An addendum amending this statement was received by the Inquiry on 15/01/24 and can be found at WIT-105947. An amended addendum was received on 16/01/2024 and can be found at WIT-106615 to WIT-106616. Annotated by the Urology Services Inquiry.

SCHEDULE

[No 105 of 2022]

Qualifications

1. Please set out all professional roles held by you and your qualifications.

Professional Roles		
Role	***Employer(s)***	***Dates***
Registered Nurse	*Various – See below*	*1974-1978*
Registered Midwife	*Royal Victoria Maternity Hospital*	*1979 -1980*
Ward Manager	*Royal Victoria Hospital (RVH)*	*1980- 1983*
Ward Manager	*Armagh City Hospital*	*1983-1985*
Registered Home Manager	*Manor Court Private Nursing Home, Dungannon*	*1985-1987*
Director of Nursing & then Chief Executive	*Sandown Private Nursing Home Group*	*1987 - 1997*
Managing Director	*Tamaris Healthcare (NI)*	*1997- 2002*
Managing Director	*Beneveagh Healthcare*	*2002 – 2005*
Non-Executive Director (NED)	*Armagh and Dungannon Health and Social Care Trust*	*1998-2002*
NED	*Southern Health and Social Care Board*	*2003-2007*
NED	*SHSCT*	*2007-2011*
Board Chair	*SHSCT*	*2011 -2020*
Board Member	*Southern Education and Library Board (SELB)*	*2001-2011*
Lay Panel Member *Courts & Tribunal Services*	*Care Tribunal*	*1998 -to date*

I have been open about that but would absolutely never try to use my position to influence others.

I feel more strongly about my professional reputation, my responsibilities as Chair of the Trust but most importantly about patient safety.
I really hope that there can be lessons learned and that measures can be taken to ensure that patient safety in a service isn't compromised by a systems failure again.

STATEMENT OF TRUTH

I believe the contents of this statement to be true.

Signed: Personal information redacted by the USI

SARAH ROBERTA BROWNLEE

Dated: 29/11/2022

NOTE:

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

Addendum Witness Statement of Roberta Brownlee

I, Sarah Roberta Brownlee, will say as follows: -

I wish to make the following amendments to my existing responses dated 29 November 2022, to Section 21 Notice number 105 of 2022

1. At WIT- 90872 para 28 I state that '*The second telephone call with Richard Pengelly was late September, again cannot recall the exact date and I did not take notes. This should state 'I cannot recall the exact date of the second phone call with Richard Pengelly and I did not take notes. I know that this call took place when I was at Silverdale Care Home. I accept, given the timeline provided by Shane Devlin and Richard Pengelly, that the most likely date this call occurred was 26 October 2020. I have checked my diary, and it confirms I was at Silverdale on that date.*
2. *At WIT-90874 para 29 I state that 'I attended the Board meeting on 22 October 2020. I had sent an earlier email to the NEDs and the CX explaining I planned to attend this meeting and declared my interest (Exhibit RB-02). The decision to attend was influenced by the second conversation I had with Richard Pengelly, in late September 2020, referenced to above at Q28. I was mindful of my obligations and accountability as Chair of the Board.*

   This should state 'I attended the Board meeting on 22 October 2020. I had sent an earlier email to the NEDs and the CX explaining I planned to attend this meeting and declared my interest (Exhibit RB-02). I was mindful of my obligations and accountability as Chair of the Board.
3. *At WIT-90884 para 42(i) I state that 'I attended the October 2020 Board meeting after having had a telephone call from Richard Pengelly (as referenced earlier) I sent an email to the CX and NEDs explaining why I was attending. I was not at the September meeting on this Urology item as Pauline Leeson Chaired this. As I have said above, Richard Pengelly phoned me in late September and then I attended the October meeting because of this phone call.*

   I now believe this timeline to be inaccurate and ask that this reference be removed from my S.21 responses.

12 November 2020

Your account number
Personal Information redacted by the USI

Your invoice number
Personal Information redacted by the USI

Your plan and extras period
12 November to 11 December 2020

Your usage period
12 October to 11 November 2020

vodafone

itemised usage

Mobile

Roberta Brownlee's mobile number redacted by the USI

UK calls

Date	Time	Phone number	Destination	Duration hh:mm:ss	Included?	VAT inc
Fri 23 Oct	09:53	Personal Information redacted by the USI	UK mobile	00:02:26	Yes	£0.000
Fri 23 Oct	11:04		Vodafone mobile	00:02:24	Yes	£0.000
Fri 23 Oct	11:07		Vodafone mobile	00:00:02	Yes	£0.000
Fri 23 Oct	11:10		Landline	00:00:04	Yes	£0.000
Fri 23 Oct	11:10		Landline	00:04:25	Yes	£0.000
Fri 23 Oct	11:43		Landline	00:14:08	Yes	£0.000
Fri 23 Oct	12:16		UK mobile	00:09:01	Yes	£0.000
Fri 23 Oct	12:35		Landline	00:01:49	Yes	£0.000
Fri 23 Oct	12:41		UK mobile	00:01:13	Yes	£0.000

UK calls

Date	Time	Phone number	Destination	Duration hh:mm:ss	Included?	VAT inc
Mon 26 Oct	10:12	Personal Information redacted by the USI	UK mobile	00:01:16	Yes	£0.000
Mon 26 Oct	10:16		Vodafone mobile	00:02:00	Yes	£0.000
Mon 26 Oct	10:21		Vodafone mobile	00:00:02	Yes	£0.000
Mon 26 Oct	11:37		UK mobile	00:07:18	Yes	£0.000
Mon 26 Oct	11:44		Vodafone mobile	00:05:18	Yes	£0.000
Mon 26 Oct	12:00		Landline	00:03:04	Yes	£0.000
Mon 26 Oct	12:04		Vodafone mobile	00:05:07	Yes	£0.000
Mon 26 Oct	13:21		Vodafone mobile	00:13:51	Yes	£0.000
Mon 26 Oct	15:17		Vodafone mobile	00:00:03	Yes	£0.000

The telephone call highlighted was a call from Roberta Brownlee to Richard Pengelly's mobile phone. Annotated by the Urology Services Inquiry.

