introduction

In accordance with the 2018/19 Annual Internal Audit plan, BSO Internal Audit carried out an audit of Risk Management during December 2018. The last audit of this topic, which focussed on directorate risk registers, took place in November 2017 when satisfactory assurance was provided.

Like all HSC Trusts, the SHSCT has recently adopted the ISO 31000:2018 risk management standard on which the previously used and now expired AS/NZ Risk Management Standard was based, and also uses the HSC Regional Risk Matrix (revised August 2018).

Risk Registers are developed at Department, Divisional, Directorate, and Corporate levels to record all forms of risk i.e. clinical, financial and operational risks. The Corporate Risk Register (CRR) records the Trust's principal risks that have serious consequences for the organization and threaten achievement of its' principal objectives and the key controls to manage those risks. The Corporate Risk Register is reviewed by SMT on a bi-monthly basis and, on behalf of the Trust Board, through the Trust Governance Committee.

During 2018/19 a number of initiatives in respect of risk have commenced. A Directors Workshop was held on the 26 April 2018, which included a 'deep dive' review of two corporate risks, Risk 4 Cybersecurity and Risk 10 HCAI. A substantive review of the CRR was undertaken by the SMT during July and August 2018 and a detailed review of each corporate risk was performed. During this work a number of corporate risks were reworked which resulted in two new risks identified as a corporate risk, five risks de-escalated for management at Directorate risk register level and one risk had its rating increased. Additionally it was agreed that an individual risks from the CRR would be reviewed in detail at each subsequent Governance Committee meeting. This process commenced at the September Governance Committee when a detailed review of Risk No 7: Loss of electrical power to main hospital block, CAH (Risk Rating – High) and Risk No 3: Medical Workforce Shortages and vacancies (Risk Rating – High) was completed.

Governance structures show that the responsibility for the management of risk lies within operational directorates and their corresponding governance arrangements, with the corporate overview role provided by the Medical Director and Corporate Governance Team.

Scope of Assignment

The scope of this audit was to review processes in place to identify and manage risks within SHSCT both at Directorate and Corporate level. The audit was based around the following potential risk:

- Ineffective risk management processes could impact on the effectiveness of the Trust and its ability to deliver services.

The objectives of the audit were:

- To ensure that there is an appropriate framework in place for risk management.
- To ensure that there is an appropriate framework in place for risk management training.
- To ensure there are appropriate controls in place for risks to be identified and included into the risk management process.
- To ensure that Management has appropriately considered the implications, controls and scoring of risks and appropriate actions to address risks have been identified and taken forward.
- To ensure that there are appropriate controls in place for directorate risks to be identified and incorporated into the risk management process.
- To ensure that there is an effective process in place for escalating and de-escalating risks.
- To ensure that there are appropriate governance arrangements in place for risk management.
- To confirm the status of implementation of each of the recommendations arising from the previous Internal Audit report on Risk Management 2017/18.

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

Level of Assurance

Satisfactory

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

Executive Summary

Internal Audit can provide satisfactory assurance over Risk Management. Satisfactory assurance is provided on the basis that there was regular review of corporate risks by the Senior Management Team and by the Board Governance Committee during 2018/19. Operational Directorate Risk Registers were also regularly reviewed and updated during 2018/19. There is evidence of escalation and de-escalation of risks between the Corporate and Directorate Risk Registers in the period tested and training has been delivered on Risk Management. Risks tested by Internal Audit were supported by detailed Risk Assessments.

In the 2017/18 Risk Management Report, there were two Priority 2 recommendations. At the date of this review, December 2018, one of the 2 recommendations (50%) had been implemented and one recommendation made had been partially implemented (50%).

There are no significant findings in this report that impact on the assurance provided.

The key finding of the audit is:

1. Risk registers at directorate/corporate level are held in different formats, rather than being consistent. Two risks reviewed did not have a risk ID recorded on the risk register. For four of the ten risks sampled, there were no future actions recorded but progress to date was recorded. On the Acute Directorate Risk Register there was no Responsible Officer identified in both cases reviewed. For seven of the ten risks reviewed, there were no specific dates noted for the implementation of actions. *This issue has been reported in the last four Risk Management audit reports.*

Other observations include:

2. The Fraud Risk Action Plan has been progressed during 2018/19. Directors have been issued with Fraud Risk Assessment Plan for their directorate and a range of supporting information. Following on from the completion of the Fraud Risk Assessments, directorate management need to assess whether any fraud risks identified should be included on Directorate Risk Registers.
3. The Risk Management Strategy is due for review. It was last updated in January 2014. It should be updated following the introduction of ISO 31000:2018 and incorporate any changes in Trust governance structures. *This issue has been previously reported.*

Summary of Findings and Recommendations

Finding	Number of Recommendations		
	Priority 1	Priority 2	Priority 3
1. Format and Population of Risk Registers	-	1	-
2. Fraud Risk Action Plans	-	1	-
3. Risk Management Strategy	-	-	1

Detailed Findings and Recommendations

1 Format and Population of Risk Registers

Findings

Internal Audit reviewed the Corporate Risk Register and the four operational Directorate Risk Registers. The five risk registers are held in three different formats, i.e. Word, Excel and DATIX, with no standardised pro-forma leading to inconsistencies in the information recorded between what are controls/actions/progress.

Gaps in information in the four Directorate Risk registers included:

- Two risks reviewed did not have a risk ID recorded on the Directorate Risk Register (MHL D).
- For four of the ten risks (2 MHL D, 2 CYP and 1 Acute) there were no future actions recorded but progress to date was recorded.
- Within the Acute Directorate risk register, for both of the risks reviewed there was no responsible officer / risk lead identified. This information was however available from the supporting Risk Assessment document.
- For seven of the ten risks selected from the risk registers, there were no specific dates noted for the implementation of actions or they were recorded as ongoing.

The Trust plans to implement the DATIX risk management module for recording all risks throughout the Trust. This will ensure a consistent format is in place at all levels throughout the Trust.

This issue has been reported annually since 2012/13.

Implications

Inconsistencies in recording of risks may arise if there is no standardised risk register.

Risk registers may not capture all the required information to ensure that the risk is appropriately managed.

Recommendation 1.1	As previously recommended, the introduction of the Datix Risk Management module would ensure a standard pro-forma of a risk register is adopted throughout the Trust. All directorate risk registers should then be reviewed and gaps in information should be completed. Management should ensure that all relevant information is recorded in relation to risks identified and that a consistent approach is adopted. Responsible Officer: Assistant Director of CSCG Original Implementation Date: March 2016, June 2016, then June 2017
Priority	2
Management Action	ACCEPTED Original Implementation Date: September 2018
Responsible Manager	Assistant Director – Clinical & Social Care Governance
Revised Implementation Date	September 2019

2 Fraud Risk Action Plans

Finding

During 2018/19 the following progress has been made in relation to fraud risk assessments. There is a Fraud Risk Action Plan 2018/19 which has been updated. All directors were sent a memo from the Director of Finance in November 2018 which included a summary of the lessons learned from fraud cases which were reported in 2017/18, a fraud risk Action Plan for each Directorate in 2018/19 which identifies the procedures/controls needed to review/re-inforce in each Directorate to assist in reducing the risk of fraud occurring. A number of guidance documents were appended to the fraud risk action plan to assist in carrying out some of the actions noted.

The out-workings of the Fraud Risk Assessments should now be considered for inclusion in respective directorate risk registers. We acknowledge that The Fraud Liaison Officer (FLO) is following up with the Nominated Leads for each directorate and will be attending the Directorate SMT/ Governance meetings to assist with progress on the Action Plan. Completion of this round of meetings is planned for 30 June 2019.

Implication

All fraud risks may not be identified and fully documented in directorate risk registers.

Recommendation 2.1	Following on from the completion of the Fraud Risk Assessments, Directorate Management teams should ensure that Fraud Action plans are discussed at the appropriate directorate Governance/ SMT meetings and fraud risks are included in the Directorate Risk Registers where appropriate.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Fraud Liaison Officer
Revised Implementation Date	30 June 2019

3 Risk Management Strategy

Finding

The Trust's Risk Management Strategy was last updated in January 2014 and is now overdue for review. The Trust has recently adopted the principles of ISO 31000:2018 risk management standard on which the previously used and now expired AS/NZ Risk Management Standard was based, and also uses the HSC Regional Risk Matrix (August 2018). This approach has been agreed regionally. The Assistant Director of Clinical and Social Care Governance informed Internal Audit it is now possible to update the Strategy.

The Risk Management Strategy is out of date in respect of Corporate Responsibility which is with the AD CSCG and reporting, which is now to the Medical Director and not the Chief Executive. Also the Strategy does not include the governance structures (i.e. the main committees across directorates responsible for managing risks).

This finding was previously reported in the 2017/18 Risk Management report.

Implication

The Risk Management Strategy is not up to date and does not currently reflect structures and practices within the Trust.

Recommendation 3.1	As previously recommended the Risk Management Strategy should be updated and made available on the Trust intranet site for all staff to access.
Priority	3
Management Action	ACCEPTED
	Original Implementation Date: February 2018
Responsible Manager	Assistant Director – Clinical & Social Care Governance
Revised Implementation Date	April 2019

Appendix A – Follow Up of 2017-18 Internal Audit Recommendations

PRIORITY UNDER NEW DEFINITIONS	AUDIT RECOMMENDATIONS	PROGRESS AS AT NOVEMBER 2018	REVISED IMPLEMENTATION DATE
1.1 FORMAT AND POPULATION OF RISK REGISTERS			
2	As previously recommended, a standard pro-forma of a risk register should be adopted throughout the Trust. All directorate risk registers should then be reviewed and gaps in information should be completed. Management should ensure that all relevant information is recorded in relation to risks identified and that a consistent approach is adopted. Responsible Officer: Assistant Director of CSCG Original Implementation Date: March 2016, June 2016, then June 2017 and September 2018	PARTIALLY IMPLEMENTED There is more consistency with the various risk registers tested during this Audit in 2018/19, there were less exceptions noted than in previous years. The standard pro-forma will be implemented when the Risk Module in Datix becomes operational. This is due to happen early 2019.	February 2019

PRIORITY UNDER NEW DEFINITIONS	AUDIT RECOMMENDATIONS	PROGRESS AS AT NOVEMBER 2018	REVISED IMPLEMENTATION DATE
2.1 FRAUD RISK ASSESSMENT			
2	As previously recommended management should complete the Fraud Risk Assessment including action plans across all directorates to ensure that Fraud risk is appropriately identified and managed. Responsible Officer: Fraud Trust Liaison officer Original Implementation Date: January 2016 then 31 March 2017 and March 2018	IMPLEMENTED The Fraud Risk Assessments have been completed within the Directorates and have been circulated back to the Directors for consideration of inclusion in the individual directorate risk registers with action plans.	

PRIORITY UNDER NEW DEFINITIONS	AUDIT RECOMMENDATIONS	PROGRESS AS AT NOVEMBER 2018	REVISED IMPLEMENTATION DATE
3.1 RISK MANAGEMENT STRATEGY			
3	The Risk Management Strategy should be updated and made available on the Trust intranet site for all staff to access. Responsible Officer: Assistant Director – Clinical & Social Care Governance Original Implementation Date: February 2018	NOT IMPLEMENTED The Risk Management Strategy has yet to be updated. The regionally agreed has AS/NZ Risk Management Standard license expired AS/NZ in July 2018. The use of the principles set out in the ISO risk management standard has been agreed regionally. The Trust are now in a position to update its risk management strategy.	April 2019

Appendix B - Definition of Levels of Assurance and Priorities

Level of Assurance

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

Recommendation Priorities

Priority 1	Failure to implement the recommendation is likely to result in a major failure of a key organisational objective, significant damage to the reputation of the organisation or the misuse of public funds.
Priority 2	Failure to implement the recommendation could result in the failure of an important organisational objective or could have some impact on a key organisational objective.
Priority 3	Failure to implement the recommendation could lead to an increased risk exposure.

Note to Report

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

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**Minutes of a meeting of the Audit Committee held on
Thursday, 14th February 2019 at 9.30 a.m. in the Boardroom,
Trust Headquarters**

PRESENT:

Mrs H McCartan, Non-Executive Director (Chair)
Mr M McDonald, Non-Executive Director
Mrs S Rooney, Non-Executive Director
Mr J Wilkinson, Non-Executive Director

IN ATTENDANCE:

Ms H O'Neill, Director of Finance, Procurement and Estates
Mrs C Cassells, Assistant Director of Finance, Financial Management, SHSCT
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Mr P Morgan, Director for Children & Young People's Services, SHSCT *(Item 6i only)*
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Mr D Lynn, Northern Ireland Audit Office
Mrs S Judt, Board Assurance Manager, SHSCT
Mrs S McCormick, Committee Secretary, SHSCT (Minutes)

APOLOGIES

Ms E Mullan, Non-Executive Director
Mrs A Rutherford, Assistant Director of Finance, SHSCT

1) CHAIR'S WELCOME

Mrs McCartan welcomed everyone to the meeting and in particular Mrs Rooney, Non-Executive Director. She advised that following the recent review of Committee membership of Non-Executive Directors conducted by the Trust Chair, Mrs Rooney has replaced Mrs P Lesson on the Committee with effect from 1 January 2019. Mrs McCartan also welcomed Mrs Cassells following her recent appointment to the post of Assistant Director of Finance - Financial Management and wished her well in the future.

Mrs McCartan reminded members of their responsibilities in keeping with Board etiquette. She asked that mobile phones are turned to silent and laptops are to be used for accessing Audit papers only during the meeting.

2) DECLARATION OF INTERESTS

Mrs McCartan asked members to declare any potential conflict of interests in relation to items on the agenda. None were received and the business of the meeting proceeded.

6i) INTERNAL AUDIT PROGRESS REPORT (8 REPORTS)**Risk Management – Satisfactory**

A Satisfactory level of assurance was provided over Risk Management on the basis that there is regular review of corporate risks by the SMT and by the Board Governance Committee during 2018/19. There is evidence of escalation and de-escalation of risks between the Corporate and Directorate Risk Registers in the period tested and training has been delivered on Risk Management. Risks tested by IA were supported by detailed Risk Assessments. Two Priority 2 and One Priority 3 recommendations were identified.

Mrs McCartan raised the issue of risk registers at Directorate and Corporate level held in varying formats. Ms McCaw updated members on a meeting she had the previous day with Mrs Trudy Reid who advised the issue was being progressed. Mrs Rooney referred to page 75 and raised concern that on the Acute Risk Register, two cases reviewed did not have a responsible officer identified. Ms O'Neill advised she would highlight this point to the Director of Acute Services.

Members welcomed the outcome of the audit exercise.



Southern Health & Social Care Trust

Risk Management 2019/20



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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 audit engagement.

Control Log

Exit Meeting Held On:	None
Working Draft Issued On:	20 March 2020
Management Meeting Held on:	None
Management Actions Due By:	3 April 2020
Management Actions Received:	16 June 2020
Final Report Issued On:	17 June 2020

Distribution List

Shane Devlin	Chief Executive (Final Report Only)
Dr Maria O'Kane	Medical Director
Helen O'Neil	Director of Finance, Procurement and Estates
Aldrina Magwood	Director of Performance and Reform
Alison Rutherford	Assistant Director of Finance – Financial Services
Trudy Reid	Assistant Director of Clinical & Social Care Governance
Stephen Wallace	Interim Assistant Director of Clinical & Social Care Governance

Introduction

In accordance with the 2019/20 Annual Internal Audit plan, BSO Internal Audit carried out an audit of Risk Management during February 2020. The last audit of this topic took place in December 2018 when satisfactory assurance was provided.

Risk Management is the process to identify and manage risk throughout the organisation. Like all HSC Trusts, the SHSCT has adopted the ISO 31000:2018 risk management standard and uses the HSC Regional Risk Matrix (revised August 2018).

Risk Registers are developed at Department/Divisional, Directorate, and Corporate levels to record all forms of risk i.e. clinical, financial and operational risks, etc. Departmental/Divisional Risk Registers are owned by Assistant Directors or Heads of Service. Each Directorate Risk Register is owned by the corresponding Director. Risks within the Trust are not escalated based on exceeding an arbitrary score. They are escalated based on whether or not the risk can or cannot be appropriately managed at Directorate level and the overall impact it may have on the Trust.

The Corporate Risk Register (CRR) records the Trust's principal risks that have serious consequences for the organisation and threaten achievement of its' corporate objectives and the key controls to manage those risks. The Corporate Risk Register is reviewed by the Trust's Senior Management Team (SMT) on a monthly basis and, on behalf of the Trust Board, through the Trust Governance Committee on a quarterly basis.

The Trust's Medical Director, is the Executive Director with delegated responsibility for Risk Management and Clinical and Social Care Governance. The Medical Director is supported in this role by the Assistant Director for Clinical and Social Care Governance.

Scope of Assignment

The scope of this audit was to review processes in place to identify and manage risks within SHSCT both at Directorate and Corporate level.

Internal Audit reviewed the following risk registers within this audit: the Trust's Corporate Risk Register and two Directorate's Risk Registers, i.e. Performance & Reform and Finance, Procurement & Estates Directorates.

ICT risks fall within the Informatics Division of the Directorate of Performance & Reform and are recorded on the Informatics Divisional Risk Register and escalated as appropriate to the Performance & Reform Directorate and/or the Trust's Corporate Risk Register. As ICT risks are one of the areas of focus for the ongoing 2019/20 IT Audit at the Trust, review of these were not included within this assignment.

The audit was based around the following risk:

- Ineffective risk management processes could impact on the effectiveness of the Trust and its ability to deliver services.

The objectives of the audit were:

- To ensure there is an appropriate framework in place for Risk Management, including review of Strategy, Policy and Procedures to ensure they are appropriate and effective, and have been appropriately screened.
- To ensure there is an appropriate framework in place for risk management training, for all staff.
- To ensure there is proper management over the corporate risk register including:
 - Review of process for risk identification, scoring and treatment.
 - Review of implications, controls and actions to address risk.
 - Escalating and de-escalating risks.
- To ensure there is proper management over the Directorate risk registers including:
 - Review of process for risk identification, scoring and treatment.
 - Review of implications, controls and actions to address risk.
 - Escalating and de-escalating risks.

- To ensure there are appropriate governance arrangements in place at both Directorate and Corporate levels of risk management.

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

Level of Assurance

Satisfactory

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

Executive Summary

Internal Audit can provide satisfactory assurance over Risk Management. Satisfactory assurance is provided on the basis that key risks to the Trust in meeting its Corporate Objectives are considered in the Trust's Corporate Risk Register. The Corporate Risk Register is subject to regular review and scrutiny by the Trust's Governance Committee and Senior Management Team (SMT). Directorate Risk Registers are also in place and subject to review. There is evidence of escalation and de-escalation of risks between the Corporate and Directorate Risk Registers.

There are no significant findings in this report that impact on the assurance provided.

The key findings of the audit are:

1. Whilst the Trust has described what risk appetite and risk tolerance are in their Risk Management Strategy, it has not defined its own risk appetite level.
2. A revised Interim Risk Management Strategy dated 2019-2022 was prepared and approved by the Trust's Governance Committee in September 2019. There is a lack of evidence that this updated Strategy has been formally issued / made accessible to all Trust staff. Audit further query why the strategy is referred to as 'interim' when it is dated for the 3 year period 2019 to 2022.
3. Risk registers at corporate / directorate level continue to be held in different formats, rather than being consistent. Internal Audit testing of a sample of 12 risks as per the most recent Corporate and Directorate Risk Registers identified that 2 did not have a risk ID recorded on the Directorate Risk Register; 6 of the 12 did not detail dates when the risks had been added to the directorate register therefore age of risks is not identifiable; 3 of the 12 did not have future actions recorded and a further 3 had existing controls noted as actions and specific date for implementation was only detailed for 1 of the 12 tested. *This issue has previously been reported.* Furthermore, the Performance & Reform Directorate's Risk Register classified some risks as 'moderate' as opposed to regionally agreed wording of 'medium' and colour coding of risk levels was not consistent with the regional model. Two of the risks per the Estates Services Risk Register have been incorrectly cross referenced to the CRR whilst the Finance & Procurement Directorate's Risk Register does not note/cross-reference where and when the risk has been escalated to the CRR.

Other observations include:

4. There is no specific risk management general awareness training module taken by all Trust staff. No records regarding risk management training are available in the sampled directorates.
5. Evidence is sporadic with regard to review of Directorate's Risk Registers at relevant meetings/forums.

Summary of Findings and Recommendations

Finding	Number of Recommendations		
	Priority 1	Priority 2	Priority 3
1. Risk Appetite	-	1	-
2. Risk Management Strategy	-	1	-
3. Format and Population of Risk Registers	-	1	-
4. Risk Management Training	-	1	-
5. Governance Arrangements	-	-	1

Detailed Findings and Recommendations

1 Risk Appetite

Finding

Whilst the Trust has described what risk appetite and risk tolerance are in the Risk Management Strategy to guide Trust staff when managing risk, it has not defined its own risk appetite level.

Implication

Failure to identify the organisation's overall risk appetite increases the risk that the organisation will be exposed to unacceptable levels of risk and inconsistency/subjectivity across Managers when managing risk.

Recommendation 1.1	The Trust's risk appetite should be clearly defined, documented in an annual risk appetite statement and communicated to all staff. The defined risk appetite should then be used throughout the Trust to assist in scoring and managing risk.
Priority	2
Management Action	ACCEPTED The Trust will define risk appetite, and document it in an annual risk appetite statement and communicated to all staff. The defined risk appetite will then be throughout the Trust to assist in scoring and managing risk.
Responsible Manager	Assistant Director Clinical & Social Care Governance (ADCSCG) / Interim (ADCSCG)
Implementation Date	September 2020

2 Risk Management Strategy

Finding

A revised Interim Risk Management Strategy dated 2019-2022 was approved by the Trust's Governance Committee in September 2019.

This updated version addresses the issues raised regarding the previous version of the strategy dated 2014 in place at the date of the last audit.

Senior staff, (directors and assistant directors) with whom Internal Audit met during the course of this audit were not aware of the revised Interim Risk Management Strategy and instead referred to the Trust's January 2014 version of this document. There is a lack of evidence that this updated Risk Management Strategy has been formally issued / made accessible to all Trust staff. Audit further query why the strategy is referred to as 'interim' when it is dated for the 3 year period 2019 to 2022.

Implication

Out of date guidance being used to inform the Risk Management processes within the Trust where the 2014 version of the strategy is still being used and referred to.

Recommendation 2.1	The necessity for the revised Risk Management Strategy to be referred to as 'interim' should be considered and addressed by Management. All Trust staff should be formally notified of and have access to the most up to date Strategy.
Priority	2
Management Action	ACCEPTED The regional revised Risk Management guidance has now been approved, the Trust will move to formalising the 'interim' strategy to a formally ratified document that is accessible to all staff.
Responsible Manager	Assistant Director Clinical & Social Care Governance (ADCSCG) / Interim (ADCSCG)
Implementation Date	September 2020

3 Format and Population of Risk Registers

Findings

As previously reported, risk registers across the Trust continue to be held in different formats, i.e. Word, Excel and DATIX, with no standardised pro-forma leading to inconsistencies in the information recorded between what are controls/actions/progress.

Internal Audit reviewed the most recent Corporate Risk Register, the Performance & Reform and Finance & Procurement Directorates Risk Register, including the Estates Services Risk Register.

Gaps in information identified from the review of a sample of 12 risks across these risk registers included:

- 2 of the 12 did not have risk ID recorded on the Directorate Risk Register. (*Performance & Reform*).
- 6 of the 12 did not detail dates when the risks had been added to the directorate register therefore age of risks not identifiable. (*2 Finance & Procurement and 4 Estates Services*).
- Implications of the risk had not been noted for 1 of the 12 sampled. (*Finance & Procurement*).
- 3 of the 12 did not have future actions recorded and 3 had existing controls noted as actions. (*1 Performance & Reform, 2 Finance & Procurement and 3 Estates Services*).
- Specific date for implementation was only detailed for 1 of the sample tested.
 - 9 of the sample did not have specific date/s for implementation of action/s (*1 CRR, 3 Performance & Reform, 1 Finance & Procurement and 4 Estates Services*).
 - 1 of the sample for which several actions were noted only had implementation dates for some (not all) of these actions (*CRR*).
 - In the 1 remaining case reference was made to 'ongoing,' (*Finance & Procurement*).
- On the Performance & Reform Directorate's Risk Register, some risks were classified as 'moderate' as opposed to regionally agreed wording of 'medium' and colour coding of risk levels was not consistent with the regional model, e.g. risks rated 'high' per this directorate's Risk Register are highlighted in red as opposed to orange. Red denotes 'extreme' rating per the Corporate Risk Register and the regionally agreed model.
- On the Estates Services Risk Register, 2 of the risks have been incorrectly cross referenced to the CRR. The Finance & Procurement Directorate's Risk Register does not note/cross-reference to where the risk has been escalated to the CRR.

The Trust plans to implement the DATIX risk management module for recording all risks throughout the Trust have not progressed since the date of the previous audit. Use of this module would help to ensure a consistent format is in place at all levels throughout the Trust.

This issue has been reported annually since 2012/13.

Implications

Inconsistencies in recording of risks may arise if there is no standardised risk register.

Risk registers may not capture all the required information to ensure that the risk is appropriately managed.

Recommendation 3.1	As previously recommended, the introduction of the Datix Risk Management module would ensure a standard pro-forma of a risk register is adopted throughout the Trust. All directorate risk registers should then be reviewed and gaps in information should be completed. Management should ensure that all relevant information is recorded in relation to risks identified and that a consistent approach is adopted using the regionally agreed scoring template / standards. Responsible Officer: Assistant Director of CSCG Original Implementation Date: March 2016, June 2016, June 2017 & Sept 2018
Priority	2
Management	ACCEPTED

Action	The Trust plans to implement the DATIX risk management module for recording all risks throughout the Trust as part of a DATIX upgrade in 2020. This was planned for April 2020 however was postponed due to the impact of the coronavirus pandemic.
Responsible Manager	Assistant Director Clinical & Social Care Governance (ADCSCG) / Interim (ADCSCG)
Revised Implementation Date	January 2021

4 Risk Management Training

Finding

Risk Management training does not form part of the Corporate Mandatory training within the SHSCT.

The Trust's revised Risk Management Strategy 2019-2022 states that, '*risk management training will be assessed and delivered by the Directorate Governance Teams, based on organisational / staff needs. Directorates are required to maintain risk management training records, monitor attendance of staff at training and report on risk management training to SMT Governance as required.*'

However, the Performance & Reform and Finance & Procurement (including Estates Services) Directorates do not have Governance Managers / Co-ordinators to make such assessments and deliver such training. These roles are only applicable in the operational directorates.

Internal Audit identified that no records regarding risk management training are retained within Performance & Reform or Finance & Procurement (including Estates Services) Directorates. One of the Assistant Director's within the Performance & Reform Directorate verbally confirmed that her four Heads of Service (HOS) had undertaken risk management training during 2019 together with staff in the IT team.

Implication

Without appropriate training, risk management processes may not be followed.

Recommendation 4.1	The requirement for Risk Management training should be clarified across the Trust and appropriate records maintained of training.
Priority	2
Management Action	ACCEPTED The Trust will seek to establish a Trustwide risk management training matrix to allow staff, particularly those who do not work in operational directorates to identify if they are required to undertake risk management training as part of their role and opportunities to avail of this will be provided. Registers of training will be retained by the responsible directorates
Responsible Manager	Assistant Director Clinical & Social Care Governance (ADCSCG) / Interim (ADCSCG)
Implementation Date	November 2020

5 Governance Arrangements

Finding

Although documented evidence exists of presentation and discussion of the Corporate Risk Register (CRR) at each of the Governance Committee meetings from April 2019 to date, there was no note per the minutes to indicate 'approval' of the CRR at each meeting.

Review of extracts of the Trust's Senior Management Team (SMT) meetings identified that these do not always provide the detail as to the risks to be escalated, de-escalated, etc. but rather simply refer to discussion having taken place regarding risks.

Review of minutes of the Assistant Director and Head of Service Meetings which took place within the Performance & Reform Directorate during the 2019/20 financial year to date identified that risk register was only on the agenda for one of these three meetings and due to time constraints the item pertaining to the risk register got carried forward to a future meeting. Audit did observe however, that evidence exists at divisional level within Performance & Reform that risk register is reviewed and discussed regularly.

Similarly, there is minimal evidence from review of minutes of Estates Services Health & Safety, Risk & Sustainability Meetings that specific discussion regarding the service's risk register takes place during these meetings – the risk register does not appear to be a standing agenda item. However, Internal Audit did observe several areas discussed at these meetings for which there was an associated risk on the service's directorate risk register, e.g. nitrous oxide monitoring.

Implication

Lack of audit trail that appropriate discussion regarding risks and risk registers is taking place regularly within directorates / service areas.

Recommendation 5.1	Review of Risk Register should be a standing agenda item for meetings within Directorates / Service areas between directors, assistant directors and Heads of Services and included on agendas and minuted, including cases where no changes take place.		
Priority	3		
Management Action	ACCEPTED The Trust will ensure that at SMT the detail of discussions of risk management are formally noted in meeting records. Similarly, each directorate senior management meetings will be required to consider local risk registers as a recurring item with detailed records retained.		
Responsible Manager	Chief Executive		
Implementation Date	November 2020		

Appendix A - Definition of Levels of Assurance and Priorities

Level of Assurance

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

Recommendation Priorities

- Priority 1** Failure to implement the recommendation is likely to result in a major failure of a key organisational objective, significant damage to the reputation of the organisation or the misuse of public funds.
- Priority 2** Failure to implement the recommendation could result in the failure of an important organisational objective or could have some impact on a key organisational objective.
- Priority 3** Failure to implement the recommendation could lead to an increased risk exposure.

Note to Report

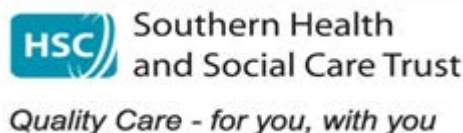
This audit report should not be regarded as a comprehensive statement of all weaknesses that exist. The weaknesses and other findings set out are only those which came to the attention of Internal Audit staff during the normal course of their work. The identification of these weaknesses and findings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

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**Minutes of a Virtual meeting of the Audit Committee,
held on Friday, 26th June 2020, at 10.45 a.m.**

PRESENT:

Mrs H McCartan, Non-Executive Director (Chair)
Mr M McDonald, Non-Executive Director
Ms E Mullan, Non-Executive Director
Mrs S Rooney, Non-Executive Director
Mr J Wilkinson, Non-Executive Director

IN ATTENDANCE:

Mr S Devlin, Chief Executive
Ms H O'Neill, Director of Finance, Procurement and Estates, SHSCT
Mr B Beattie, Acting Director of Older People and Primary Care, SHSCT *(Item 8i only)*
Mrs H Trouton, Executive Director of Nursing Midwifery & Allied Health Professionals *(Item 8i only)*
Mrs V Toal, Director of Human Resources and Organisational Development, SHSCT *(Item 8i only)*
Mrs C Cassells, Assistant Director of Finance, Financial Management, SHSCT
Mrs A Rutherford, Assistant Director of Finance, Financial Services, SHSCT
Mrs C Doyle, Corporate Financial Accountant, SHSCT
Mrs F Jones, Corporate Financial Accountant/Fraud Liaison Officer, SHSCT
Mrs C McKeown, Head of Internal Audit
Ms B Bourke, Grant Thornton
Ms L Kelly, Grant Thornton
Mr S Knox, Northern Ireland Audit Office (NIAO)
Mrs S Judt, Board Assurance Manager, SHSCT
Mrs S McCormick, Committee Secretary, SHSCT (Minutes)

APOLOGIES

None

1) CHAIR'S WELCOME

Mrs McCartan welcomed everyone to the meeting via Video Conferencing facilities in order to comply with social distancing restrictions due to the current Covid-19 pandemic. She particularly welcomed Mr Devlin, Trust Chief Executive and representatives from both Internal and External Audit and the NI Audit Office.

2) DECLARATION OF INTERESTS

Mrs McCartan asked members to declare any potential conflict of interests in relation to items on the agenda. None were received and the business of the meeting proceeded.

8) INTERNAL AUDIT**Risk Management – Satisfactory**

Mrs McKeown advised that a Satisfactory Level of assurance was provided on the basis that key risks to the Trust in meeting its Corporate Objectives are considered in the Trust's Corporate Risk Register (CRR) and the Register is subject to regular review and scrutiny by the Trust Governance Committee and Senior Management Team (SMT). Directorate Risk Registers are also in place and subject to review and escalation and de-escalation of risks between the Corporate and Directorate registers is evident. There were no significant findings identified through the assignment however, Mrs McKeown pointed out that whilst the Trust risk appetite and risk tolerance are included in the Organisation's Risk Management Strategy, the Trust should consider including a definition of its own risk appetite level. Four Priority 2 and One Priority 3 recommendations were identified.

In regards to risk appetite, Mrs McCartan stated a Board Workshop scheduled for June, focusing on the theme of Risk Appetite, had been postponed due to current pressures in relation to Covid-19. She referred to the NIAO Guide for audit and risk committees on financial reporting and management during Covid-19 and said the Trust was aware of the importance of reassessing risk appetite at this time. The Chief Executive advised it was hoped to reschedule the postponed workshop to a later date.

Mrs McCartan referred to the implementation of the regional DATIX risk management module. The Chief Executive advised that the module would enable visibility across the Trust. Mrs McCartan urged caution with a large risk module holding too many risks that then become unmanageable. In conclusion Mrs McCartan welcomed the outcome of the report.



Southern Health & Social Care Trust

Retention of Board /Committee Minutes and Papers 2020/21



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Acknowledgement

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

Control Log

Exit Meeting Held On:	22 December 2020
Working Draft Report Issued On:	23 December 2020
Management Actions Received:	08 January 2021
Final Report Issued On:	14 January 2021

Distribution List

Shane Devlin	Chief Executive
Sandra Judt	Board Assurance Manager
Helen O'Neill	Director of Finance, Procurement & Estates
Alison Rutherford	Assistant Director of Financial Accounting and Services

Introduction

In accordance with the 2020/21 Annual Internal Audit Plan, BSO Internal Audit carried out an audit of Good Management Good Records (GMGR) during October / November 2020. Although this is the first time an Internal Audit of this topic has been performed, some aspects of it were previously covered within the Review of Board Effectiveness performed in February / March 2019 when a satisfactory assurance was provided.

The Inquiry into Hyponatraemia Related Deaths (IHRD), issued in January 2018 recommended (recommendation 70) that effective measures should be taken to ensure that minutes of Board and committee meetings are preserved. The ALB Board Effectiveness sub group of the DoH IHRD project requested that Internal Audit test these measures in all HSC organisations, hence this audit has been included on the internal audit programme in all HSC organisations.

Section J1 and J2 of Good Management Good Records (GMGR) states that agenda and papers from Boards and Board sub-committees should be retained for the following retention periods with records subsequently transferred to Public Records Office Northern Ireland (PRONI):

Ref	Record Type	Minimum Retention Period	Final Action
J1	Agendas and Minutes of Trust/HSCB/ Agency/Departmental Board Meetings (Master Copies including associated papers). <i>This includes legacy Trusts.</i>	20 years	Transfer to PRONI
J2	Agendas and minutes of major committees, sub-committees (master copies, including associated papers).	10 years – Normal review process	Transfer to PRONI

The Department of Health (DoH) sought assurance in respect of recommendation 70 IHRD from the all Arm's Length Bodies (ALBs) on 5th August 2019. On 31st August 2019, the Trust responded confirming that they complied with Section J Disposal Schedule of GMGR in relation to the retention of Trust Board papers and Board Committee papers.

The Southern Health & Social Care Trust (SHSCT) was formed in April 2007 from the amalgamation of 4 legacy Health Trusts (Craigavon Area Hospital Group Trust, Craigavon & Banbridge Community Trust, Newry & Mourne Trust, and Armagh & Dungannon Trust. The SHSCT Board has corporate responsibility for oversight of the delivery of health and social care services for its population in compliance with the aims and objectives of the Department of Health and for promoting the efficient, economic and effective use of staff and other resources by the Trust. In practice it provides oversight through 6 sub-committees:

- Governance Committee (established 2007);
- Audit Committee (est. 2007);
- Remuneration Committee (est. 2007);
- Endowments & Gifts Committee (est. 2007);
- Patient & Client Experience Committee (est. 2010);
- Performance Committee (est. 2019).

The Board Assurance Manager is responsible for maintaining records of Trust Board and its sub-committees' meetings. Trust Policy is to retain an electronic version for all SHSCT Board and Sub-committee meeting agendas, minutes and papers presented since its inception in 2007. These are held by the Chief Executives' Office on a shared drive with access restricted, and back-ups managed through the Trust's IT Department processes. A paper copy of these records is held for a period of one year at the CEO's Office, after which they are transferred to the Closed Records Stores at St. Lukes' Hospital, Armagh or Chestnut Building, Lurgan Hospital, under the management of the Information Governance Department who have detailed records of specific bays and boxes. The Board Assurance Manager maintains a register of records and where these records are held / located.