Addendum Witness Statement of Roberta Brownlee

I, Sarah Roberta Brownlee, will say as follows:-

I wish to make the following amendments to my existing responses dated 29 November 2022, to Section 21 Notice number 105 of 2022

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2. *At WIT-90874 para 29 I state that 'I attended the Board meeting on 22 October 2020. I had sent an earlier email to the NEDs and the CX explaining I planned to attend this meeting and declared my interest (Exhibit RB-02). The decision to attend was influenced by the second conversation I had with Richard Pengelly, in late September 2020, referenced to above at Q28. I was mindful of my obligations and accountability as Chair of the Board. This should state 'I attended the Board meeting on 22 October 2020. I had sent an earlier email to the NEDs and the CX explaining I planned to attend this meeting and declared my interest (Exhibit RB-02). I was mindful of my obligations and accountability as Chair of the Board.*
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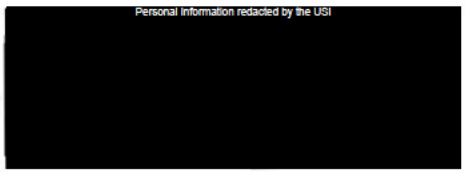
Signed: 

Dated: 16/1/2024

Qualification	***Institution***	***Date***
Postgraduate Diploma in Neurosurgical and Neuromedical Nursing,	*Royal Victoria Hospital*	*1983*
Masters in Executive Leadership	*University of Ulster*	*1996-1998*
Business Management and Culture of an Organisation	*Queen's University Belfast – Institute of Lifelong Learning*	*2002*

Role

2. Please set out the dates of your tenure as Chair of the Southern Trust Board and your duties and responsibilities in that role.

<u>Tenure</u>

I was appointed Chair of Southern Health and Social Care Trust (SHSCT) Board on 7 March 2011 and completed my first four-year term. I was re-appointed as Chair for a further four-year term from March 2015 to March 2019. I was further appointed and remained in this position until November 2020. I was asked to remain in post whilst new Chair was appointed but this appointment took longer than expected, so in March 2020 I was asked again to remain in post until a successor was appointed.

It is important to note that I was asked to stay on as there was no permanent Chief Executive in post from early March 2015 to Shane Devlin was appointed in March 2018. During this three-year period, I had four different Interim Chief Executives (one being off on Personal Information redacted by the USI *and then returned to post). Also contributing to my extension was the onset of the Covid Pandemic in February 2020. I recall asking the Department of Health (DoH) Permanent Secretary Richard Pengally on the telephone, (I didn't keep a note of this call but from recollection it was possibly Summer 2020 as I was Chair of a Consultants interview panel which was being held at the Seagoe Hotel),*

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SCHEDULE

[No 105 of 2022]

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Lay Panel Member *Courts & Tribunal Services*	*Care Tribunal*	*1998 -to date*

Lay Committee Member	*Abbeyfield Society*	*1997-2002*
Chair	*Macmillan Cancer, Craigavon Area Branch*	*No dates at hand c.1999- 2001*
Co – Founder of Craigavon Urological Research & Education Charity (CURE)	*Director & Committee member*	*CURE 2005 -2012*
Member of Board of Governors	*Three different schools (Primary, Post-primary, and Grammar)*	*2001 -2011*
Board Member and Deputy Board Chair	*Agri Food & Biosciences Institute (AFBI) Board*	*2016-2020 2020– to date*
Board Member	*Prison Service Pay Review Board (PSPRB)*	*2015-2019*
External Assessor for Performance and Staff Development of Principals in Controlled and Maintained Schools.	*Education Authority*	*2005-2011*
Director and Care Home Owner.	*Silverdale Care Home*	*2005 - present*

Professional Qualifications

Qualification	***Institution***	***Date***
Postgraduate Diploma in Neurosurgical and Neuromedical Nursing,	*Royal Victoria Hospital*	*1983*
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when the new Chair would be appointed as I was aware the interview process was completed and I had stayed on longer than expected. Richard Pengally told me on that call that interviews for my replacement had taken place and he would try and expediate the decision for the new Chair. I have recollection of telling Richard Pengally that I did not wish to be in post during the investigation into Mr O'Brien and my reasons for that.

Duties and Responsibilities

I had substantial responsibilities as the Chair of SHSCT *('the Trust') Board. I was accountable for the performance management of the Trust in its broadest sense; the effective and efficient use of resources, oversight, governance and accountability. The appointment of the Chief Executive and Senior Executive appointments. The performance management of the Chief Executive (CX) were all duties which fell under my remit.*

I adhered to Corporate Governance Codes of Conduct and Accountability.

I had the privilege to work with six Ministers of Health and two Permanent Secretaries during my tenure. My annual appraisal was completed formally and very effectively, and I was always commended for my work and had excellent outcomes signed off.

At no time during my time in office did any Chief Executive (CX), Member of Senior Management Team (SMT), Non-executive Director (NED), Minister of Health or Permanent Sectary ever speak to me about my work performance or raise any concerns about my conduct or work.

On the contrary, I was highly praised and received an MBE (New Year's Honours List 2019) for my services to SHSCT and my commitment to charity work in NI. I was awarded a Lifetime Achievement Award (2015) by Royal College of Nursing for my outstanding contribution to Health and Social Care.

CODE OF ACCOUNTABILITY

Status

1. HSC bodies are established under statute as corporate bodies, which means that they are separate legal entities. Statutes and regulations may prescribe the structure, functions and responsibilities of these bodies and may prescribe the way chairs and members of boards are to be appointed.

Statutory Accountability

2. The Health and Social Care (Reform) Act (Northern Ireland) 2009 provides the legislative framework within which HSC bodies operate. Under section 2(1) of the 2009 Act, the Department has a general duty to promote an integrated system of:
    - health care designed to secure improvement in the:
        - physical and mental health of people in Northern Ireland; and
        - prevention, diagnosis and treatment of illness, and
    - social care designed to secure improvement in the social well-being of people in Northern Ireland.

3. In terms of service commissioning and provision, the Department discharges its duty under section 2(1) of the Reform Act primarily by delegating its statutory functions to the Health and Social Care Board (HSCB) and by establishing bodies to exercise specific functions on its behalf. All these bodies are accountable to the Department for the manner in which they perform their devolved duties, manage their assets and for adherence to high standards of public administration. The Department is in turn accountable, through the Minister, to the Assembly for the manner in which this overall duty is performed.

4. Along with those of the Department itself, the finances of all HSC bodies are subject to statutory review by the Comptroller and Auditor General for Northern Ireland on behalf of the Assembly.

5. The boards of HSC bodies must cooperate fully with the Department, the Department's appointed auditors and the Northern Ireland Audit Office in accounting for the use they have made of public funds, the delivery of patient care and other services, and compliance with statutes, directions, guidance and policies of the Department.

The Board of Directors

6. The composition of the board of each HSC body is specified in its founding legislation. Typically, a board comprises executive board members, employees of the HSC body, and part-time non-executive board members under a part-time chair appointed by the Minister for Health, Social Services and Public Safety. Whatever its composition, board members share corporate responsibility for all decisions of the board. There is a clear division of responsibility between the chair and the chief executive. The chair's role and the board functions are set out below. The chief executive is directly accountable to the chair and non-executive members of the board for the operation of the organisation and for implementing the board's decisions. Boards are required to meet regularly and to retain full and effective control over the organisation. The chair and non-executive board members are responsible for monitoring the executive management of the organisation and are responsible to the Department for the discharge of these responsibilities.

7. HSC boards have corporate responsibility for ensuring that the organisation fulfils the aims and objectives set by the Department/Minister, and for promoting the efficient, economic and effective use of staff and other resources. To this end, the board shall exercise the following key functions:

SICKNESS ABSENCE & COVID ABSENCE

Key points / Priorities / Challenges

- Rebuild of Occupational Health & Wellbeing service following Covid-19. Referrals had to be triaged during pandemic due to diversion of resource to respond to Covid-19 Occupational Health advice and support.
- Case management reviews of each long term sickness absence case (both Covid-19 related and non Covid-19 related absence)
- Focus on returning remaining employees to the workplace who have been Covid-19 shielding is ongoing and nearing completion – using risk assessed approach
- Increase in numbers of pregnant employees who go off work at 28 weeks – challenges finding green areas for some professional staff.
- Occupational Health support for Long Covid-19 cases – these are complex cases
- Review of sickness absence management and procedural arrangements required post Covid-19

Headlines

Absence Type	2019/20	2020/21
Normal Sickness Absence	5.33%	5.79%
Absence due to Covid-19 Sickness & Self Isolation	0.22%	2.99%
Total Absence (Normal Sickness, Covid and Self Isolation)	**5.55%**	**8.78%**

Mental Health absence specifically **	2019/20	2020/21
% Hours Lost due to Mental Health Absences	1.83%	2.51%
Hours Lost due Mental Health Absences as a % of Normal Sickness Absence Only	34.40%	43.37%

	Dec-20	Jan-21	Feb-21	Mar-21
% Hours Lost – Mental Health specifically, in last 4 months of 2020/21	2.61%	2.47%	2.37%	2.01%

*** Coding categories for Mental Health absence are: Stress, Anxiety, Depression, Grief / Bereavement, Stress-work-related, Other Mental Health, Panic Attacks, Eating Disorder, Bi-polar, Insomnia, Bipolar Disorder, Eating Disorder, OCD, Self-harm, Psychosis*

Directorate	Number of Staff Absent due to COVID-19 (exc. Bank)		Number of Staff Absent due to Self-Isolation/Shielding (exc. Bank)	
	9 May 2021	16 May 2021	9 May 2021	16 May 2021
Acute	14	13	23	21
CYPS	4	5	3	4
HROD	1	1	0	0
MHDS	3	2	7	4
OPPC	17	19	3	5
P&R	0	1	0	0
Total	**39**	**41**	**36**	**34**

26 employees currently off with +Covid-19 / Covid-19 symptoms for 3 months or more. Longest absence is 440 days. Average length of absence is 163 days.