Scope of Assignment

This audit reviewed the SHSCT's processes for retaining Trust Board and board subcommittee agenda, minutes and papers; including documentation of where/how these records were retained securely to maintain their integrity. This also included the storage of the four legacy Trusts' records within the required retention period. Records for both the SHSCT and the 4 legacy Trusts were physically inspected at Closed Stores. .

Internal Audit reviewed a sample of 10 Trust Board meetings over the past 20 years and 25 meetings (5 from each of the subcommittees listed above (Performance Committee was excluded as this committee was only recently initiated) over the past 10 years.

The audit was based on the risk that records (agendas, minutes and associated papers) were not retained in line with GMGR J1-J2.

The objective of this audit was to ensure Trust Board and its sub-committee records (agendas, minutes and associated papers) were retained in line with GMGR J1 and J2.

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

Level of Assurance

Satisfactory

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

Executive Summary

Internal Audit can provide satisfactory assurance in relation to the retention of Board and Board Sub-Committee agendas, minutes and papers in line with the requirements of J1-J2 GMGR. Satisfactory assurance has been provided on the basis that the processes in place for retaining Southern Health & Social Care Trust (SHSCT) Board and Subcommittee agendas, minutes and associated papers were robust. Records were retained securely ensuring integrity was maintained. However exceptions were noted in the retention of some Trust Board legacy documents. Furthermore the Trust is aware of the need to be in compliance with GMGR (in relation to the transfer of records to PRONI) and has been liaising with PRONI on when this transfer can commence.

There are no significant findings in this report that impact on the assurance provided.

The key finding of the audit is:

1. GMGR requires Board records to be retained for 20 years. The records for legacy Craigavon Area Hospital Trust were missing and there were considerable gaps identified in relation to records in relation to the legacy Craigavon & Banbridge Community Trust.

The other finding of the audit is:

2. In accordance with GMGR, records older than 20 years (for Trust Board) or 10 years (for Sub Committees) should be transferred to PRONI. The Trust has not yet transferred any of these records to PRONI.

Summary of Findings and Recommendations

Finding		Number of Recommendations		
		Priority 1	Priority 2	Priority 3
1.	Completeness of Legacy Trust Papers	-	1	-
2.	Transfer of Records to PRONI	-	-	1

Detailed Findings and Recommendations

1 Completeness of Legacy Trust Papers

Finding

GMGR requires Board records to be retained for 20 years. While the records for the SHSCT (2007 – 2020) and both legacy Armagh & Dungannon and Newry & Mourne Trusts were complete, the records for legacy Craigavon Area Hospital Trust were missing and there were considerable gaps identified in the legacy Craigavon & Banbridge Community Trust records.

The Department of Health (DoH) sought assurance in respect of recommendation 70 IHRD from the all Arms Length Bodies (ALBs) on 9th August 2019. On 12th September 2019, the Trust responded confirming that they complied with Section J Disposal Schedule of GMGR in relation to the retention of Trust Board papers and Board Committee papers. This response did not highlight the gaps identified above by Internal Audit.

Implication

Records not available to support discussion held/decisions made for a number of legacy Trust meetings.

Recommendation 1.1	Management should attempt to locate the required missing minutes, agendas and papers for the relevant legacy Trusts. In the event that they cannot be located, the Trust should update their assurance to the Department of Health.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Sandra Judt, Board Assurance Manager
Implementation Date	June 2021

2 Transfer of Records to PRONI

Finding

In accordance with GMGR J1 Agendas and Minutes of Trust Board Meetings (master copies including associated papers) should be retained internally for 20 years and any beyond 20 years should be transferred to Public Records Office Northern Ireland (PRONI). The role of PRONI is to provide records management and guidance to public bodies.

In accordance with J2 Agendas and Minutes of Sub Committee (Master Copies including associated papers) should be retained internally for 10 years and any beyond 10 years should be transferred to PRONI. The Trust has not transferred any sub-committee minutes greater than 10 years old to PRONI.

The Trust has not transferred any Board and Committee papers to PRONI for any of its 4 legacy Trusts. Board papers up to 31 October 2000 and Committee papers up to 31 March 2007 (when the 4 legacy organisations were dissolved) should have been transferred.

Implication

Records not being transferred to PRONI in line with GMGR.

Recommendation 2.1	Management should ensure that applicable records are transferred to PRONI in line with GMGR.
Priority	3
Management Action	ACCEPTED
Responsible Manager	Catherine Weaver, Head of Information Governance
Implementation Date	December 2021

Appendix A - Definition of Levels of Assurance and Priorities

Level of Assurance

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

Recommendation Priorities

Priority 1	Failure to implement the recommendation is likely to result in a major failure of a key organisational objective, significant damage to the reputation of the organisation or the misuse of public funds.
Priority 2	Failure to implement the recommendation could result in the failure of an important organisational objective or could have some impact on a key organisational objective.
Priority 3	Failure to implement the recommendation could lead to an increased risk exposure.

Note to Report

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

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**Minutes of a Virtual meeting of the Audit Committee
held on Thursday, 4th February 2021 at 9.30 a.m.**

PRESENT:

Mrs H McCartan, Non-Executive Director (Chair)
Mr M McDonald, Non-Executive Director
Mr J Wilkinson, Non-Executive Director

IN ATTENDANCE:

Mr S Devlin, Chief Executive
Ms H O'Neill, Director of Finance, Procurement and Estates, SHSCT
Mrs C Cassells, Assistant Director of Finance, Financial Management, SHSCT
Mrs A Rutherford, Assistant Director of Finance, Financial Services, SHSCT
Mrs F Jones, Corporate Financial Accountant/Fraud Liaison Officer, SHSCT
(Items 9i-9ii only)
Mrs C McKeown, Head of Internal Audit
Ms J McCaw, Assistant Head of Internal Audit
Mr N Gray, Director, Northern Ireland Audit Office (NIAO)
Mr S Knox, Manager, Northern Ireland Audit Office (NIAO)
Mr B Clerkin, Partner, ASM - External Audit
Mr J McCallion, Manager, ASM - External Audit
Mrs S Judt, Board Assurance Manager, SHSCT
Mrs S McCormick, Committee Secretary, SHSCT (Minutes)

APOLOGIES

None.

1) CHAIR'S WELCOME

Mrs McCartan welcomed everyone to the virtual meeting, particularly Mr Clerkin and Mr McCallion, ASM Belfast, recently appointed as the Trust's External Auditors for the next three years and Mr N Gray, Director, NIAO.

2) DECLARATION OF INTERESTS

Mrs McCartan asked members to declare any potential conflict of interests in relation to items on the agenda. None were received and the business of the meeting proceeded.

6i) INTERNAL AUDIT PROGRESS REPORT (5 REPORTS)

Retention of Board/Committee minutes and papers – Satisfactory

At the outset, Mrs McKeown advised the assignment had been undertaken across all five HSC Trusts and explained its context in respect of recommendation 70 from The Inquiry into Hyponatraemia Related Deaths (IHRD).

A Satisfactory level of assurance was provided on the system of internal control in relation to the retention of Board and Board Sub-Committee agendas, minutes and papers in line with the requirements of GMGR J1-J2, on the basis that the processes in place for retaining such were robust. However exceptions were noted in the retention of some Trust Board legacy documents. Furthermore, the Trust is aware of the need to be in compliance with GMGR in relation to the transfer of records to PRONI and has been liaising with PRONI on the matter. One Priority 2 and One Priority 3 recommendations were identified.

Members welcomed the outcome of the assignment and Mr McDonald emphasized the importance of effective record keeping into the future to support Governance and provide assurance.



Southern Health & Social Care Trust

Governance during COVID-19 2020/21



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Acknowledgement

Internal Audit wishes to thank management and staff at the Southern HSC Trust for their assistance and co-operation during the course of the audit engagement. We recognise and appreciate that the Southern HSC Trust has continued to effectively engage with us during extremely challenging times for staff.

Control Log

Exit Meeting Held On:	None
Working Draft Issued On:	27 January 2021
Management Actions Received:	14 February and 29 April 2021
Final Report Issued On:	29 April 2021

Distribution List

Shane Devlin	Chief Executive
Helen O'Neill	Director of Finance, Procurement and Estates
Dr Maria O'Kane	Medical Director
Alison Rutherford	Assistant Director of Finance
Trudy Reid	Assistant Director Clinical & Social Care Governance (COVID19)

Introduction

In accordance with the 2020/21 Annual Internal Audit Plan, BSO Internal Audit carried out an audit of Governance during COVID-19 in October and November 2020. The audit covered the initial surge period March to June 2020.

This audit reviewed how SHSCT governance arrangements were refined and developed to address the consequences of the global pandemic and ensure the organisation continued to operate with adequate and effective governance during COVID-19. Additional governance structures were established in March 2020 primarily through the Bronze Incident Co-ordination Team and Bronze Operational Group; these complimented the existing key governance structures within the Trust, such as Trust Board, Audit Committee, Governance Committee, Patient Client Experience Committee and Performance Committee which continued to meet throughout this period.

HSC Silver

The role of HSC Silver is to provide a co-ordinated approach to ensure there is an appropriate and proportionate level of preparedness across the health and social care sector to enable an effective public health and HSC response to COVID-19. It oversees and works with a range of key stakeholders, including: the other UK countries; the Republic of Ireland; independent health and social care providers and those with responsibility for public health. HSC Silver will report and escalate relevant issues through the chair to DoH (NI) GOLD.

Trust Bronze Incident Co-ordination Team (SMT Bronze)

The Trust Bronze Incident Co-ordination Team is chaired by the Medical Director and all other members of SMT are standing members of this group. In addition, given, the nature of the response required, the Team also included GP Colleagues, Consultant Microbiologist, Lead for Infection Control who provided expert infection, prevention and control advice. This team met on a daily basis. Trust Bronze Incident Co-ordination Team (SMT Bronze) reported to HSC Silver through the Medical Directors office via daily teleconferencing.

The key objective of this Team was to ensure that the Trust provided a proportionate, effective and co-ordinated response to COVID-19. This Team was the overarching decision making body for major decisions which were escalated from the operational team or delegated from HSC Silver.

Trust Bronze Operational Team

A Bronze Operational Team, chaired by the Medical Director, was established. This draws staff from all professions and membership included Assistant Directors, Heads of Service, Consultant Medical Staff, IT, Estates, and Communications i.e. all key staff within the Trust who had a role in preparing the Trust for COVID-19 and managing it on a daily basis.

Individual Directorate surge plans were developed for the initial surge of COVID-19. Initial key planning and contingency actions taken by Trust SMT Bronze and Operational Teams to prepare for and manage the pandemic included:-

- Delivery of significant training and upskilling of staff with approximately 380 doctors and nurses trained in advanced skills in treating and caring for the critically ill COVID-19 patient requiring intubation and organ support, in just under 3 weeks.
- Major re-organisation of the 2 main hospital sites which involved significant capital investment e.g. repurposing of staff restaurant, ward and other service areas, establishment of staff village in main carpark, providing screening in service areas, as well as changes as detailed below.
- Management of the emergency department patient flow particularly in relation to COVID positive patients which ultimately lead to the closure of the ED department at Daisy Hill and establishment of a Respiratory and Non-Respiratory ED on the Craigavon Hospital site.
- Movement of specialities such as Obstetrics & Gynae to the Daisy Hill hospital site, and the use of Daisy Hill for continuation of Red Flag cancer surgery as the Trust established separate clean and dirty sites to manage the pandemic.
- Arrangement for the provision of PPE to Care Homes and Independent Sector providers
- Zoning of the hospitals in respect of RED, AMBER and GREEN PPE areas and the establishment of donning and doffing areas for staff.
- Establishment of separate Mental Health Emergency Assessment Centre taking these patients away from the main Emergency Department.

- Key communication with staff in relation to redeployment, supply of PPE etc.

Normal Governance Structures

Board meetings have continued virtually through the pandemic. Initially the Board agreed formal meetings of Board Sub Committees would not take place during March/April/May 2020 to release SMT for COVID-19 planning and that this would be reviewed periodically. However on review of minutes Governance Committee met as planned in May, Audit Committee met in May and June and Endowments and Gifts Committee met in February and June and Patient Client Experience Committee met in March and June, and the Performance Committee met in May. At executive level, Senior Management Team (SMT) has also continued to meet twice weekly. At Trust Board on 26 March 2020 the Standing Orders were reviewed and quorum arrangements amended to absent SMT from attendance at Trust board with only the Chief Executive and Director of Finance required to attend. These amended arrangements were reviewed by the Board at its meeting on 30 June 2020.

Governance arrangements were further enhanced through the establishment of an information hub which provided a weekly brief to the Chair and Non Executive Directors detailing key operational issues, including challenges with PPE, Staff absence due to COVID-19, number of COVID positive inpatients, number of Covid patients in ICU, Estates issues, Service implications e.g. services being stood down etc. From April the Chief Executive held weekly meetings with the Chair and Non-Executive Directors in relation to the Trust response to COVID19.

COVID-19 Financial Governance

The DoH issued preliminary guidance in April 2020 entitled COVID-19 – Funding And Approval Processes, requiring Trusts and other ALBs to complete a business case template (Annex A) for all planned COVID expenditure. This was updated on 25 July 2020 with the release of HSC (F) 25-2020 – COVID-19 Funding and Approval Process. It introduced a new regional Management Board for Rebuilding HSC Services with oversight of COVID-19 and Non-COVID-19 activities. Paragraphs 25-27 of this guidance states - some expenditure will have been committed in the early stages of COVID-19 in advance of formal approval templates being completed. Retrospective approval is required for this historic expenditure and a regional approach to combine these expenditures and revised timescales was agreed for submission of the corresponding Annex A forms (to commissioners by 16th November 2020 and, once approved to be submitted to DoH by 30th November 2020).

The SHSCT established a single cost centre (C0919D) for the coding of all COVID-19 related expenditure. All spend must be approved by one of a limited number of staff. In line with regional COVID-19 planning, a number of historic procurements / costs were approved regionally by HSC Silver, and not at local Bronze Command level by the Trust such as regional Personal Protective Equipment (PPE) orders. Up to 30 June 2020, the SHSCT reported to the DoH that it had incurred additional COVID-19 revenue expenditure of £13.5M.

COVID Monetary Donations Received

Internal Audit reviewed the COVID 19 register in relation to COVID-19 monetary donations received and noted £44,832 was received in cash donations, £1,556 had been spent to date, and as at 30 November 2020 a balance of £43,275 remained. (This excludes monies received from NHS Charities Together). At Trust Board in September 2020 it was reported that work was ongoing to ensure that this fund is invested appropriately and spent in full by the end of this financial year. It will be reported to the Endowment and Gifts Committee in line with normal practice.

Scope of Assignment

The audit reviewed the robustness of the governance arrangements that the Trust put in place to address the consequences of COVID-19. This included a review of the Bronze Incident Co-ordination Team and Bronze Operational Teams and also the management decisions made through review of the minutes. The audit reviewed the arrangements in place to ensure that key governance arrangements continued throughout the pandemic period particularly at Trust Board and Trust Board sub-committee level. Controls over financial governance as well as donations, gifts and hospitality received during COVID-19 were tested. The arrangements for learning from the initial surge were also reviewed as part of the audit.

The audit was based on the risk that the Trust may not appropriately deliver service or manage risk associated with COVID-19 if there are not appropriate governance arrangements in place.

The objectives of this audit were:

- To ensure SHSCT were able to maintain service delivery with appropriate governance processes were in place during COVID-19.
- To ensure actions/decisions taken during COVID-19 are supported by appropriate and adequate documentation.
- To ensure that there are appropriate controls in place in regard to additional expenditure incurred in relation to COVID-19
- To ensure that gifts and hospitality had been appropriately controlled during COVID-19.

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

Level of Assurance

Satisfactory

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

Executive Summary

Internal Audit can provide satisfactory assurance in relation to Governance during COVID-19. Governance structures were enhanced in line with regional and local emergency response plans to allow effective monitoring and accountability. Governance Structures existing prior to COVID-19 Trust Board, Governance Committee, Audit Committee, Performance Committee, Patient Client Experience Committee, and SMT, continued to operate during the first wave of the pandemic. These Committees were briefed which provided assurance on the adequacy of the Trusts response to the pandemic. In addition from April 2020 the Chief Executive and Director of Finance held weekly meetings with the Chair and Non-Executive Directors and Trust Board members were provided with a weekly newsletter update on key areas including PPE issues, staffing issues, services stood down etc. Also a control room was established in the Boardroom at Trust HQ during April to assist Directors in co-ordinating and monitoring the key actions taken and a dashboard established by Informatics to monitor and report COVID activity / statistics etc.

In line with the Trust's Corporate Emergency Management Plan, a Bronze Incident Co-ordination Team and a Bronze Operational Team were established which included clinical membership, and these met virtually on a daily basis during the early stages of the pandemic. However whilst these meetings were minuted, the minutes did not provide a clear audit trail of the key decisions taken and approved by these groups. Review of a sample of expenditures across 4 key areas- PPE, Estates Works, Medical Equipment and Staff Accommodation (£1.589M), found that although supporting documentation (e.g. procurements for Estates and Medical Equipment as well as Direct Award Contracts for locally sourced PPE & Staff Accommodation) was available, there was not a clear audit trail back to initial related operational decisions at either Bronze Incident or Operational Groups or other sub-groups.

There are no significant findings in this report that impact on the assurance provided.

The key finding of the audit is:-

1. In line with the Trust's Corporate Emergency Management Plan, a Bronze Incident Co-ordination Team and a Bronze Operational Team were established to manage the Trust response to COVID-19. However whilst these meetings were minuted, they did not provide a clear audit trail of the key decisions approved by these groups. As per the emergency plan, an action log was to be maintained to record the time and details of events, key decisions made, information passed onto others, instructions issued or requests made. However no action log has not been made available. Additionally no minutes were available for weekend meetings of the groups during March 2020, and 2 sets of agenda for the Bronze Incident Co-ordination Team were not minuted. Audit tested a sample of expenditures across 4 key areas- PPE, Estates Works, Medical Equipment and Staff Accommodation (£1.589M), and found that although supporting documentation was

available, there was not a clear audit trail back to initial related operational decisions at either Bronze Incident or Operational Groups or other sub-groups.