NI is linked in nationally with NHS Employers regarding developments on the management of cases associated with absence due to 'Long Covid'. A principle document is currently in development nationally regarding how absence related to Covid-19 should be managed. Full pay applies nationally currently. A joint approach in Northern Ireland has now commenced with Trade Union side regarding the management of cases where staff are off absent long term relating to Covid-19. There is no doubt this is a complex issue and there is much to be worked through from a support, assessment, treatment perspective, and also issues relating to terms and conditions.

Current waiting times for Occupational Health referrals are:
Consultant Physician – 4 weeks
OH Nurse – 2 weeks

STAFF HEALTH & WELLBEING SUPPORT

In addition to the previously reported staff support service during the pandemic, in order to respond to the psychological needs of staff Dr Lorraine McGurk, Consultant Clinical Psychologist for Staff Wellbeing, continued to accept referrals from OH colleagues and provided psychological assessment, consultation and intervention as part of the Occupational Health Service. Details of the individual clinical activity offered by Dr McGurk in the last financial year is as follows:

Total No of Referrals	Total Appts Offered	Total Discharges
30	*172*	*28*

A group-based therapeutic intervention was also offered as part of the Occupational Health Service. The 'Staff Wellbeing' group started in February 2021. It was offered on a weekly basis via zoom (due to infection control restrictions) to six members of staff referred to OHS for work-related distress. A compassion-focused therapy model was used in this therapeutic group. All participants reported increased understanding and knowledge of their emotional experiences and having learned how to manage their thoughts and feelings using approaches taught over the duration of the group.

Personal Information redacted by USI

Given the mental health absence rates, additional resources on a non–recurrent basis are required, and bids for non-recurring funding against E&G funding are currently being developed for consideration to seek to secure additional funding. No funding from region as yet with the exception of a pilot to commence in BHSCT with ICU staff.

In November 2020, three Psychological Therapists were recruited to the staff support team for a six month period using NHS charities funding. They came into post in January 2021, offering direct support specifically across the hospital sites within the Trust. A further bid may be possible to NHS charities funding, and this is currently being explored, however there are operational pressures in core services from which the 3 staff have been seconded from, so it will be a challenge going forward to maintain this level of resource as it is likely the staff will be required to return to their core roles.

Psychologists also delivered an outreach service to community based staff and services during the past year. The team have worked in conjunction with local services and the Promoting Wellbeing Team. The supports evolved and adapted based on the support needs of the teams. Group intervention acted as the main form of intervention for the community input. Community teams who received support included Primary Mental Health Team, Support and Recovery, Community Addictions Team, Podiatrists, Physiotherapists, Public Health Nurses, Physical Disability Team and School Nursing.

Review of Occupational Health & Wellbeing Services - HSC wide

SHSCT has led the development of Terms of Reference for a review of Occupational Health & Wellbeing Services – HSC Wide. This is a key action in the regional HSC Workforce Strategy. A review will support the obvious and pressing requirement to respond to the impact of the current pandemic on staff wellbeing, particularly psychological health of staff.

An evidence based review of occupational health and wellbeing within HSC would be consistent with and support the significant organisation change that HSC is likely to undergo, over the next few years.

The Terms of Reference are currently with the DOH for consideration.

members had a broad breadth of knowledge and skills. Our self-assessment brought this reassurance.

5. What, if any, training did you receive to assist you in carrying out your role as Chair of the Board?

I attended numerous training sessions during my tenure and as an experienced NED across a variety of sectors both in the Private, Public and Voluntary Sectors I gained a broad breadth of skills, knowledge and experience. I also had held Senior Executive positions spanning 25 years plus. I do not have specific details of the training sessions I attended.

I remember receiving training from the Institute of Lifelong Learning at Queen's University Belfast on what a good Board looks like, on Governance, Risk, Quality Assurance, Serious Adverse Incidents and associated learning. I completed a MSC in Executive Leadership which afforded me visits to Harvard and Lausanne Business Schools this involved Governance, Human resources, Business management and a wide range of high-quality opportunities.

6. Do you consider that the training provided to (i) you and (ii) other Board members was adequate in enabling you to properly fulfil your roles? Please explain your answer by way of examples, as appropriate.

Yes, I do. We were an effective Board - used as a role model – and the members had a broad range of expertise and experience. As detailed above, we completed yearly individual assessments on our own skills and weaknesses. Training needs were identified, and training was provided. We were a forward-thinking Board and had many innovative initiatives in place.

I introduced Leadership Walks to improve the Governance arrangements. We introduced at the start of each Board meeting "Good News or Innovative stories" this detail was shared by frontline staff. We invited four or five staff from each Directorate to the Board room for their own learning and to see how the Board operated. These

for identifying my strengths and weaknesses and where training might be required. There was always the option of completing the form anonymously too, and this was for the purposes of collecting honest feedback. Board members were always very supportive and responsive in this aspect.

Organising training for Board members

The Board Assurance Manager organised any training for Board members when needs had been identified from the analysis gathered, this was for both NEDs and for the Senior Management Team. I was always involved in the training that was required.

4. What, if any, training did Board members receive during your tenure? Please provide all dates and an outline of the purpose and nature of the training received.