Other Findings are:

2. The Trust held Staff Engagement sessions in May and June to identify lessons for learning from the first surge of COVID-19. Following these engagement sessions a lessons learned report has been compiled, however at the date of Internal Audit fieldwork this report had not been finally signed off or agreed. The Trust has already identified that its Influenza Pandemic Response Plan and Lockdown/Controlled Access Plan will require further development.
3. Issues were noted in respect of recording of gifts/hospitality/donations received for use across the Trust. It is appreciated that these arrangements have been stood down since the first wave of the pandemic.

Summary of Findings and Recommendations

Finding		Number of Recommendations		
		Priority 1	Priority 2	Priority 3
1.	Recording of Key Decisions and Actions	-	2	1
2.	Lessons Learned	-	2	-
3.	Management of Gifts and Hospitality	-	2	1

Detailed Findings and Recommendations

1 Recording of Key Decisions and Actions

Findings

COVID-19 required the Trust to rapidly participate in both local and regional planning to respond to the pandemic in a timely and effective way. In line with the Trust's Corporate Emergency Management Plan, a Bronze Incident Coordination Team and a Bronze Operational Team were established to manage the Trust's response. The Corporate Emergency Management Plan sets out as part of the management of an incident including a pandemic situation that an action log is maintained which should record the time and details of events, key decisions made, information passed onto others, instructions issued or requests made. A copy of the action log for both these groups was not available.

However whilst these meetings were minuted, they did not provide a clear audit trail of the key decisions approved by these groups. Review of minutes identified while some actions are discussed, these do not have a timeframe for review or implementation timescale and it is difficult to ensure that actions are taken and closed off without appropriate supporting documentary evidence.

Review of the minutes of these groups also identified that:-

- Minutes of weekend meetings of these 2 groups were not available for the last 2 weekends in March 2020.
- The minutes of Bronze Incident Co-ordination Team (SMT Bronze) for the 27th March only contained agenda headings no actual notes of the meeting.
- The minutes of the Bronze Incident Co-ordination Team (SMT Bronze) for the 30th March contained no notes.

Internal Audit reviewed 4 areas of COVID-19 related spend to ensure the commitment to incur the spend had been considered at the appropriate level i.e. Bronze Command and that the decisions taken in respect of that commitment had been documented in relevant action logs. The following spend was specifically reviewed:

No	Supplier	Type of spend	£
1	Local Suppliers (4)	PPE inc visors, masks, scrubs etc	£0.417m
2	Respiratory Health Equipment Suppliers	Anaesthetic I Flow machines, Monitors etc	£0.485m
3	Estate Related Works (2 MTC Contractors, and Electrical Wholesaler)	Estate Related Works, Village, Mortuary, Screens, DHH ED etc	£0.455m
4	3 Local Hotels	Accommodation	£0.232m
Total			£1.589m

The majority of expenditure on health equipment was procured through existing regional contracts. Due to need for expediency in respect of Estates Works it was decided to utilise the 2 main MTC contractors for CAH and DHH hospital sites, as they were readily available and familiar with the estate. Procurement of electrical supplies were made through the regional contract provider.

None of the spend from local PPE suppliers or for accommodation at local hotels reviewed had been subject to procurement; however for all 7 suppliers tested in these 2 payment areas, appropriate Direct Award Contracts (DACs) were put in place retrospectively and had been appropriately approved in line with relevant guidance.

Internal Audit found in all 4 areas of spend examined, the expenditure decisions/approval could not be readily traced to related discussions at Bronze Command.

Implications

Failure to appropriately record decisions and actions taken could result in negative public/media interest in how the Trust managed the pandemic.

Risk of inappropriate spend where decisions to commit COVID-19 expenditure is not considered and documented at Bronze Groups.

Recommendation 1.1	In line with requirements of the Trust Corporate Emergency Management plan, the Trust should ensure that a log is maintained which records the time and details of events, decisions made, information passed onto others, instructions issued or requests made, including financial approvals..
Priority	2
Management Action	ACCEPTED For information, an action log is available for consideration
Responsible Manager	Medical Director
Implementation Date	Implemented

Recommendation 1.2	The terms of reference of Bronze Incident & Operational Groups, and subgroups in directing, and approving emergency COVID-19 actions including expenditure should be clarified.
Priority	2
Management Action	ACCEPTED This section of the plan will be reviewed, as part of the overall review of both Pandemic and Corporate Plan
Responsible Manager	Medical Director
Implementation Date	1 st September 2021

Recommendation 1.3	Upon the establishment of incident management groups an appropriately experienced senior administrator should be appointed to formally maintain an action log documenting the key decisions taken at these fora.
Priority	3
Management Action	ACCEPTED
Responsible Manager	Medical Director
Implementation Date	1 st October 2021

2 Lessons Learned

Findings

The Trust held Staff Engagement sessions in May and June to identify lessons learned from the first surge of COVID-19. Following these engagement sessions a lessons learned report has been compiled however at the date of Internal Audit fieldwork (November 2020) this report had not been presented to Trust Board for final agreement.

It is important that learning is not only identified but also that the Trust now take the appropriate action promptly to ensure that the learning identified is embedded across the organisation to reflect the new normal.

Internal Audit acknowledge that the Trust has identified that their Influenza Pandemic Response Plan and Lockdown/Controlled Access Plan will require further development as a result of the lessons learned from COVID-19.

Recommendation 2.1	Management should ensure that the individual learning points identified from the first wave are taken forward and shared across the organisation promptly to ensure that this learning helps to inform new ways of working in the ongoing pandemic.
Priority	2
Management Action	PARTIALLY ACCEPTED Lessons learned were shared with Operational Teams. Moving forward, lessons learned will be incorporated into reviews of Emergency and Pandemic Response Plans, or escalated to regional colleagues where appropriate.
Responsible Manager	Medical Director
Implementation Date	1 st October 2021

Recommendation 2.2	The Trust Pandemic Plan and the Lockdown plan should be promptly updated following the outcome of the review of lessons learned as a result of COVID-19.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Medical Director
Implementation Date	1 st October 2021

3 Management of Gifts and Hospitality

Finding

During the first surge of COVID-19 the magnitude of the general public's generosity and their desire to help the Trust and its staff meant the Trust quickly became inundated with offers of help. In an effort to ensure that all offers were responded to timely, donors thanked and gifts/donations appropriately dealt with, the Directorate of Finance, Procurement and Estates, established a single point of contact through a new email address. Donations received included PPE, food/beverages offers of accommodation, equipment, and monetary donations which were managed by the Trust's Finance Department.

In review of the central COVID-19 register of donations, the volume of items received and the monetary value of cash donations were not always recorded. The central COVID-19 register included items that people had phoned to offer but in some cases these offers of gifts/hospitality were not subsequently received/deemed suitable.

Not all offers of assistance came directly through the central team; some were received and accepted by individual staff or teams. These were not notified to the central COVID-19 register and were also not reported through for inclusion on the Trust's Gifts and Hospitality Register.

It is appreciated that the Trust has not received these types of gifts/hospitality/donations since the initial wave of the pandemic. In the event that gifts/hospitality/donations of this nature increase during future waves, there is a need for the Trust to strengthen processes and controls around reporting and recording of gifts or hospitality received both centrally and by individual staff or teams.

The Trust Gifts Hospitality and Sponsorship Policy was due for review in February 2019 this review had not been completed.

Implications

Failure to appropriately record donations and actions taken could result in negative public/media interest.

Risk of loss or theft if the value and volume of goods donated is incomplete.

The Trust policy for receipt of gifts and hospitality has not been adhered to.

Recommendation 3.1	The central COVID-19 register should where possible include the volume of items received or a monetary value where this is applicable and can be easily identified. The register should be updated to accurately reflect what was actually received.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Senior Finance Manager
Implementation Date	Complete

Recommendation 3.2	The Trust Gifts, Hospitality and Sponsorship Policy should be reviewed, updated and reissued to staff.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Corporate Financial Accountant/Fraud Liaison Officer Board Assurance Manager
Implementation Date	March 2021

Recommendation 3.3	A reminder should be issued to staff of the requirement to record or register gifts or hospitality they received at individual/team level in line with the Trust Gifts, Hospitality and Sponsorship Policy.
Priority	3

Management Action	ACCEPTED
Responsible Manager	Board Assurance Manager
Implementation Date	April 2021

Appendix A - Definition of Levels of Assurance and Priorities

Level of Assurance

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

Recommendation Priorities

Priority 1	Failure to implement the recommendation is likely to result in a major failure of a key organisational objective, significant damage to the reputation of the organisation or the misuse of public funds.
Priority 2	Failure to implement the recommendation could result in the failure of an important organisational objective or could have some impact on a key organisational objective.
Priority 3	Failure to implement the recommendation could lead to an increased risk exposure.

Note to Report

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

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**Minutes of a Virtual meeting of the Audit Committee
held on Thursday, 6th May 2021 at 9.30 a.m.**

PRESENT:

Mrs H McCartan, Non-Executive Director (Chair)
Mr M McDonald, Non-Executive Director
Mr J Wilkinson, Non-Executive Director

IN ATTENDANCE:

Mr S Devlin, Chief Executive
Ms H O'Neill, Director of Finance, Procurement and Estates, SHSCT
Mrs C Cassells, Assistant Director of Finance, Financial Management, SHSCT
Mrs A Rutherford, Assistant Director of Finance, Financial Services, SHSCT
Mrs F Jones, Corporate Financial Accountant/Fraud Liaison Officer, SHSCT *(Item 7 onwards)*
Mrs C McKeown, Head of Internal Audit
Ms J McCaw, Assistant Head of Internal Audit
Mr S Knox, Manager, Northern Ireland Audit Office (NIAO)
Mr B Clerkin, Partner, ASM - External Audit
Mr J McCallion, Manager, ASM - External Audit *(Item 7 onwards)*
Ms J Brown, Systems Accountant, SHSCT *(Item 7 onwards)*
Mr D O'Prey, Acting Corporate Financial Accountant, SHSCT *(Item 7 onwards)*
Mrs S Judt, Board Assurance Manager, SHSCT
Mrs S McCormick, Committee Secretary, SHSCT (Minutes)

APOLOGIES

None.

1) CHAIR'S WELCOME

Mrs McCartan welcomed everyone to the virtual meeting particularly representatives from both Internal and External Audit and the Trust's Finance Team.

2) DECLARATION OF INTERESTS

Mrs McCartan asked members to declare any potential conflict of interests in relation to items on the agenda. None were received and the business of the meeting proceeded.

6i) INTERNAL AUDIT PROGRESS REPORT (10 REPORTS)**Governance during Covid – Satisfactory**

A Satisfactory level of assurance was provided in relation to Governance during Covid-19 on the basis that Governance Structures were enhanced in line with regional and local emergency response plans to allow effective monitoring and accountability. A number of key findings were raised including the recording of key decisions and actions, lessons learned and some issues in respect of recording of gifts/hospitality/donations received for use across the Trust. Six Priority 2 and Two Priority 3 recommendations were identified.

On behalf of members Mrs McCartan welcomed the assignment outcome. She referred to and welcomed the weekly information meetings established between the Chief Executive and the Trust Chair and Non-Executive Director colleagues in relation to the Trust response to Covid. In terms of lessons learned, the Chief Executive advised it had been agreed through the Trust Bronze Operational Team to complete a learning exercise encompassing the past 15 month period. The lessons learned summary report previously presented to Trust Board will be refreshed and presented to Trust Board in due course.



Southern Health & Social Care Trust

Information Governance - 2020/21



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Acknowledgement

Internal Audit wishes to thank management and staff at the Southern HSC Trust for their assistance and co-operation during the course of the audit engagement. We recognise and appreciate that the Southern HSC Trust has continued to effectively engage with us during extremely challenging times for staff.

Control Log

Exit Meeting Held On:	27 January 2021
Working Draft Issued On:	12 February 2021
Management Actions Received:	09 March 2021
Final Report Issued On:	10 March 2021

Distribution List

Shane Devlin	Chief Executive (final report only)
Aldrina Magwood	Director of Performance & Reform
Mark Toal	Acting Assistant Director of Informatics
Catherine Weaver	Head of Information Governance
Helen O'Neill	Director of Finance, Procurement & Estates
Alison Rutherford	Assistant Director of Financial Accounting and Services

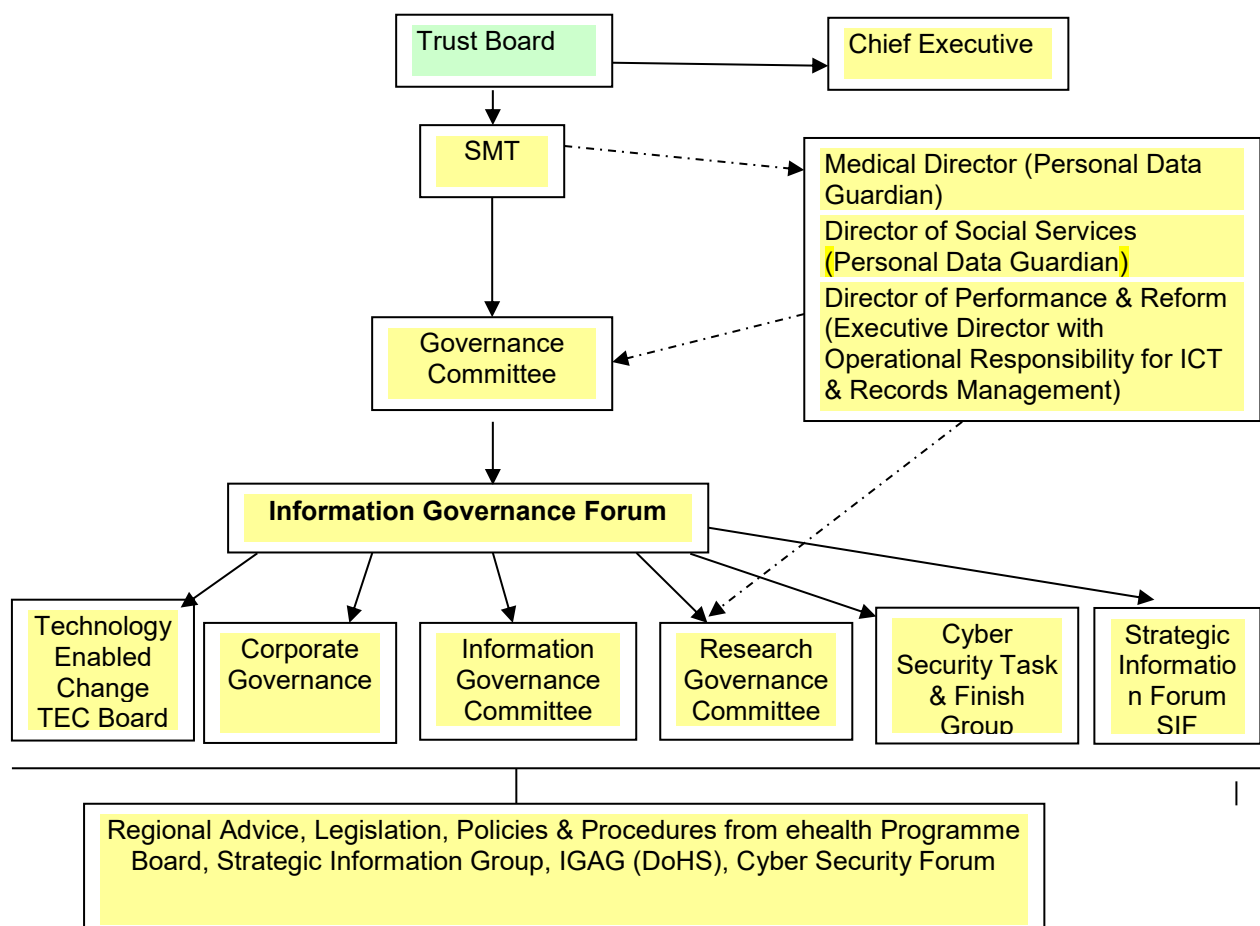
Introduction

In accordance with the 2020/21 Annual Internal Audit Plan, BSO Internal Audit carried out an audit of Information Governance during December 2020 and January 2021. The last Internal Audit of this topic was performed during 2017/18 and focussed on GDPR Readiness when Satisfactory assurance was provided.

The General Data Protection Regulation (GDPR), which came into effect on 25 May 2018, introduced a new framework of rights and duties for the protection of personal data. The Regulation harmonised data privacy laws across Europe and strengthens and extends individual's rights and protections in relation to their personal data. Subsequently, the Data Protection Act 2018 (DPA) ensured the standards set out in the GDPR had effect in the UK. As well as strengthening some of the requirements of the GDPR the DPA also provides some exemptions from the GDPR. This legislation will continue to be enforced after the UK's exit from the European Union. The Trust has a statutory responsibility to know what personal data it holds, how and why it is processed, who has access to it, and with whom it is shared.

This is managed and overseen by the Information Governance Management Team, which is part of the Informatics Division within the Directorate of Performance and Reform, and is responsible for providing expert advice and assistance and for implementing the requirements of the Trust's Information Governance Framework. The Framework shows the structure and roles of the Senior Information Risk Owner (SIRO), (Director of Performance & Reform), Personal Data Guardians (PDG) (Medical Director and Executive Director of Social Work), Data Protection Officer (DPO) (Head of Information Governance), c.122 Information Asset Owners (IAOs), Information Governance Leads (IGLs) and key staff across the Trust to ensure good information governance is in place across the organisation.

The Information Governance Forum is responsible for ensuring the Trust is compliant with information governance legislation and information handling requirements and good practice standards. The committee oversees and influences the development of Information Governance and Data Security across the Trust and with third party suppliers and contractors. The Information Governance Forum provides assurance to the Board via the Governance Committee. There are a number of sub groups that report to the Forum including the Data Protection Sub Group, Information Governance committee and Cyber Task and Finish Group. The diagram below shows these structures and links to regional groups:



The SIRO produces and presents a quarterly Information Governance report to the Trust Governance Committee, detailing key issues and activities. The table below shows the number of FOI and DPA (Subject Access Requests – SARs) received and responded to within 20 days (FOI) or 30 days (SAR) in the 9 month period January 2020 to September 2020. The majority of these FOI & SAR requests relate to the Acute Directorate and are received most frequently from members of the public. There has been a reduction in request volumes in 2020 due to the pandemic.

	2020 Requests processed	2019 Comparative Requests processed	2020 Requests Responded on time (within 20 or 30 working days) & %	2019 Comparative Requests Responded on time (within 20 or 30 working days) & %
FOI Requests (20 days)	242	301	206 (85%)	240 (79%)
DPA (SARs – 30 days)	310	498	239 (77%)	406 (81%)

In the period January to September 2020 the Trust recorded a total of 115 data incidents - 62 of these were categorised as a data breach and 53 data incidents. Subsequently the Trust reported four data breach incidents to the ICO, who was satisfied with actions taken by the Trust.

In response to both the COVID-19 pandemic and the organisational escalation of remote homeworking by its staff, the Trust has developed and shared with staff a number of policies and guidance, including:

- Homeworking during COVID-19 Guidance for Trust Staff; the guidance highlights staff responsibility to comply with confidentiality and data protection policies and ensure safe storage of information while working from home. The guidance also requires line managers to assess the sensitivity and confidentiality of work to be undertaken at home prior to approval;
- Employees Guide to Handling Information across various platforms including the Trust Facebook page;
- Guidance on the Sharing of COVID Test Results which outlines the conditions required for sharing this information (based on ICO guidance); and
- Video Consultation and Meeting Guidance which is being utilised during the pandemic in absence of face to face interactions.

The Trust has also reviewed and strengthened data sharing arrangements in place with other agencies through their Data Access Agreements and with a number third party providers though enhanced contract clauses.

Scope of Assignment

The focus of this assignment was to review Information Governance within the SHSCT and covered the period from January 2020 to October 2020. Policies and procedures were reviewed along with governance structures and reporting arrangements at SMT and Board level. Internal Audit obtained information on processes around data storage and data transfers on-site, off-site, by third parties, and electronically and assessed for adequacy. Information Asset Registers (IARs) were reviewed along with processes around establishing, reporting on and learning from data incidents and breaches. Internal Audit tested compliance with the Freedom of Information Act and the Information Management Assurance Guidance. Information Governance and GDPR training was reviewed along with procedures in place around Data Protection Impact Assessments (DPIA's).

The audit was based on the risk that non-compliance with Information Governance legislation and/or best practice could result in legal action and damage the organisations reputation.

The objectives of this audit were:

- To ensure that policies/procedures had been established to facilitate compliance with relevant legislation including General Data Protection Regulation (GDPR) and Data Protection Act (DPA) 2018.
- To ensure that comprehensive oversight and control existed within the organisation and appropriate governance structures were in place.

- To ensure that an effective reporting, monitoring and review process was in place within the organisation.
- To ensure that the Trust was aware of instances where data was transferred outside the organisation and that in such circumstances appropriate controls were in place to ensure the data was transferred securely.
- To ensure the Trust had considered the mechanisms for retaining sensitive data to ensure it was appropriate and sufficient safeguarding controls had been put into place.
- To ensure appropriate training has been provided to staff on data protection and information governance.
 - To review awareness of the Freedom of Information (FOI) Act 2000.
 - To ensure that the Trust received assurance that all third parties working on its behalf were compliant with information governance requirements.
- To ensure that an appropriate process was established to record, investigate, monitor and report on data incidents and personal information breaches.
- To ensure that SHSCT is compliant with the HSC Information Management Assurance Guidance.

Limitation of Scope: Due to the COVID-19 pandemic, Internal Audit was unable to undertake visits to a sample of SHSCT sites to assess security arrangements for both electronic and manual records.

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

Level of Assurance

Satisfactory

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

Executive Summary

Internal Audit can provide Satisfactory assurance in relation to Information Governance within the Trust. Satisfactory assurance is provided on the basis that there is a comprehensive and well established Information Governance framework in place. The Governance Committee, through the Information Governance Forum, monitor information governance. Up to date policies and procedures to support the framework are in place and available to staff, and a corresponding IG training programme has been rolled out to staff, and uptake is monitored quarterly. There is a robust system for the monitoring and review of the Information Asset register and risk assessments are performed for information assets across the organisation.

As per DPA 2018 / GDPR requirements Data Protection Impact Assessments (DPIAs) were completed for new projects (50% of these were due to changes brought about by COVID19). There is quarterly and annual reporting on Information Governance through the Governance Committee, and annually requirements are monitored through the HSC Information Management Assurance Checklist, with action plans in place to address any gaps, which were also reported in the Governance Statement in the 2019/20 annual accounts and concurs with the findings in this audit.

There are no significant findings in this report.

The key findings are as follows:

1. From January to October 2020 a total of 115 data incidents were recorded in the IG incident register. However 5 of these incidents were not recorded by managers on the Datix System, and consequently could result in under-reporting. A review of the register identified that while it was complete regarding evidence of investigation and subsequent actions taken, some gaps in completeness of data were noted.

2. Freedom of Information (FOI) requests are not always being responded to within 20 days as required. In the 12 month period October 2019 until September 2020 87% of FOI requests have been responded to within the 20 day timescale; the most common cause of delayed responses is late or 'incomplete responses' received from the nominated Response Coordinators.
3. Subject Access Requests (SAR) response timeframe of 30 days (90 for complex cases) is not consistently being met, with 21% of requests not being responded to in the required timeframe in the 12 month period October 2019 to September 2020. An analysis of the SAR response times shows that there has been a decrease in the Trust response to SARs within the required legal timeframe to 69% in quarter 2 2020/21, against a corresponding increase in volumes of requests received compared to quarter 1. Further analysis found this was the lowest compliance rate for over 3 years.
4. Information Governance Training is available across the Trust however uptake to September 2020 was 77% compared to 82% in September 2019 and does not meet the target of 95%;

Other findings are:

5. The Information Governance Forum has not met during the first half of 2020/21 due to the impact of COVID19, however meetings recommenced in November 2020.
6. The Photography of Service User Policy, Data Protection Policy and ICT Project Management Policy were recently revised and updated and presented to Policy Committee in November 2020, however had not been confirmed as approved at date of fieldwork. Also the Trust Incident Reporting Procedure is dated October 2014 and has not been updated in line with the new regional Incident Management Procedure.

Summary of Findings and Recommendations

Finding		Number of Recommendations		
		Priority 1	Priority 2	Priority 3
1.	Recording of Data Breaches	-	1	1
2.	FOI Requests	-	1	-
3.	Subject Access Requests (SARs)	-	2	-
4.	Information Governance Training	-	1	-
5.	Information Governance Forum Meetings	-	1	-
6.	Policies and Procedures	-	-	1

Detailed Findings and Recommendations

1 Recording of Data Breaches

Finding

The Trust IG Teams holds a register of all data incidents and these are designated as either a data incident or data breach. From January to October 2020 a total of 115 incidents were recorded. A review of the register identified while it was complete regarding evidence of investigation and subsequent actions taken, some gaps in completeness of data were noted:

- 5/115 data incidents had not been recorded on Datix by the reporting manager and potentially incidents may not be recorded and subsequently reported. However in these cases all were reported by other means to IG Team e.g. email or telephone and subsequently reported;
- whether the incident was reported to ICO was not recorded in 10 /115 cases; the criteria for reporting to ICO was not met in these 10 cases.
- 1/4 incidents reported to the ICO was not reported within 72 hours as required. Reporting was delayed in order to ensure all information was available for the report, and the ICO was satisfied with action taken.

Implication

Potential for under-reporting of IG incidents if cases are not recorded on Datix system through IR1, and subsequently not investigated timely.

Non-compliance with legislation and/or best practice could result in legal action and damage the organisations reputation.

Recommendation 1.1	Trust Managers should ensure that all data breaches are fully and promptly recorded on the DATIX system using the IR1 process and the appropriate checkbox completed on DATIX to ensure onward reporting to the Information Governance Team.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Assistant Director of Clinical Governance
Implementation Date	June 2021

Recommendation 1.2	The Trust should ensure that all data breaches are recorded accurately on the register and all elements required are fully completed.
Priority	3
Management Action	ACCEPTED
Responsible Manager	Head of Information Governance
Implementation Date	June 2021

2 Freedom of Information Requests (FOI)

Finding

Responding to most FOI requests within the 20 day legislative requirement remains a challenging timescale for the Trust to consistently achieve. However it is recognised that considerable work has been performed to increase compliance rates since our last audit. The table shows that in the 12 month period October 2019 to September 2020 87% of FOI requests have been responded to within the 20 day timescale and 94% have been responded to within 25 days.

In October to December 2019 92% were completed within 20 days however this has reduced to 85% in the July to September period. However Internal Audit recognise that prior to the pandemic there had been a steady increase in the numbers responded to within the 20 days and action has already been taken to address the increased response times including Information Governance Managers meeting weekly to discuss ongoing FOI cases. Additionally, the Information Governance Managers meet with the Information Governance Officers to discuss individual FOI queries, escalation points and liaise with senior managers in an attempt to increase compliance rates.

	Oct Dec 2019	Jan Mar 2020	Apr Jun 2020	Jul Sep 2020	12 month period Oct 19 Sep 20
Response within 20 days	99	71	54	80	304
Response 21-25 days	7	12	2	5	26
Response 26-40 days	2	1	6	6	15
Response 41+ days	0	0	2	3	5
Total Requests in Period	108	84	64	94	350
% completed within 20 days	92	85	84	85	87
% outside 20 day target	8	15	16	15	13

Implications

Increasing volumes of FOI requests post COVID19 could result in reputational damage and increased potential for fines should the Trust fail to meet the legal requirement to respond to all FOI requests within 20 days.

Recommendation 2.1	The Trust should ensure escalation procedures are actioned with Assistant Directors / Directors to increase managers FOI request response compliance with the legally required timeframe of 20 days.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Head of Information Governance
Implementation Date	June 2021

3 Subject Access Requests (SAR)

Finding

Under the GDPR / Data Protection Act 2018, the Trust must respond to a Subject Access Request (SARs) within 30 calendar days. For complex requests the deadline can be extended by an additional 60 days bringing the response timescale to 90 calendar days. In the 12 month period October 2019 to September 2020 the Trust received 487 SARs, the significant majority relating to the Acute Directorate.

An analysis of the SAR response times shows that there has been a decrease in the Trust response to SARs within the required legal timeframe to 69% in quarter 2 2020/21, against a corresponding increase in volumes of requests received compared to quarters 1. Further analysis found this was the lowest compliance rate for over 3 years.

	Oct Dec 2019	Jan Mar 2020	Apr Jun 2020	Jul Sep 2020	12 month period Oct 19 Sep 20
Response within 30 days (90 days for complex cases)	147	76	71	92	386
Responses outside required timeframe	30	5	25	41	101
Total Requests in Period	177	81	96	133	487
% completed within 30 days (90 days for complex cases)	83%	94%	74%	69%	79%
% outside 30 day target (90 days for complex cases)	17%	6%	26%	31%	21%

In practice SARs are increasingly more complex. Whilst, there is no legal definition of a complex request a regional agreement was reached based on experience of processing SARs that the following non-exhaustive list of features may be used to identify a request as complex;

- Significant amount of third party personal data
- Large amount of redaction required prior to release of information
- Large volume of notes held
- Historical information rather than current information
- Records that cross more than one discipline
- Records that cross one or more electronic systems or that are held in different formats
- Assessment as to capacity under the Mental Capacity Act required

This definition needs to be consistently applied to ensure appropriate classification and reporting against timescales.

Implications

The Trust is not complying with the requirements of the GDPR / Data Protection Act in relation to the release of requested data within legal timesframes and rising volumes of SARs post COVID19 increases risk of potential enforcement by the ICO including fines, and reputational damage.

Recommendation 3.1	The Trust should ensure escalation procedures are actioned with Assistant Directors / Directors to increase managers SAR request response compliance with the legally required timeframe of 30 days and 90 days in complex cases.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Head of Information Governance

Implementation Date	22/ 02/2021
Recommendation 3.2	The Trust should review processes for classifying SARs, as complex requests may not always be appropriately identified and therefore the incorrect timescale applied.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Head of Information Governance
Implementation Date	March 2021

4 Information Governance Training

Finding

At 30 September 2020 the overall total of employees trained in Information Governance was 77% (82% in Sept 2019) against a target rate of 95%. Following recent review of training statistics the ICO queried whether the Trust was under-reporting compliance.

An analysis by directorate is shown in the table below. All directorates with exception of Medical Directorate at 47% showed a reasonable uptake of Information Governance training.

Directorate	Not Trained	Trained	Head Count	% Trained
Acute Services	1248	3242	4490	72%
Chief Executive's Office	4	11	15	73%
Children & Young People's Services	367	1256	1623	77%
Executive Directorate of Nursing & Midwifery and AHP's	12	27	39	69%
Finance & Procurement	70	212	282	75%
HR & Organisational Development	68	118	186	63%
Medical	58	51	109	47%
Mental Health & Disability Services	333	1326	1659	80%
Older People & Primary Care	434	2530	2964	85%
Performance & Reform	34	136	170	80%
Grand Total	2628	8909	11537	77%

Implication

Non compliance with this mandatory training requirement increases the risk to the effectiveness of information governance within the Trust.

Recommendation 4.1	The Trust should work to improve its compliance with mandatory Information Governance Training in a return to Business as Usual. As per the ICO recommendation, the process for generating and reporting on compliance figures should be reviewed to ensure accuracy of reporting.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Head of Information Governance
Implementation Date	May 2021

5 Information Governance Forum

Finding

The Terms of Reference of the Information Governance Forum state the group should meet on a quarterly basis. This was not the case during 2020/21 to date, the IG Forum were due to meet in April, August and November 2020. However due to COVID there were no meetings in April or August. The group did meet in November 2020, the first meeting since February 2020.

Implications

If Information Governance Forum meetings are not held regularly and attended by all relevant persons there is a risk that monitoring of compliance with information governance may be adversely impacted within the Trust.

Recommendation 5.1	Going forward the Information Governance Forum should meet in accordance with the terms of reference.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Director of Performance & Reform / Senior Information Risk Owner
Implementation Date	June 2021

6 Policies and Procedures

Finding

Internal Audit reviewed policies and procedures and noted the following:

- The Photography of service User Policy, Data Protection Policy and ICT Project Management Policy were recently revised and updated and presented to Policy Committee in November 2020 - however had not been confirmed as approved at date of fieldwork.
- The Trust Incident Reporting Procedure is dated October 2014 and has not been updated to align with the new regional Incident Management Procedure which is now available.

Implication

Formal up to date guidance is not available to Trust staff.

Recommendation 6.1	The Trust should update these policies to ensure they reflect current legislation and Trust processes.
Priority	3
Management Action	ACCEPTED
Responsible Manager	Head of Information Governance
Implementation Date	May 2021

Appendix A - Definition of Levels of Assurance and Priorities

Level of Assurance

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

Recommendation Priorities

Priority 1	Failure to implement the recommendation is likely to result in a major failure of a key organisational objective, significant damage to the reputation of the organisation or the misuse of public funds.
Priority 2	Failure to implement the recommendation could result in the failure of an important organisational objective or could have some impact on a key organisational objective.
Priority 3	Failure to implement the recommendation could lead to an increased risk exposure.

Note to Report

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

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**Minutes of a Virtual meeting of the Audit Committee
held on Thursday, 6th May 2021 at 9.30 a.m.**

PRESENT:

Mrs H McCartan, Non-Executive Director (Chair)
Mr M McDonald, Non-Executive Director
Mr J Wilkinson, Non-Executive Director

IN ATTENDANCE:

Mr S Devlin, Chief Executive
Ms H O'Neill, Director of Finance, Procurement and Estates, SHSCT
Mrs C Cassells, Assistant Director of Finance, Financial Management, SHSCT
Mrs A Rutherford, Assistant Director of Finance, Financial Services, SHSCT
Mrs F Jones, Corporate Financial Accountant/Fraud Liaison Officer, SHSCT
(Item 7 onwards)
Mrs C McKeown, Head of Internal Audit
Ms J McCaw, Assistant Head of Internal Audit
Mr S Knox, Manager, Northern Ireland Audit Office (NIAO)
Mr B Clerkin, Partner, ASM - External Audit
Mr J McCallion, Manager, ASM - External Audit *(Item 7 onwards)*
Ms J Brown, Systems Accountant, SHSCT *(Item 7 onwards)*
Mr D O'Prey, Acting Corporate Financial Accountant, SHSCT *(Item 7 onwards)*
Mrs S Judt, Board Assurance Manager, SHSCT
Mrs S McCormick, Committee Secretary, SHSCT (Minutes)

APOLOGIES

None.

1) CHAIR'S WELCOME

Mrs McCartan welcomed everyone to the virtual meeting particularly representatives from both Internal and External Audit and the Trust's Finance Team.

Information Governance – Satisfactory

Ms McCaw spoke to the report and advised a Satisfactory level of assurance was provided on the system of internal control in relation to Information Governance within the Trust on the basis that there is a comprehensive and well established Information Governance framework in place. No significant findings were identified that impact on the assurance provided. Six Priority 2 and Two Priority 3 recommendations were identified. Members welcomed the detail.



Southern Health & Social Care Trust

Whistleblowing Processes 2019/20



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Acknowledgement

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

Control Log

Working Draft Report Issued On: 24 March 2020
 First Draft Issued On: 18 May 2020
 Management Actions Received: 18 May 2020
 Final Report Issued On: 19 May 2020

Distribution List

Shane Devlin	Chief Executive (Final Report Only)
Helen O'Neill	Director of Finance, Procurement & Estates
Vivienne Toal	Director of Human Resources & Organisational Development
Alison Rutherford	Assistant Director of Finance
Siobhan Hynds	Deputy Director of Human Resources
Sarah Moore	Head of Employee Relations

Introduction

In accordance with the 2019/20 Annual Internal Audit Plan, BSO Internal Audit carried out an audit of Whistleblowing Processes during February and March 2020. The last Internal Audit of this topic was performed during November 2015, when a satisfactory level of assurance was provided.

Since then, the report by Sir Robert Francis entitled "Freedom to Speak Up - An Independent Review into Creating an Open and Honest Reporting Culture in the NHS" was produced in 2015, as this was a major area of concern arising from the Inquiry into Mid Staffordshire NHS Foundation Trust. It acknowledged the contribution staff can make to patient care through speaking up, while there was felt to be a continuing problem with regard to the treatment of staff who raise genuine concerns about safety and other matters of public interest, and the handling of those concerns. His report identifies 5 overarching themes:

- culture change
- improved handling of cases
- measures to support good practice
- particular measures for vulnerable groups
- extending the legal protection.

He sets out 20 principles to guide the development of a consistent approach to raising concerns under these 5 themes. The overarching principle is that every organisation needs to foster a culture of safety and learning in which all staff feel safe to raise a concern.

Whistleblowing can be defined as "A worker raising a concern about wrongdoing, risk or malpractice with someone in authority either internally and/or externally (i.e. prescribed organisations such as regulators, professional bodies, media, MPs)". Organisations wishing to maintain a trusted reputation in accordance with best practice and comply with legislation relating to whistleblowing should have a whistleblowing policy and procedure as part of their overall governance and risk management environment. The SHSCT updated its policy and procedure "Your Right to Raise a Concern" (Whistleblowing) in April 2018 to take account of updated legislation which came into force in Northern Ireland in October 2017.