I cannot remember dates, but the Board Assurance Manager would have notes and minutes of all these training records: Risk management and appetite for risk; What does a good Board look like; Governance; Culture and Openness to name but a few. All new NEDs had an induction which included a "buddy system", manual of information on Board Assurance documents, visits to every Directorate for on site learning with each Director. On going meetings with myself, the Board Assurance Manager and the Chief Executive as needs arose. I was responsible for NEDs training needs and the Chief Executive for the Senior Management Team (SMT) which flowed from their appraisal system and their monthly performance meetings with the Chief Executive. Then collectively all training needs that was specific to the Board training needs were planned and delivered.

I introduced away days for the Board (off site) for the purposes of reflection, self-assessment, critical analysis of how the Board operated each time it had meetings. External Speakers came on every occasion and the Permanent Secretary also attended on occasions. I felt that SHSCT was a highly skilled and effective Board and that

by Interim Chief Executive, Francis Rice; an introduction to each Directorate by the individual Directors; role of Committees delivered by Committee Chairs (responsible NEDs). MHPS training did not take place until 30th August 2017. I do not feel that MHPS equipped me to fulfil my role as a NED in the process. This continued to be an issue for the NEDs. Training delivered by Esther Gishkori, Director of Acute Services was poor. NEDs were brought to one of her staff meetings in Craigavon Hospital to observe. I complained to the Chair that this was not induction so a second Induction meeting was organised which Mrs Gishkori attended with one of her Assistant Directors. I continue to complete a number of mandatory e learning courses such as Fire Safety, Information Governance, Infection Control and Safeguarding as required. *Please see:*

8. January 2017 NED Induction Programme
9. Training Record - Pauline Leeson

6. Do you consider that the training provided to (i) you and (ii) other Board members was adequate in enabling you to properly fulfill your roles? Please explain your answer by way of examples, as appropriate.

6.1 NED induction training was basic. It included training on MHPS in August 2017. I felt that the training did not sufficiently inform or support me to fulfil the role as a non-medical person. After informal discussion led by John Wilkinson, NED, who had an ongoing complex case, we requested additional training which was delivered in December 2021. I still find the role of the NED in the MHPS process confusing and vague even though I have participated as a NED in 3 straightforward MHPS cases. My understanding is that the NED role is to ensure that the MHPS process is staying to a timeline and is not an advocacy role for the clinicians involved but it is unclear if it is a clinical process or a HR process. I also think myself and other NEDS would have benefitted from more training on Serious Adverse Incidents (SAIs). The Senior Leadership Team received training on SAI Framework in November 2019. *(please see (TRU 21459 – 21486*). The paper was circulated to NEDs in a Governance meeting for discussion on 13th February 2020 but we would have benefitted more from training in terms of understanding the process and what NEDs should be looking for when SAI reports come to the Governance Committee for scrutiny. However, it has only been since Dr O Kane became Medical Director and thereafter that information on MHPS has been collated and presented to the Governance Committee in a systematic way to improve learning. These reports outline the issue, what NED is involved, who is the clinical Investigator, the timescale and the outcome. It enables us to see trends/patterns and if there is delay.

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 3rd 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	30th June 2019

Recommendation	See recommendation 6.1

staff were frontline or middle management. I also invited Users to join the Board meetings.

In 2011 I set up a Patient and Client Experience Committee (Sub-Committee of the Board). This was Chaired by a NED and full membership included advocates, users of the service, and carers. This became one of the most powerful Sub-Committees of the Board on informing members of patient's experiences. From memory we won awards for this innovative committee through which we shared and learnt together.

Board

7. Please set out the frequency and duration of your engagement, and if different, the Board's engagement, whether formal or informal, with senior members of the Trust's management team, including the Chief Executive. Please provide notes and minutes of any of these engagements involving urology or Mr. O'Brien.

When I was in my office (approx. four days per week early am to late pm), I would have seen the CX most days. I met with the CX formally usually once per month, but this was subject to change due to busy work schedules. However, most days if myself and CX were both in the office we would have had informal chats and indeed had many cups of coffee together informally for updates.

My office was beside the CX and many of the directors were on the same floor. This was a small office space we had our own HQ canteen which we shared with the Clinical Education Centre (CEC). This allowed many opportunities to meet SMT informally. I only met with SMT on official Board meeting days. However, when a new Director was appointed as part of their induction, I always met with them. I have no notes of ever meeting with a SMT member formally and if informally no notes. My style of management being a "people's person" if the door were open of a director's office, I would always have spoken in to say even a hello. This was very well known my style. The same to all admin and office support staff who shared the same corridor and small

canteen area. I "walked the walk as well as talking the talk" - I was a visible Chair. I liked to meet all grades of staff and made time to stop and have a brief chat.

I never formally or informally discussed urology services or Mr O'Brien with any member of SMT.

In all my years as Chair I never met with Mr O'Brien formally and have no notes of any meeting.

I never remember any of the Urology Consultants speaking to me formally re Urology services. I knew many of the Urology staff, but none came to me formally. I would have visited the canteen often during my tenure and met many staff including staff from the Urology Dept, during my travels. No one ever spoke to me formally or informally about clinical issues about Mr O'Brien.

It was only when Dr Richard Wright (then Medical Director) walked into my office (2016/2017 year- when Francis Rice was Interim Chief Executive) to inform me that concerns that had been raised about Mr O'Brien. Dr Wright did not go into any detail of the concerns during that discussion (referred to later in my statement). Then, in July 2020, Shane Devlin Chief Executive came to my office and said there were concerns being investigated regarding Mr O'Brien. Shane mentioned it was to do with storage of patients records not having been triaged and followed up in a timely manner. No further detail from my recollection was shared at that time.