Subsequently to help promote whistleblowing in the Trust, the 'See Something; Say Something' initiative was introduced during 2018/19. Board support for the initiative was provided through the appointment of a lead Non-Executive Director for Whistleblowing to regularly liaise with and support the Deputy Director HR (Trust Whistleblowing Lead), training was provided to senior managers, a promotional campaign was targeted at all staff and regular reporting to senior management via the Governance Committee was introduced. During 2019/20 a workshop was held with senior managers / investigators to review the first year of operation of the 'See something Say Something' campaign and an action plan was agreed, which the Director of Human Resources is taking forward.

Since September 2017 there have been 43 cases formally investigated under the Trust's 'Your Right to Raise A Concern' (whistleblowing) policy, with 17 of those cases in the 2019 calendar year. For each individual case the Deputy Director of Human Resources brings the case to an Oversight Committee which comprises of the Director of Human Resources, the Executive Director (as appropriate to the case), and the Director from the relevant operational area. The Oversight Committee is the decision taker. There is also an Investigation Panel / team established, comprising of a trained investigator from HR and one from the panel of trained investigators.

Scope of Assignment

The scope of this audit was to review whistleblowing processes within the SHSCT. Internal Audit reviewed 'Your Right to Raise a Concern' (whistleblowing) policy and procedures as well as related policies, carried out an analysis of recent cases, reviewed processes for identifying and investigation of reported cases, and reporting and governance arrangements as well as the culture of openness in relation to raising of concerns. A sample of whistleblowing cases reported between the period 1 January 2019 and 31 December 2019 were reviewed, and discussions held with a number of the investigators.

The audit was based on the risk of a weak whistleblowing policy and its implementation resulting in non-reporting of concerns, or failure to thoroughly investigate concerns, and / or failure to protect the whistleblower leading to reputational damage / financial loss to the Trust and / or patient risks.

The objective of this audit was to ensure that whistleblowing policies and procedures are effective, complement other business policies, and are promoted to staff.

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

Level of Assurance

Satisfactory

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

Executive Summary

Internal Audit can provide satisfactory assurance in relation to Whistleblowing Processes within the SHSCT. Satisfactory assurance has been provided on the basis that the Trust has:

- updated whistleblowing policies and procedures;
- actively promoted whistleblowing to staff through the 'See Something; Say Something' initiative introduced during 2018/19. Board support for the initiative was provided through the appointment of a lead Non-Executive Director for Whistleblowing to regularly liaise with and support the Deputy Director HR (Trust Whistleblowing Lead);
- Testing found a comprehensive log of whistleblowing cases is maintained within HR. Based on sample testing, when potential whistleblowing cases were identified they were appropriately investigated and case reports produced were presented by Investigators to the Oversight Committee for decision taking.
- There was regular reporting on whistleblowing cases and initiatives to the Governance Committee during 2019.

Some areas require further development in order to build on the progress made to date. These include further work to avoid potential delays in notification of cases to HR and subsequent investigations commencing where a third party is involved, increasing identification and training of case investigators particularly within the Acute and Mental Health Directorates and processes for sharing learning from Whistleblowing Cases.

There are no significant findings in this report that impact on the assurance provided.

There are three key findings in this report:

1. Delays were noted at two stages in the investigation process. Firstly when the potential case is actually reported to Human Resources (HR) and secondly the time between the concern being raised with HR and the commencement of the investigation process. Often this is due to either notification by the whistleblower to a prescribed organisation, or the need to engage with third parties such as BSO, CFPS, PSNI, Professional bodies or internal safeguarding team, disciplinary etc.
2. There have been a limited number of investigators appointed and trained particularly within the Acute and Mental Health Directorates. The Management Development Programme also trains a limited number of staff every year and the programme includes whistleblowing policies and procedures.
3. Within the Trust, there is no formal process in place to share lessons learned from whistleblowing cases. The introduction of the planned staff newsletter will assist with this process.

Other findings include:

4. There is scope to further enhance the whistleblowing culture in the Trust through development of "advocate or champion" roles, particularly amongst medical, nursing and social care staffing areas, further linkages with corresponding professional organisations and incorporating the findings from the IHRD Openness sub-group.
5. The Disciplinary Policy, Grievance Policy, Gifts, Hospitality and Sponsorship Policy and the Conflicts of Interest Policies are overdue for review.

Summary of Findings and Recommendations

Finding		Number of Recommendations		
		Priority 1	Priority 2	Priority 3
1.	Delays in Whistleblowing Investigations	-	2	-
2.	Investigators and Training	-	1	-
3.	Sharing of Lessons Learned	-	1	-
4.	Culture	-	-	2
5.	Policies and Procedures	-	-	1

Detailed Findings and Recommendations

1 Delays in Whistleblowing Investigations

Finding

Delays were noted at two stages in the investigation process. Firstly when the potential case is reported to Human Resources (HR) and secondly the time between the concern being raised with HR and the commencement of the investigation process.

Internal Audit analysed the 17 cases raised in 2019:

- All had two dates recorded, one for when the concern was raised and one for when the concern was raised with HR. 14 of these cases were raised with HR the same day or within 2 days of the concern being raised. One was reported to HR 9 days after being raised; one 15 days later; and one 16 days later. One was reported via the Chief Executive's office and two directly with the BSO Counter Fraud Service.
- There were at times considerable delays between the date the concern was raised with HR and the date of the commencement of the investigation. In 4 cases an investigation was not deemed applicable, in 4 cases the investigation commenced between 4 and 18 days of being reported to HR. There was a considerable delay for the remaining 9 cases:
 - 2 cases - 1-2 months after being reported;
 - 2 cases - between 2-3 months;
 - 1 case between 3-4 months;
 - 1 between 5-6 months;
 - 1 between 7-8 months; and
 - 2 investigations over 6 months were ongoing in so far as they resulted in widespread service reviews by independent investigators appointed by the Trust.

There were a range of reasons for these delays such as ongoing investigations by third parties e.g. PSNI, BSO CFPS etc, internal investigations by the Safeguarding Team or under the other policies such as disciplinary or harassment/ bullying policy, or sometimes the staff member(s) under investigation were on long term sick leave and the investigation was delayed until they return to work (under advice by Occupational Health Team).

Implications

Delays in reporting potential whistleblowing cases to Human Resources may be evidence of lack of clarity over the Whistleblowing Policy and will delay investigation.

Delays in commencement and completion of the whistleblowing investigation can lead to a lack of faith in the whistleblowing process and a negative view of whistleblowing in general.

Recommendation 1.1	The Trust should review and strengthen its communication and reporting processes with third party organisations, both prescribed and investigatory to ensure that whistleblowing cases are promptly notified to the Trust and that where external investigations are performed these take place within agreed timescales.		
Priority	2		
Management Action	ACCEPTED		
Responsible Manager	Deputy Director of HR & Corporate Financial Accountant / FLO		
Implementation Date	September 2020		

Recommendation 1.2	The Head of Employee Relations should implement an appropriate reporting template to ensure that all delays to the investigating process are promptly notified, and fully recorded on the WB log. This should be regularly monitored by the Head of Employee Relations. The Trust should consider introducing the role of a Whistleblowing Advocate within each Directorate to promote the WB process and support whistleblowers.		

Priority	2
Management Action	ACCEPTED
Responsible Manager	Head of Employee Relations
Implementation Date	September 2020

2 Investigators and Training

Finding

There have been a limited number of investigators appointed and trained. There were 26 investigators appointed and trained in May 2018. It was noted that there were only one each from Acute and MHLD, two of the major operational areas within the Trust. Most investigators have been involved in at least one investigation and all investigators who conducted the investigations were previously trained.

The Trust provides training to new managers as part of the Management Development Programme and this includes training on whistleblowing policies and procedures. The Trust plans to continue this training programme for managers. A report to the Governance Committee in November 2019 stated that *'current capacity to provide training and awareness for managers and staff, and the capacity to manage cases expeditiously, continues to be challenging.'* This is due to day to day pressures within operational directorates and due to shortages in staffing generally.

Implications

Staff may not be properly trained to handle whistleblowing concerns or may not be fully aware of their rights to raise concerns.

Limited numbers of investigating officers within Acute and MHLD Directorates may lead to delays in commencing investigations.

Recommendation 2.1	A request for more investigators should be made through Directors, in particular targeting Acute and Mental Health & Disability Directorates where current uptake is minimal and training provided as necessary.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Deputy Director – HR Services
Implementation Date	November 2020

3 Sharing of Lessons Learned

Finding

Within the Trust there is no formal process in place to share lessons learned from whistleblowing cases with managers.

This was referenced in the report to the Governance Committee in November 2019 which stated as part of what the Trust should do next that it 'consider how we share positive outcomes across the organisation to ensure all staff are confident they will be supported when raising a concern'.

One of the main ways that this is to be progressed is through a staff newsletter. Sharing of positive outcomes will mainly be via the newsletter which will be issued (quarterly or bi-annually). The first newsletter is still in draft form and has not yet been circulated to staff.

The Trust report through their Governance Committee Annual report, it is included in the Trust Annual Report. Reports are made twice a year to the Governance Committee.

Implications

Learning from whistleblowing cases reported may not be shared in the most effective way and therefore timely action may not take place to prevent recurrence.

Failure to maximise opportunity to promote benefits of whistleblowing.

Recommendation 3.1	Learning from Whistleblowing cases should be appropriately shared across Directorates using an appropriate medium / forum.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Deputy Director – HR Services
Implementation Date	September 2020

4 Culture

Finding

Although progress has been made to ensure that raising concerns is part of the culture of the Trust as detailed in the introduction of this report, there is scope to further embed a culture of whistleblowing and ensure it is an accepted mainstream practice.

One option which is under consideration is the introduction / development of an Advocate role to support staff across the organisation. These individuals would act as 'champions' for whistleblowing and provide expertise / knowledge across their professional groups / business areas. We understand options such as the introduction of an annual promotional week similar to the Fraud Awareness Campaign week are under consideration.

Testing of whistleblowing cases found evidence of involvement and linkages with professional organisations such as NISCC, NIPEC etc. However there is scope to further develop links with these and other professional representatives such as NMC, NIMDA, GMC etc.

Regional work is ongoing through the IHRD Openness sub-group and the Trust is represented on this forum through the Medical Directorate. The findings from this group as they are developed need to be incorporated into Trust whistleblowing policies and procedures.

Implications

Potential opportunities to maximise promotion of whistleblowing to all staff groups and areas may not be being realised.

Failure to maximise development of whistleblowing with a care focus as envisaged by Francis.

Recommendation 4.1	Management should develop a comprehensive promotional campaign to build on the 'See Something; Say Something' initiative. Consideration should be given to how this can be used to raise awareness among frontline staff in direct patient care areas and professional groups.
Priority	3
Management Action	ACCEPTED
Responsible Manager	Deputy Director – HR Services
Implementation Date	November 2020

Recommendation 4.2	Management should further develop whistleblowing links with regional professional groups and incorporate findings from IHRD Openness sub-group.
Priority	3
Management Action	ACCEPTED
Responsible Manager	Trust Professional Leads
Implementation Date	November 2020

5 Policies and Procedures

Finding

On review of the main policies related to the right to raise concerns, which are noted in the introduction, Internal Audit found that for four of the eleven the review dates had passed.

Disciplinary Policy - This was last reviewed in April 2015 and was due for review in April 2017.

Grievance Policy - This was last reviewed in October 2016 and was due for review in October 2018.

Gifts, Hospitality and Sponsorship Policy - This was last reviewed in February 2016 and was due for review in February 2019.

Conflicts of Interest Policy - This was last reviewed in December 2015 and was due for review in December 2017.

Implication

Policies and Procedures not regularly reviewed will not be reflective of best practice / legislation / current operational processes and consequently inappropriate practice or lack of clarity over responsibilities etc.

Recommendation 5.1	The Trusts Disciplinary Policy, Grievance Policy, Gifts, Hospitality and Sponsorship Policy and the Conflicts of Interest Policy should be updated and amended to reflect best practice and any changes and re issued to staff as soon as possible. Where the Trust policy is based on regional agreed policies / approaches the Trust should raise this through the appropriate regional fora.
Priority	3
Management Action	ACCEPTED
Responsible Manager	Director of HROD Assistant Director of Finance
Implementation Date	30 November 2020

Appendix A - Definition of Levels of Assurance and Priorities

Level of Assurance

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

Recommendation Priorities

- Priority 1** Failure to implement the recommendation is likely to result in a major failure of a key organisational objective, significant damage to the reputation of the organisation or the misuse of public funds.
- Priority 2** Failure to implement the recommendation could result in the failure of an important organisational objective or could have some impact on a key organisational objective.
- Priority 3** Failure to implement the recommendation could lead to an increased risk exposure.

Note to Report

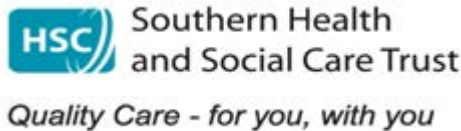
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**Minutes of a Virtual meeting of the Audit Committee held on
Wednesday, 27th May 2020 at 9.15 a.m. in the Boardroom,
Trust Headquarters**

PRESENT:

Mrs H McCartan, Non-Executive Director (Chair)
Mr M McDonald, Non-Executive Director
Ms E Mullan, Non-Executive Director
Mrs S Rooney, Non-Executive Director
Mr J Wilkinson, Non-Executive Director

IN ATTENDANCE:

Mr S Devlin, Chief Executive *(Item 6i onwards)*
Ms H O'Neill, Director of Finance, Procurement and Estates, SHSCT
Mr B Beattie, Acting Director of Older People and Primary Care, SHSCT *(Item 6i only)*
Mrs M McClements, Interim Director of Acute Services, SHSCT *(Item 6i only)*
Mr J McEntee, Assistant Director of Disability Services *(Item 6i only)*
Mrs V Toal, Director of Human Resources and Organisational Development, SHSCT *(Item 6i only)*
Mrs C Cassells, Assistant Director of Finance, Financial Management, SHSCT
Mrs A Rutherford, Assistant Director of Finance, Financial Services, SHSCT
Mrs C Doyle, Corporate Financial Accountant, SHSCT
Mrs F Jones, Corporate Financial Accountant/Fraud Liaison Officer, SHSCT *(Item 7i only)*
Mrs C McKeown, Head of Internal Audit
Ms J McCaw, Assistant Head of Internal Audit
Ms B Bourke, Grant Thornton
Mr S Knox, Northern Ireland Audit Office (NIAO)
Mrs S Judt, Board Assurance Manager, SHSCT
Mrs S McCormick, Committee Secretary, SHSCT (Minutes)

APOLOGIES

None

1) CHAIR'S WELCOME

In order to comply with social distancing restrictions due to the current Coronavirus pandemic (COVID-19), Mrs McCartan welcomed everyone to the meeting via Video Conferencing facilities. She particularly welcomed representatives from both Internal and External Audit respectively and advised that Mr Devlin, Trust Chief Executive would join the meeting later in the agenda.

2) DECLARATION OF INTERESTS

Mrs McCartan asked members to declare any potential conflict of interests in relation to items on the agenda. None were received and the business of the meeting proceeded.

6) INTERNAL AUDIT**i) INTERNAL AUDIT PROGRESS REPORT (5 Reports)****Whistleblowing – Satisfactory**

A Satisfactory level of assurance was provided on the system of internal control in relation to Whistleblowing processes within the Trust on the basis that i) updated policies and procedures are in place, ii) Whistleblowing has been actively promoted, iii) a comprehensive log of Whistleblowing cases is maintained by HR and iv) there has been regular reporting of Whistleblowing cases and initiatives through to the Trust Governance Committee in 2019. No significant findings were identified through the assignment; however, members noted a number of key findings and further work is required in areas including; the investigation process, training and lessons learned. Four Priority 2 and Three Priority 3 recommendations were identified.

Mrs Toal welcomed the audit assignment and the opportunity it has provided in terms of highlighting areas for improvement. She referred to the gap around sharing lessons learned and stated that the introduction of a staff newsletter would assist this. Members noted the newsletter will include examples of positive outcomes, with the first issue envisaged to be ready in September 2020. Mrs Toal assured members that learning from each incident is taken very seriously and the Trust is proactive in raising awareness through the 'See Something; Say Something' initiative.

In response to a question from Ms Mullan, Mrs Toal alluded to the challenges impacting the provision of training internal investigators. She also referred to the day to day pressures on staff within operational Directorates meaning that the capacity to manage cases quickly becomes difficult. Mrs Toal advised that the Trust also has access to an associated list of Investigators from the Leadership Centre and, if appropriate from Counter Fraud and Probitry Services (CFPS) and stated this provides a greater level of independence. Ms Mullan went on to ask if the Lessons Learned from Whistleblowing cases would be included in the Lessons Learned Forum update to Governance Committee to which Mrs Toal advised this group was more clinically focused and hence why a newsletter is being explored.

In concluding discussion, Mr Wilkinson as Non-Executive Director with responsibility for Whistleblowing welcomed the report, however concurred with colleagues some further work is required around learning lessons and training.

Mrs Toal left the meeting at this point.



Southern Health & Social Care Trust

Fraud Processes 2019/20



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Acknowledgement

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

Control Log

Exit Meeting Held On:	11 November 2019
Working Draft Issued On:	12 December 2019
Management Meeting Held On:	08 January 2020
First Draft Issued On:	08 January 2020
Management Actions Due By:	23 January 2020
Management Actions Received:	09 January 2020
Final Report Issued On:	09 January 2020

Distribution List

Shane Devlin	Chief Executive (Final Report only)
Helen O'Neill	Director of Finance, Procurement & Estates
Alison Rutherford	Assistant Director of Finance
Fiona Jones	Fraud Liaison Officer (FLO)

Introduction

In accordance with the 2019/20 approved Annual Internal Audit plan, BSO Internal Audit carried out an audit of Fraud Processes during October 2019. The last Internal Audit of this topic was performed during November 2015, when a satisfactory level of assurance was provided.

There are a number of anti-fraud and associated policies and procedures in the Trust. These include:

- Anti-fraud policy including fraud response plan;
- Standing Financial Instructions;
- Anti-Bribery Policy;
- Gifts Hospitality and Sponsorship Policy;
- Conflicts of Interest Policy;
- Code of Conduct for HSC Employees;
- Your right to raise a concern (Whistleblowing).