No other member of the SMT, any other Urology staff ever raised any concerns with me formally or informally. The Leadership walks from my recollection had not picked up any Urology clinical concerns.

8. How is the Board informed of concerns regarding patient safety and risk?

Normally concerns regarding patient safety and risk would be brought to the attention of the Board via the CX or relevant SMT member to the Confidential Governance meeting or the Confidential Board meeting. The Governance Committee is a sub-committee (delegated schemes to Sub Committees) of the Board and Chaired by a NED. Meetings were held every three months.

	One weakness, from a personal reflection, is that during my early tenure the relationships between me and the Chair, Roberta Brownlee (whose tenure ended in November 2020, were not as strong as they could have been. Outside of public Trust Board meetings we had clashed a small number of times on the difference between the roles of a Chief Executive and a Chair. In my opinion, given the lack of consistency of personnel in the Chief Executive post prior to my tenure, the Chair had understandably become more involved in the operational delivery of the Trust. As the new Chief Executive, I found her approach 'overreaching' and in many cases unhelpful. On reflection, I know that this imperfect relationship may have had an impact on the functioning of the Board and I know, through discussion, some members of SMT found the relationship with the Chair difficult at times. I have provided further understanding of this issue in question 69 In some cases I felt undermined by the Chair as she often chose to interact directly with the members of SMT outside of my knowledge.

Q69	**Was the Board, individually and collectively, motivated to address concerns regarding governance and clinical and patient safety as they arose within Urology Services or more generally? Did they always follow up on concerns raised? Were meetings conducted in an open and transparent manner? What was your experience of the Boards appetite for identifying concerns and implementing lessons learned?**
Response	In this answer I can describe my experience from my tenure. As to the period before my tenure, previous Chief Executives and Directors would be better placed to respond. As you can see from the examples given in response to question 23, there is no doubt in my mind that, during my tenure, the Trust Board invariably were open, transparent and challenging with regards to identifying concerns and implementing lessons learned. Specifically with regards to Urology, during my tenure when items were brought to Trust Board I did not feel that the conversation was quite as open as with other topics. On reflection, I would question the total commitment of the Chair of the Trust to be totally open with regards to her willingness to criticise Urology and, specifically, Mr O'Brien. At the confidential meeting of the Trust Board on the 22 October 2020, we tabled the details of the case so far and strongly debated the concerns with regards to Mr O'Brien. I have included a section of the minutes below *"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?"* I was left with the strong impression during the meeting that the Chair was advocating on behalf of Mr O'Brien, a feeling which was shared and relayed to me by a number of SMT colleagues. It was common knowledge amongst the Trust Board and the SMT that the Chair had previously been a patient of Mr O'Brien and that she was a personal friend. I felt aggrieved that the Chair had not declared a conflict of interest in the conversation at the Board meeting. I discussed my concerns with members of SMT and was considering what I should do. A few days later (I cannot recall the exact date as I did not note the time and date of the

Can you help us just with some examples of what you say were clashes on the difference between your role and hers?

A. Yes. The role of the Chair, for me, is obviously to have overall responsibility for the running of the Board and to be assured of the governance of the organisation. The job of the Chief Executive is to ensure the organisation delivers to its objectives within that framework.

It would not have been unusual for the Chair to have made direct approach to Directors to enquire about issues, to ask them to do certain things. An example of that, for example, we discussed yesterday Mrs. Gishkori and Mrs. Gishkori's exit from the organisation. In the background, unbeknown to me, the Chair was having conversations with Esther to try and encourage Esther to take the job that I was suggesting that we wanted to explore. It was this idea that the Chair had huge authority, huge power, had been in the organisation and its predecessor for potentially 16 years, I think probably, she was a Non-Executive Director in the predecessor and then became of the Chair of the organisation. In many cases I found that if I were to want a non-executive to work with me on anything, I had to formally request permission to do so. However, the Chair was more than willing and able to walk down the corridor and start to have conversations with executive directors about things

BOARD MEMBER'S ASSESSMENT OF THE CHAIR'S PERFORMANCE

Chair: ROBERTA BROWNLEE

Period of report: From 01/04/2018 To 31/03/2019

The following markings should be used to assess performance:

1 = Very effective 2 = Effective 3 = Partially Effective 4 = Not Effective

1. Attendance and commitment	
(a) Attendance at Board and other meetings	**Marking:** 1
2. Strategic leadership	
(b) Leads the Board effectively in setting the strategic direction of the Trust and ensuring the Trust's plans (and in particular, its statutory functions) are effectively delivered	**Marking:** 2
(c) Is visible within the Trust and is viewed as being accessible to Board Members and staff	**Marking:** 1
(d) Is alert to changes in the business needs of the Trust and ensures that these are communicated to Board Members and responded to, as appropriate	**Marking:** 1
(e) Leads the Board in holding management to account for performance through purposeful challenge and scrutiny, ensuring that good performance is recognised, and any under-performance is promptly addressed	**Marking:** 2

(f) Ensures that the principles of effective governance are known to, understood and practised by Board Members (NEDs & The Senior Management Team) individually and collectively	Marking: 1
(g) Ensures that the performance of the Board (and individual Committees) is reviewed regularly	Marking: 1
3. Builds effective relationships	
(h) Develops a mutually beneficial relationship with the Minister? and DoH Officials demonstrating a clear understanding of the Trust's and his/her responsibilities to both the Minister and Department	Marking: 1
(i) Develops an appropriate relationship with the Chief Executive and SMT (supportive yet challenging)	Marking: 2
(j) Promotes effective teamwork between Board Members and ensures that the Board operates as a cohesive team	Marking: 1
(k) Ensures that the Trust is well connected with its stakeholders and that any concerns or difficulties are addressed promptly and effectively	Marking: 1
4. Communication	
(l) Represents the Board and the Trust effectively with stakeholders	Marking: 1
(m) Has open and effective lines of communication (formal and informal) with Board Members and DoH and meets regularly with Chairs of Committees	Marking: 1

5. Chairing the Board	
(n) Ensures that the Board agenda, discussions and challenge at meetings are focused on strategy, performance (including financial), governance and compliance, corporate risks and feedback from stakeholders	Marking: 2
(o) Ensures that the Board receives and makes decisions based on high quality financial and performance information	Marking: 1
(p) Ensures that there is a culture of performance delivery and Board decisions are implemented promptly and effectively	Marking: 2
(q) Meetings are chaired effectively (start and finish on time; open debate encouraged; constructive challenge welcomed; conflict well handled; outcomes of discussions/decisions well summarised)	Marking: 1
Overall marking:	1
Comments	

Name of Board Member: SHANE NEVIN

Signature: [redacted] Personal Information redacted by the USI

Date: 4/9/19

A. I had hoped this document would be an opportunity for us to have a conversation about how we could improve that relationship.

151 Q. First of all, most of the -- it's a box?

A. Yes, it is. 1, 2, 3, 4.

152 Q. Most of your assessment of her is in the very effective or effective category; is that fair?

A. Yeah.

153 Q. If you scroll through it, just scroll down through it?

A. It is fair.

154 Q. I think there's a specific -- just scroll down, please. Keep going. Keep going all the way through it, please. Just stop there. Effective relationships specifically on a relationship with you developed an appropriate relationship with the Chief Executive and SMT, supportive yet challenging.

You've described it as effective?

A. In the context of the document, I had hoped, as I said before, I found it very difficult to give feedback to the Chair because feedback was not often accepted in the way it was meant. I had hoped that by calling out a small number of twos there would be a point of conversation that we could have around those and explore why I felt it wasn't the top mark. That may sound a little odd to you, but it was really important to have an opportunity to raise, not everything is perfect, and here are things I would wish we would discuss. That didn't happen in that way and that's the

undermined by the Chair as she often chose to interact directly with the members of SMT outside of my knowledge."

Please comment on what Mr. Devlin states in this paragraph indicating in which respect(s) you agree or disagree with it, and why? Please provide examples and all relevant details.

I was shocked to read these comments by CX Shane Devlin. I was under the impression that I had a very good working relationship with Shane. I never once recall "clashing with him" as he refers. We had many meetings formally and informally. We walked the sites on occasions and had many cups of coffee together. We talked often of his children and their progress through university and school. Shane Devlin and his wife attended a formal Charity function as guests of mine. I strongly refute that I did not have a good working relationship with him. We agreed to differ on some occasions, but this was professionally and respectfully done.

If Shane believed our relationship to be a difficult one, it certainly was not made apparent on any occasion. We had many Board Development Days where we met to discuss the functioning of the Board and our relationships. I fostered an open, transparent and honest culture and wanted the environment to be one where members could discuss and resolve any issues between themselves.

As Shane rightly says, there had been some 'lack of consistency in personnel in the Chief Executive post' and associated instability. I felt that my position as a long-standing Chair provided much needed stability for the NEDs, and I had built very good professional relationships with them. This is what Shane was unsettled by.

I found Shane Devlin to be a strong confident CX and certainly would not have expected him to hold back in challenging me if he felt I was overarching or unhelpful. I append the 2018/2019 360 feedback form provided by Shane Devlin (Exhibit RB-05). You will note that his assessment of me in role as Chair was uniformly either 'very effective' or 'effective' – the two highest scores.

clinical issues or Mr O'Brien on the Risk Register or being brought by the Chair of Governance to myself.

9. Please explain your specific role as Chair in assuring yourself and the Board that the clinical governance systems in place are adequate.
Governance was always high on the Board Agenda. The Board's role and functions were clearly defined in the Governance Board Assurance Statement. At each Board meeting the agenda was alternated to have Performance Strategy and Governance given as priority.

As Chair I regularly assessed the systems through internal audit, external audit, Board Assurance Framework, Performance reports, Board Committee minutes, Serious Adverse Incidents, Medical Director and Director of Nursing reports to the Board, Patient safety and quality of care reports to the Board, Corporate Risk Register, and the Management Statement signed by the Accounting Officer – the CX.

Each CX that I worked with undertook a Clinical and Social Care Governance Review as well as the high-level overarching Governance reviews generally.

The Governance Sub Committee (I was not a member of this) of the Board was Chaired by an NED. The minutes of these Governance meetings came to Trust Board for approval. Prior to coming to the Trust Board following each of the Governance meeting the Chair of this Committee plus the CX and the Board Assurance Manager would meet with me formally in a planned diary meeting to give feedback on the agenda and the findings. A written report was always provided by the Chair in advance. This helped complete the circle of Governance.