The Anti-Fraud Policy and Fraud Response Plan were updated in 2018. The Trust also has a Fraud Action Plan for 2019/20 which was approved by the Audit Committee in June 2019.

The DoH wrote to HSC organisations in October 2018 regarding their fraud processes and reporting of cases to BSO Counter Fraud and Probity Service (CFPS), who are the regional counter fraud specialists, with a remit of countering fraud across all HSC organisations. HSC organisations were subsequently requested to complete and return a fraud template and various documents to confirm their fraud risk processes, which the SHSCT did in November 2018. In June 2019, the DoH informed Trusts of the need for a regional co-ordinated approach to counter fraud including development of Fraud Awareness Strategy, Regional Counter Fraud Action Plan and Fraud Risk Assessments. The Trust is currently participating in these regional developments.

All cases of suspected fraud within Health & Social Care (HSC) must be reported to CFPS by the Trust's Fraud Liaison Officers (FLO). While all suspected fraud cases are reported to CFPS, not all are referred to CFPS for investigation. The Trust will perform initial preliminary work under advice from CFPS to ascertain whether fraud has occurred and subsequently in conjunction with CFPS will decide the most appropriate course of action e.g. disciplinary routes, adult safeguarding, or full fraud investigation by CFPS and / or involvement of the PSNI etc. All cases reported to the FLO are recorded on the case management system REFRAIN which is a regional system used by both BSO CFPS and Trust FLOs. Service Directorates, primarily through their Directorate Governance Leads, are responsible for recording all financial incidents and / or losses on DATIX. The Fraud Liaison Officer (FLO) works with CFPS to promote and develop an anti-fraud culture within the Trust. The FLO will provide advice and guidance where required to mitigate the risk of fraud and can take the lead or work with the lead on fraud investigations within the Trust. The FLO will also provide Fraud Awareness training and ensures the Audit Committee is kept up to date with fraud related issues and investigations.

During 2019/20 year to date (end of September 2019) there have been 13 cases of suspected fraud reported to CFPS, of which 4 have been referred to PSNI for investigation. A further 10 cases from prior years remain under investigation 5 by CFPS and 5 by the Trust which are primarily due to ongoing actions to recover monies owing.

During 2018/19 there were 26 suspected fraud cases identified / reported within the SHSCT. All identified actual, suspected and potential frauds were reported to the Audit Committee as a standing agenda item. 54% of the 2018-19 reported cases involved staff pay and allowances claims. In conjunction with investigation and advice from the CFPS, none of the cases were referred to the PSNI.

Scope of Assignment

The scope of this audit was to review fraud processes within the SHSCT. Internal Audit reviewed anti-fraud policies and procedures, and considered promotion of fraud awareness, identification and investigation, fraud governance as well as the Trust relationship with BSO CFPS. A sample of frauds reported between the period 1 September 2018 and 31 August 2019 were reviewed.

The audit was based on the risk of financial loss or reputational risk through weak fraud prevention, identification, reporting and investigation processes.

The objectives of this audit were to ensure:

- The Trust has in place appropriate anti-fraud policies and procedures to include fraud awareness, detection, prevention and investigation / response
- The Trust actively promotes fraud awareness and zero tolerance amongst staff and service users.
- The Trust has systems in place to identify fraud risk areas and controls and / or actions to mitigate those risks.
- Reported cases of alleged / potential fraud are appropriately investigated by the Trust in a timely manner.
- There is a formalised relationship with BSO Counter Fraud and Probity Services.
- There is appropriate governance arrangements are in place within the Trust.

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

Level of Assurance

Satisfactory

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

Executive Summary

Internal Audit can provide satisfactory assurance in relation to Fraud Processes within the Trust. Satisfactory assurance has been provided on the basis that appropriate anti-fraud policies and procedures are in place. Testing found when potential frauds were identified they were promptly reported to the FLO and subsequently to CFPS and investigated appropriately as per the Trust's Fraud Response Plan. Fraud awareness is promoted throughout the Trust through ongoing training provided by the FLO and CFPS which is targeted at specific teams etc. More than 3000 staff have undertaken the fraud e-learning module in the past 3 years. The FLO has well established links with HR teams (who lead on whistleblowing & disciplinary processes) and the Adult Safeguarding Team (vulnerable adults processes). There is a positive working relationship between the Trust and Counter Fraud Services, and regular reporting on fraud cases to the Audit Committee.

There are no significant findings in this report that impact on the assurance provided.

The key finding of the audit is:

1. The FLO has fostered good working relationships with Human Resources and Adult Safeguarding Teams who lead on related investigations, although this was not evident with directorate governance teams. While the Director of Finance (DoF) and the FLO have provided all directorates with overarching generic Fraud Risk Assessments and guidance, there is limited evidence that Directorate Governance Teams have utilised this information to identify and assess specific fraud risks to meet their own needs and to take ownership of the process.

Other findings include:

2. Under the Fraud Risk Assessment Action Plan 2018/19 an Anti- Fraud Checklist raising awareness of all the Trust's anti-fraud and financial governance policies was circulated to all directors in November 2018. This had not been followed up with directorates since 31 March 2019 as confirmation that it was issued to all staff.
3. The Gifts, Hospitality and Sponsorship Policy and the Conflicts of Interest Policies are both overdue for review.
4. The FLO has not had any recent specific training in the area of fraud.
5. The Partnership Agreement between the SHSCT and BSO Counter Fraud Services has not been renewed and signed since 2017.
6. Currently the Trust does not utilise social media platforms to promote anti-fraud awareness and prevention.

Summary of Findings and Recommendations

Finding		Number of Recommendations		
		Priority 1	Priority 2	Priority 3
1.	Identifying and Assessing Fraud Risks within Directorates	-	1	2
2.	Completion of the Anti-Fraud Checklist	-	1	-
3.	Policies & Procedures	-	-	1
4.	Fraud Liaison Officer (FLO) Training	-	-	1
5.	CFPS Partnership Agreement	-		1
6.	Promotion of Anti-Fraud Culture	-	-	1

Detailed Findings and Recommendations

1 Identifying and Assessing Fraud Risks within Directorates

Finding

During the audit it was noted that there were good working relationships between the Fraud Liaison Officer (FLO) and other departments, including the Safeguarding team, the Whistleblowing Oversight Group and Human Resources staff. However there has been no regular feedback to the FLO from the directorate governance teams who work within the various service directorates in relation to progressing the first objective of the Fraud Action Plan 19/20, which is:

'Progress the Trust FRA Directorate work programme to include promotion at directorate Governance and SMT groups; collation of the FRA templates and Action Plan responses; sharing of best practice and planned update on FRA for 20/21.'

While the DoF and FLO have provided all directorates with overarching generic Fraud Risk Assessments and guidance and the FLO has attended Directorate Governance meetings to launch and promote FRA programmes, there is limited evidence that Directorate Governance SMT have utilised this information to consider specific fraud risk areas within their directorate and tailor Fraud Risk Assessments to meet their own needs in order to take ownership of the process, as required within the Fraud Action Plan 19/20.

The FLO does not receive regular reports produced from DATIX from Directorate Governance Teams of incidents which may have potential fraud implications.

While regular updates to the FLO on cases with potential fraud implications are provided by the Safeguarding team, the Whistleblowing Oversight Group and Human Resource due to the close working relationships, these are not formally reported to the FLO through DATIX or other sources.

A similar issue was previously reported in finding 2 of the 2018/19 Risk Management Report

Implications

All fraud risks may not be identified and fully documented.

Directorates may fail to learn from previous fraud cases.

Recommendation 1.1	The FLO should attend a minimum of one Governance SMT meeting annually within each operational directorate to promote fraud prevention and to assist directorates further develop utilisation of the generic fraud risk assessments (FRAs) previously issued to identify and assess specific fraud risks. Review of FRAs should become a standing item on agendas for Directorate and Divisional SMT Governance meetings.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Fraud Liaison Officer (FLO)
Implementation Date	June 2020

Recommendation 1.2	The FLO should receive a report produced from DATIX, filtered to identify all financial incidents and or losses for each directorate for review each quarter.
Priority	3
Management Action	ACCEPTED
Responsible Manager	Fraud Liaison Officer (FLO)
Implementation Date	June 2020

Recommendation 1.3	The FLO should explore with HR and the Safeguarding Teams how the timeliness of reporting from these teams to the FLO can be improved.
Priority	3
Management Action	ACCEPTED
Responsible Manager	Fraud Liaison Officer (FLO)
Implementation Date	June 2020

2 Completion of the Anti-Fraud Checklist

Finding

Under the Fraud Risk Assessment Action Plan 2018/19 an Anti- Fraud Checklist raising awareness of all the Trust's anti-fraud and financial governance policies was circulated to all directors in November 2018. This had not been followed up with directorates since 31 March 2019 as confirmation that it was issued to all staff.

Implications

Incomplete assurance that all staff are aware of their personal requirements as per the Trust's anti-fraud policies and financial governance policies.

Recommendation 2.1	As part of annual meetings with directorate governance teams (see recommendation 1.1) the FLO should promote the use of The Anti-Fraud Checklist as a key tool in delivering awareness of the Trust's anti-fraud policies to all staff within the directorates. An annual reminder should also be issued by the FLO to each Director to promote the use of use of The Anti-Fraud Checklist across their directorate.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Fraud Liaison Officer (FLO)
Implementation Date	June 2020

3 Policies and Procedures

Finding

On review of the main policies related to fraud awareness, which are noted in the introduction, Internal Audit found that for two of the seven the review dates had passed.

Gifts, Hospitality and Sponsorship Policy - This was last reviewed in February 2016 and was due for review in February 2019.

Conflicts of Interest Policy - This was last reviewed in December 2015 and was due for review in December 2017.

Implications

Policies and Procedures not regularly reviewed will not be reflective of the current arrangements. This can lead to confusion over responsibilities etc.

Recommendation 3.1	The Gifts, Hospitality and Sponsorship Policy and the Conflicts of Interest Policy should be updated and amended to reflect best practice and any changes and re issued to staff as soon as possible.
Priority	3
Management Action	ACCEPTED
Responsible Manager	Assistant Director of Finance (ADOF)
Implementation Date	March 2020

4 Fraud Liaison Officer (FLO) Training

Finding

The FLO has not had any recent specific fraud training. In the past she has attended CIPFA awareness training.

We were informed that the CFPS are to co-ordinate regional training for all the FLOs, which is to be Northern Ireland specific, and will include input from the Police Service Northern Ireland and Public Prosecution Service.

Implication

Non development of FLO role and opportunities to maximise fraud promotion, advisory and reporting services.

Recommendation 4.1	The Trust should liaise with CFPU (as the regional fraud specialists) with a view to developing specific training for all the FLOs across the region.
Priority	3
Management Action	ACCEPTED
Responsible Manager	Assistant Director of Finance (ADOF) and Fraud Liaison Officer (FLO)
Implementation Date	June 2020

5 CFPS Partnership Agreement

Finding

The Partnership Agreement between BSO CFPS and SHSCT, was signed by DOF SHSCT and AD CFPS BSO) in March 2017. It was effective from the 1 January 2017 and was to be reviewed annually. The Partnership Agreement has not been updated since then.

Implication(s)

Potential for dispute between parties to the agreement if it is not regularly updated as per review schedule.

Recommendation 5.1	The Trust should address with BSO CFPU the need to review and update The Partnership Agreement between both organisations.
Priority	3
Management Action	ACCEPTED
Responsible Manager	Assistant Director of Finance (ADOF)
Implementation Date	30 June 2020

6 Promotion of Anti-Fraud Culture

Finding

Currently the Trust does not utilise any form of social media to raise fraud awareness. We observed that the Trust has a twitter feed and a Facebook page.

Implication

Non-utilisation of new technology to maximise promotion opportunities for fraud awareness and prevention with staff and public.

Recommendation 6.1	The FLO should liaise with the Trust's Communication Team to consider opportunities to develop the use of social media platforms to assist in the area of anti-fraud awareness.
Priority	3
Management Action	ACCEPTED
Responsible Manager	Fraud Liaison Officer (FLO)
Implementation Date	30 June 2020

Appendix A - Definition of Levels of Assurance and Priorities

Level of Assurance

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

Recommendation Priorities

Priority 1	Failure to implement the recommendation is likely to result in a major failure of a key organisational objective, significant damage to the reputation of the organisation or the misuse of public funds.
Priority 2	Failure to implement the recommendation could result in the failure of an important organisational objective or could have some impact on a key organisational objective.
Priority 3	Failure to implement the recommendation could lead to an increased risk exposure.

Note to Report

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

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**Minutes of a meeting of the Audit Committee held on
Thursday, 6th February 2020 at 9.30 a.m. in the Boardroom,
Trust Headquarters**

PRESENT:

Mrs H McCartan, Non-Executive Director (Chair)
Ms E Mullan, Non-Executive Director
Mr J Wilkinson, Non-Executive Director

IN ATTENDANCE:

Ms H O'Neill, Director of Finance, Procurement and Estates, SHSCT
Mr B Beattie, Acting Director of Older People and Primary Care, SHSCT *(Item 6i only)*
Mrs M McClements, Interim Director of Acute Services, SHSCT *(Item 6i only)*
Mrs V Toal, Director of Human Resources and Organisational Development,
SHSCT *(Item 6i only)*
Mrs C Cassells, Assistant Director of Finance, Financial Management, SHSCT
Mrs A Rutherford, Assistant Director of Finance, Financial Services, SHSCT
Mrs F Jones, Corporate Financial Accountant/Fraud Liaison Officer, SHSCT
Ms J McCaw, Assistant Head of Internal Audit
Ms H Crilly, Senior Internal Auditor
Ms R Marsden, Grant Thornton
Ms L Murphy, Northern Ireland Audit Office (NIAO)
Mrs S Judt, Board Assurance Manager, SHSCT
Mrs S McCormick, Committee Secretary, SHSCT (Minutes)

APOLOGIES

Mr M McDonald, Non-Executive Director
Mrs S Rooney, Non-Executive Director

1) CHAIR'S WELCOME

Mrs McCartan welcomed everyone to the meeting and in particular she referred to Ms Marsden, attending her first Audit Committee on behalf of external auditors, Grant Thornton and likewise, Ms Crilly accompanying Ms McCaw, Internal Audit. At this point, Mrs McCartan

reminded members of their responsibilities in keeping with Board etiquette. She asked that mobile phones are turned to silent and laptops are to be used for accessing Audit papers only during the meeting.

2) DECLARATION OF INTERESTS

Mrs McCartan asked members to declare any potential conflict of interests in relation to items on the agenda. None were received and the business of the meeting proceeded.

6) INTERNAL AUDIT

i) INTERNAL AUDIT PROGRESS REPORT (6 Reports)

Fraud Processes 2019/20 – Satisfactory

A Satisfactory level of assurance was provided on the system of internal control in relation to Fraud Processes within the Trust on the basis that appropriate anti-fraud policies and procedures are in place. Testing identified that suspected fraud cases were reported to the Fraud Liaison Officer (FLO) and subsequently to the Counter Fraud and Probity Services (CFPS) in a timely manner and investigated appropriately as per the Trust's Fraud Response Plan. Overall, positive working relationships were displayed between the Trust and Counter Fraud Services and regular reporting on fraud cases evidenced through to the Audit Committee. Training in fraud awareness throughout the Trust is also well established. The exercise evidenced no significant findings, however some strengthening was required in terms of working with Directorate Governance teams to further develop use of the generic fraud risk assessments (FRAs). Two Priority 2 and Six Priority 3 recommendations were identified.

Ms O'Neill welcomed the outcome of the report. She stated that the FLO attends at least one Directorate Governance SMT meeting annually to promote fraud prevention and give advice on FRAs. Ms O'Neill commended the significant work undertaken by Mrs Jones in her role as FLO and pointed out this work was set to increase, particularly in terms of Whistleblowing cases.

On behalf of Committee members, Mrs McCartan welcomed the outcome of the IA report and noted thanks to the FLO.

Minutes of a Virtual Confidential Meeting of Trust Board
held on, Thursday, 22nd October 2020 at 9.25 a.m.

PRESENT

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

IN ATTENDANCE

Mr B Beattie, Acting Director of Older People and Primary Care
Dr D Gormley, Deputy Medical Director (deputising for Dr O'Kane)
Mr B McNeany, Director of Mental Health and Disability Services
Mrs M McClements, Director of Acute Services
Mrs A Magwood, Director of Performance and Reform
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs J McKimm, Head of Communications
Mr E McAnuff, Boardroom Apprentice
Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES

Mr M McDonald, Non-Executive Director
Dr M O'Kane, Medical Director
Mr Ajay Mirakhur, CPANI/QUB Mentee

1. CHAIR'S WELCOME

The Chair welcomed everyone to the virtual meeting.

2. DECLARATION OF INTERESTS

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. There were none declared.

3. MINUTES OF PREVIOUS MEETING

The Minutes of the meeting held on 24th September 2020 were agreed as an accurate record and duly signed by the Chair.

4. MATTERS ARISING**i) Message of gratitude to staff from the Chair and Non Executive Directors**

The Chair agreed to consider the issue of a message via global email from herself and the Non Executive Directors to express their gratitude to staff for their hard work and commitment during the past eight months.

Action: Chair

5. MUCKAMORE ABBEY HOSPITAL – REPORT OF THE INDEPENDENT LEADERSHIP AND GOVERNANCE REVIEW

The Chief Executive stated that it was important for Trust Board to take the opportunity to reflect on the learning from this report. Members agreed that this would be the focus at a Board Workshop in early 2021.

Mr McNeany gave a short presentation on the main themes. He stated that the Trust had not been waiting on the issue of this report and had already implemented many of the findings around safeguarding, leadership and a number of practice based improvements, particularly around the use of seclusion.

There was a short discussion with regards to leadership and governance arrangements in the context of Trust Board. The following five key questions for Board members to consider at the Workshop were agreed as:-

1. Does Trust Board show 'a lack of curiosity'?
2. Is there a disconnect between governance processes and structures and safeguarding?
3. Is Trust Board using the Delegated Statutory Functions report correctly?
4. Learning Disability targets – are they the right targets for Performance Committee to monitor?
5. Is there effective escalation of issues to Trust Board?

Culture was discussed in which Mr McNeany advised that the Review Team considered that *'the problem was not in governance, but rather in people's response to working in a closed environment, with its own set of norms and values and with loyalty to the group rather than the patients or their employing Trust'*. In relation to this, Mrs McCartan raised the fact that vulnerable patients and their families were failed by a hospital which operated as a place apart, out of the line of sight of the Trust. She asked what assurances does Trust Board have in this regard and requested that this issue also be examined at the Board Workshop.

Directors gave examples of governance and leadership approaches across their Directorates including senior leadership walks. They recognised the need not to be complacent and welcomed the Workshop as an opportunity for Trust Board to examine potential blind spots across the Trust.

Action: Focus of Board Workshop on 25th February 2021

6. i) COVID-19 UPDATE

The Chief Executive provided a verbal update. He spoke of the escalating pressures on the hospital system due to the continued and sustained community transmission of Covid-19. He stated that inpatient demand had now exceeded that of the first phase with 77 Covid positive inpatients as at 20.10.20 compared to a peak of 63 in the first phase. Members discussed the potential risk of spread in the acute hospitals given the limited side room capacity which limits the Trust's potential to respond adequately to Covid-19. The Chair particularly raised her concern about the potential risk of spread in the

overcrowded Emergency Department at Craigavon Area Hospital. Mrs McClements acknowledged that the biggest risk period was between the swab test and the result and she spoke of measures in place such as more fast swabs, optimising community care and discharge, promoting safety in hospital flow etc.

ii) SAI Outbreak

The Chief Executive reported that the Panel Chair has given a commitment to feedback any immediate learning to the Trust. An early learning report has been produced and shared. Mrs McClements highlighted three key learning points; i) communication with families and relatives; ii) restricting visiting and iii) looking after staff.

7. UPDATE ON CLINICAL CONCERNS WITHIN UROLOGY

The Chief Executive informed members of discussions with the Department in relation to an intended statement by the Minister for Health to the NI Assembly. The Trust has advised that a public statement at this stage would be premature as the Trust has not completed a review of processes to the detail it requires. The Chief Executive therefore sought Trust Board approval to request a delay in the Ministerial announcement.

Members discussed the fact that there is likely to be significant media interest in this case with the potential for significant reputational risk to the Trust. Members emphasised the Trust's duty of care to patients and the importance of the Trust completing its investigative work to ensure that the information it provides is complete and accurate.

Dr Gormley spoke to a report which provides 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. He reminded members that Early Alerts submitted to the Department of Health have been part of this process advising them of the professional performance and patient safety concerns. Dr Gormley advised that in relation to the SAI process, the Panel Chair has been appointed as well as a Subject Matter Expert.

He informed members of an issue that has recently arisen regarding the Consultant's prescribing of the medication Bicalutamide which appears to be outside established NICE guidance. A review is underway to identify patients receiving this treatment.

The Chair advised that Consultant A had written to herself in June 2020, the content of which she had shared with the Non Executive Directors in which Consultant A raised concerns at how the HR processes were being managed and requesting that his formal grievance and its included Appeal are addressed. The Chair was advised that this matter was being progressed through HR processes. The Chair also raised the fact that a number of different Urology Consultants had been in place over the years and asked why they had not raised concerns about Consultant A's practice and similarly, why had his PA not raised concerns regarding some delays in dictation of patient discharges. The Chair also asked should a GP not have recognised the prescribing of Bicalutamide as an issue?

Dr Gormley stated that patients remained under this one Consultant's care and this will be examined under the SAI process. The Chair then asked about Consultant A's appraisals and asked if performance issues had been identified through this process and if so, were professional development and training needs then identified. Dr Gormley advised that Consultant A's appraisals were also part of the review process.

In terms of systems and processes, Mrs McClements spoke of the SAI process since 2016 when a robust action plan was put in place at that time to address such issues as triaging, communication etc. and the work since June 2020 to scope and review the patient records of Consultant A's cases. Mr McAnuff noted that when performance issues were identified, additional measures were put in place and asked if these additional measures had not effected positive change, what further controls would need to be put in place should there be concerns raised about other Consultants. Mrs McClements referred to the query as to whether such clinical concerns could happen elsewhere and she advised that the Trust required more time to conduct its review and scoping exercises.

In response to a question from the Chair as to whether one Consultant Urologist reviewing the patient files was sufficient, Mrs

McClements provided assurance that in addition to Mr Mark Haynes' involvement, there is some clinical nurse specialist input and the Head of Service is involved in reviewing systems and pathways. She referred to the multi-disciplinary aspect of this work as detailed in the paper. In addition, there has been Independent Sector Consultant sessions reviewing oncology patients and Subject Matter Experts engaged as part of SAI process.

Mr Wilkinson stated that this was a complex case with various strands. He advised that whilst he supported the Trust's request for a delay in a Ministerial announcement, it was important that this was not a prevaricated delay.

Ms Donaghy referred to this case coming into the public arena and asked about natural justice and Consultant A's right of reply. She raised her concern at the issues Consultant A had raised in his grievance around his appraisals, pressure of work etc. and she asked that these are addressed as part of any review. Mrs McCartan restated the importance of the Trust releasing information only when it is assured it is accurate. Mrs Leeson highlighted the importance of due process being followed with SAIs completed as a priority to ensure learning from this case for the benefits of patients.

Following discussion, the consensus view of Trust Board was to approve the Trust's request to seek a delay in the Ministerial announcement. Members emphasised the importance of a robust timeline to conclude the review processes. It was agreed that following the Trust Board meeting, the Chief Executive would informally advise the Department of Health of the Trust Board's decision followed by a formal letter.

Action: Chief Executive

8. FINANCE REPORT

Ms O'Neill presented the Finance report for the 6 months ending 30 September 2020. Ms O'Neill reported a deficit at month 6 of £1.6m and advised that this position assumes that full funding will be secured for the cost of Covid-19 incurred to date at a value of £24m and that Transformation funding will be received for all schemes

supported by DoH to continue with the exception of the known pay pressure associated with 20/21 Pay uplifts.

Ms O'Neill advised that the Finance Directorate, as per normal practice, is carrying out a mid-year hard close. The purpose of this is to give assurance that all significant cost and income activities are being properly accounted for. Mrs McCartan referred to the challenge to produce a financial plan that will enable the Trust to achieve a break-even outturn at year end. Ms O'Neill responded by advising that the predicted year-end deficit was now £5.4m, a revision downwards from the original deficit predicted of £7m, and is a combination of marginal additional income, increased in year unplanned expenditure benefit as a direct result of the suspension of services as part of our Covid-19 response and further in year natural slippage on demography. She further advised that the outcome of the mid-year hard close will be used to prepare a detailed forecast year-end position and this position will be kept under close scrutiny in the coming months.

SIGNED: _____

DATED: _____

BOARD REPORT SUMMARY SHEET

Meeting: Date:	Trust Board - Confidential
Title:	Clinical Concerns within Urology – Southern Trust
Lead Director:	Dr Maria O'Kane Melanie McClements
Purpose:	Update
<u>Key strategic aims:</u> Safe and Effective Care	
<u>Key issues/risks for discussion:</u> This report is an update to the report that was shared at the September Confidential Board meeting, this report was shared with the Department of Health on the 14 th October. It 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.	



Report to Department of Health on Consultant A

Date:	14 October 2020
Title:	Clinical Concerns within Urology – Southern Trust
Lead Directors:	Mrs Melanie McClements – Director of Acute Services Dr Maria O’Kane – Medical Director
<u>Key Strategic aims:</u> Delivery of safe, high quality effective care	
<u>Key Issues/risks:</u> 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. Consultant A is no longer employed as of 17th July 2020, having given his notice of his intention to retire from his substantive post. The Trust declined his request to return given outstanding employment matters relating to a previous MHPS case commenced on 30th December 2016. Any patients identified where clinical concerns have been raised will be reviewed and followed-up. Due to capacity issues there is likely to be impact on other patients who are awaiting urological appointments/follow up. Plans have been put in place to respond to primary care colleagues and to establish a targeted help line for patient concerns.	

Background

On 7th June 2020, the Trust became aware that 2 out of 10 patients listed for surgery under the care of Consultant A were not on the hospital's Patient Administration System at this time. As a result of these potential patient safety concerns a review of Consultant A's work was conducted to ascertain if there could be wider service impacts.

As a result of these potential patient safety concerns a review of Consultant A's work was conducted to ascertain if there were wider patient safety concerns and service impacts. The internal reviews, which considered cases over an 18 month period (period 1st January 2019 – 30 June 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 160 emergency patients listed as being taken to theatre. 3 patients had not had their stent management plans enacted. Clinical Management has been subsequently arranged for these 3 patients.
- The second internal review was for 343 elective-in patients taken to theatre. Out of the 343 patients reviewed there have been **2 of these patients who have been identified as meeting the threshold of needing a Serious Adverse Incident Review.**

The following areas have been identified that immediately need to be reviewed and actions taken on these patients to mitigate against potentially preventable harm

1. **Jan 2019- June 2020** - Pathology and Cytology results: 168 patients with 50 patients needing reviewed. From this there has been **3 confirmed SAI with a further 5 requiring a review follow-up** to determine if they have come to harm.
2. This exercise has also now identified concerns of clinical practice in the prescribing of Bicalutamide drug has revealed examples of poor practice, delay in following up the recommendations from results/MDM's and delay in dictation to other health care professionals in the ongoing care and treatment of the patients. The full extent of this is not yet clear.
3. **Jan 2019- June2020** - Radiology results –1536 patients listed on NIECR. These patients may have had the results manually signed off and actioned but as we have identified cases where this hasn't happened we need to review all of these records to reassure ourselves that these have all been actioned. This exercise is ongoing.
4. **Jan 2019-July 2020** - MDM discussions – there are 271 patients who were patients of Consultant A and who were discussed at MDM, a review of these patient records is being undertaken. There are currently **2 confirmed SAI's and a further 2 needing a review follow-up** to determine if they have come to harm. This exercise is ongoing.

5. **Oncology Review Backlog** – 236 review oncology outpatients will be seen face to face by a retired Urologist in the independent sector. This consultant will either discharge or make appropriate plans for ongoing management and referral back the Southern Trust Urology Team MDM for further review/management. (Note 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).
6. **Patients on Drug “Bicalutamide” (raised in point 2 above)** - *this 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 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 provide a review to ascertain if the ongoing treatment with this agent is indicated or if an alternative treatment / management plan should be offered.

Summary table of Serious Adverse Incidents

Element of Concern
MDM *RIP ** was diagnosed with locally advanced prostate cancer in August 2019. An MDT discussion on 31 October 2019 recommended androgen deprivation therapy (ADT) and external beam radiation therapy (EBRT). ** was not referred for EBRT and his hormone treatment was not as per guidance. In March 2020 ** PSA was rising and when restaged in June 2020 ** had developed metastatic disease
Review Op Backlog In May 2019 ** had an assessment which indicated he had a malignant prostate. ** was commenced on androgen deprivation therapy (ADT). Reviewed in July 2019 in outpatients and planned for repeat PSA and further review. Patient lost to review and attended Emergency Department in May 2020. Rectal mass investigated and diagnosed as locally advanced prostate cancer
Elective Exercise ** had a follow up CT scan of chest abdomen and pelvis performed on 17 December 2019 which was reported on 11 January 2020. The indicate for this was restaging of current renal cell carcinoma. ** had a right

radical nephrectomy March 2019. The report noted possible sclerotic metastasis in L1 vertebral body. Result was not actioned. Patient contacted with result on 28 July 2020 and further assessment required
Elective Exercise Patient underwent TURP on 29/1/20. Pathology reported incidental prostate cancer. No follow-up or action from pathology result until picked up from elective exercise
MDM CT renal report of 13/11/2019 unsigned on NIECR. No record of action taken recorded in NIECR. Case identified at urology MDM of 3/9/2020 following review of backlog
Pathology Patient diagnosed with prostate cancer Gleason 7. MDM 08/08/19- Significant Lower urinary tract symptoms but declined investigations. On maximum androgen blockade - No onward oncology referral was made.
Pathology Diagnosed with penile cancer, recommended by caner MDM for CT scan of Chest, Pelvis and Abdomen to complete staging. Same delayed by 3 months.
Pathology Patient diagnosed with a slow growing testicular cancer (Seminoma) had delayed referral to oncology and therefore delay in commencing chemotherapy.
MDM/ Bicalutamide (**RIP) MDM outcome not followed and inadequate treatment given. MDM outcome = commence LHRHa. Started on low dose of bicalutamide (unlicensed and sub-therapeutic dosage), subsequently represented with local progression January 2020 and appropriate treatment (Degeralex) was given along with TUR and stent / nephrostomy. The evidence for LHRHa in context of metastatic disease is that it reduces the risk of local progression (renal failure and spinal cord compression). This man had inadequate treatment and experienced a complication likely as a result of this.

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. This doctor is already known to the GMC.
- In consultation with NHS Resolutions and the GMC, from discovery until the date of termination of contract, restrictions were placed by the Trust on the Consultant's practice. Consultant A was to no longer undertake clinical work and could 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 by the Southern Trust since the 29th July 2020, the Responsible Officer authority has now passed to the GMC. Consultant A has asked for all correspondence through his solicitor, Tughan and Company, Belfast. In keeping with the Regional Guidance, Health and Social Care Board, Procedure for the Reporting and Follow up of Serious Adverse Incidents (November 2016), the Trust together with the PHA and the Board has facilitated the establishment of a panel to undertake the Serious Adverse Incident Reviews identified in the course of reviewing Consultant A's patients. This is chaired by an independent Chair, with a Urology Consultant recommended by the Royal College of Surgeons as a Urology Subject Expert (from England).
- Early Alerts have been submitted to the Department of Health advising them of the professional performance and patient safety concerns.
- Two separate weekly meetings have been established since 11 August 2020
 - i. Internal oversight meeting - chaired by Director of Acute Services and Medical Director as Deputy Chair;
 - ii. External – Chaired by Director of HSCB with representatives from Trust, PHA, HSCB and Department of Health.

Preliminary discussions have 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 reviews

Timescales

Initial scoping exercises as outlined have been completed and initial reviews of aspects of Consultant A's work from January 2019 are underway as described. The Royal College of Surgeons has advised that any look backs required should be undertaken using a chronological and incremental approach, beginning with most recent first has been implemented. A resource plan is in development to identify clinical capacity for patient assessment and clinical management, information and communication; this will present significant challenges given the current workforce issues within the Urology speciality and in the context of an ongoing Covid 19 Pandemic

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 included in Appendix One.

Appendix One

Detail on Previous Concerns with timeline details

Previous concerns relating to Consultant A

Previous concerns were raised in relation to Consultant A in March 2016, and managed within the Maintaining High Professional Standards framework 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. 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 letters**
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 patients 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.
- **Patients' 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 the then Director of Acute Services Acute Directorate and the previous Interim 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 ULSI from 16 November 2016 following surgery and was due to return to work on 2 January 2017. An on-going Serious Adverse Incident (SAI) review within the Trust identified a Urology patient Patient 10 who with a poor clinical outcome because the GP referral was not triaged by Consultant A.

An SAI review 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 review 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 patient's letters (783 letters dating back to June 2015) who had not been triaged by Consultant A.

It should be noted that the issues of concern relating to patient Patient 10 were wider than the referral delay. It was considered 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 professional 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 review by late December 2016, the Trust's Medical Director determined that it was necessary to take formal action to address the concerns.

The 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
- there was concern that some of the patients seen by Consultant A had their clinical notes taken back to his home. As such these were then not readily available within the Trust secure systems. The clinical management plan for these patients was unclear, and may have been 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 aimed 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 a 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 under the terms of MHPS..

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. (There were a total of 288 casenotes returned and 668 patients identified as having had no dictation done following their clinical episode).

20 January 2017

During the period of the 4 week immediate exclusion period notified to Consultant A on 30 December 2016, Mr CW Clinical Director 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 [Personal Information redacted by the USI]. 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 NICE 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.

Quality care – for you, with you

GOVERNANCE COMMITTEE COVER SHEET

Meeting Date	16 th 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:

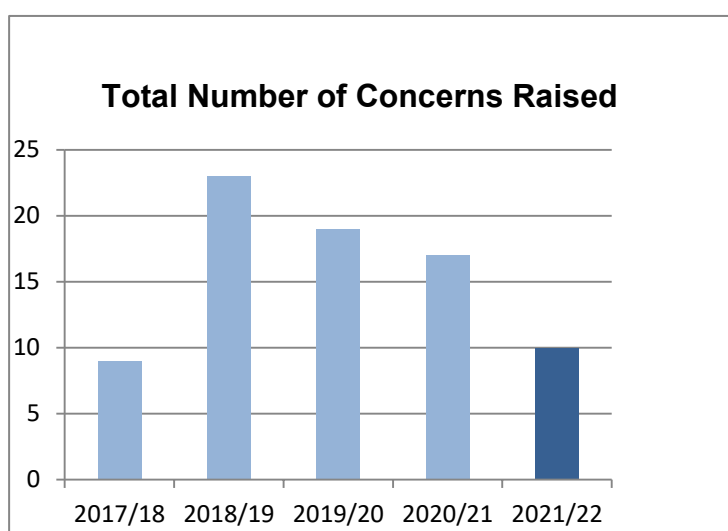
Corporate Risk Register	Links to People Risk
Board Assurance Framework	
Equality and Human Rights	

Raising Concerns (Whistleblowing)

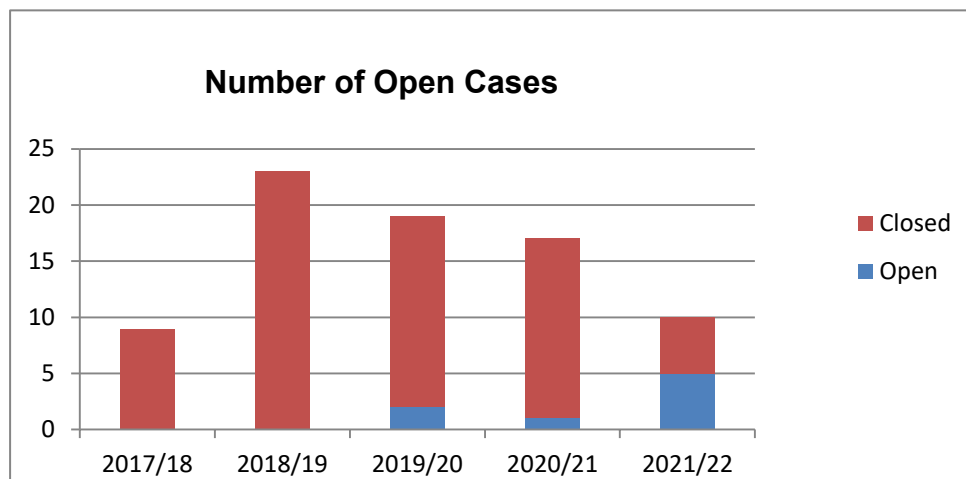
1.0 Case Review (April 2021 to September 2021)

- 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 Probitry 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 MHL.

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