The Leadership walks undertaken by the NEDs quarterly and me monthly provided further assurance. These Leadership reports all came to the Governance Committee as a means of reporting. Each Directorate has their own Governance Lead which fed into the structures of each Directorate. NEDS had to visit the Children's Home quarterly -

In delivering these responsibilities, I am accountable for the Trust's performance to the Health and Social Care Board (HSCB) and DoH and report through agreed performance management arrangements established for the 2020-21 year including those actions put in place to respond to and subsequently to recover/rebuild from Covid-19 pandemic surge(s). The mechanisms I use to assure myself and Trust Board are below:

- Trust Governance Committee - Provides assurance to the Board on all aspects of the governance agenda (except financial control). This forum brings a range of clinical governance metrics and allows for dynamic triangulation and challenge and scrutiny to be offered by committee members
- Controls Assurance Standards – The Controls Assurance assists in the provision of evidence of the Trust performance to manage in meeting our objectives to protect patients, staff, public and other stakeholders against risks from all sources
- Trust Integrated Governance Framework 2017 - The framework sets out the arrangements for integrated governance within the Southern Health and Social Care Trust for the four year period 2017/18 to 2020/21. It is based on the extant integrated governance strategy 2007 to 2009 which was approved by Trust Board in February 2008 and covers all domains of governance associated with the delivery of health and social care services including corporate governance, clinical and social care governance, information governance, risk management, performance management and financial governance.
- Trust Governance Statement – As part of the Trust Annual Report the Governance Statement provides assurance that the Board exercises strategic control over the organisation through a system of corporate governance which includes:
    - Management Statement and Financial Memorandum;
    - Standing orders including powers reserved to the Board and powers delegated to its Committees and standing financial instructions
    - An Audit Committee;
    - A Governance Committee;
    - An Endowments and Gifts Committee;
    - A Remuneration Committee;
    - A Patient and Client Experience Committee; and
    - A Performance Committee.

The Trust adopts an integrated approach to governance and risk management and has an Integrated Governance Framework in place which covers all domains of governance associated with the delivery of health and social care services. Committee structures are in place to reflect this integrated approach and to support the Trust Board. The following describes in more detail the role of the Trust Board, its Committee structure and attendance during the reporting period.

In 2019 I commissioned two reviews to provide assurances around clinical governance processes. Having worked in other Trusts I was concerned that the assurance processes were not as robust as I had been used to. In particular the importance of a completely integrated governance system was not as explicit and in my experience felt under resourced. Therefore I progressed with two reviews.

- Trust Board development workshop, 13 November 2019, which consisted of the following elements
    - Board contribution to the Trust's performance
    - Board culture of collaboration, co-production and learning
    - Strategy, Accountability and Culture and Corporate plan priorities
    - Continuing development and collectively leadership on the implementation of the Corporate plan

- 2019 HSC Leadership Centre - Review of Clinical and Social Care Governance (appendix 13) - Health and Social Care (HSC) Leadership Centre undertook an independent review of clinical and social care governance within the Trust, including

governance arrangements within the Medical Directorate and the wider organisation. The output of this review was a series of recommendations for implementation by the Trust.

There were a total of 48 recommendations made which were broadly categorised under the following themes;

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

These recommendations became the basis of our Clinical and Social Care Governance (CSCG) change journey.

How do you ensure that the Board is appraised of both serious concerns as well of current performance against applicable standards of clinical care and safety?

As Chief Executive I ensure Trust Board is appraised of both serious concerns and current performance against applicable standards of clinical safety via the following mechanisms:

- Non-Executive Director briefings conducted by myself (monthly currently, previously were weekly during pandemic period)
- Trust Governance Committee - As above, Governance Committee also allows for issues of serious concerns / performance issues that are identified to be raised and discussed directly with Governance Committee members
- Trust Board Meetings – Trust Board meetings hold a 'confidential' session at the beginning of each meeting that is closed to the public allowing for sharing of information on concerns / performance issues that are identified to be raised and discussed directly with Trust Board members. These confidential meetings are minuted to ensure an accurate record but they are not held in public session so that issues of policy in development or confidential in terms of identifiable information can be shared

What is your view of the efficacy of these systems?

As reference above, in 2019, I commissioned the HSC Leadership Centre to review the complete governance system within the Trust. I was concerned that the system was disjointed and that from my experience the system was not operating as I had experienced in other HSC organisations. I had a number of concerns based on my experiences;

1. The level of expenditure on the governance functions felt light. I was used to appropriately funded teams for areas such as SAI management, complaints, standards and guidelines.
2. There was little evidence of a systematic and dynamic flow of clinical and social care information to SMT on a regular basis. Clearly if there was an issue of concern there was evidence of items being raised. However my concern was that this was based on a 'push' system from the directorates, not from a regular systematic review process.
3. The level of data and statistical evidence being brought to the SMT, in respect of quality and safety, was lower that what I was used to in other organisations.

The Chair stated that mindful of the Board Behaviours that all members subscribe to, and in the spirit of openness and honesty, as Chair of the Trust Board, she felt very offended by the report in how it was written in relation to Trust Board. For example, she was named as a contributor, when, in fact, had not been involved and only met the author at the final draft stage. Whilst she agreed with the Chief Executive that he can undertake a review at any time, she understood that it was a review specific to clinical and social care governance, yet it went wider than its terms of reference and strayed into corporate governance which she felt should have involved herself and the Non-Executive Directors. She made the point that Trust Board has a responsibility to ensure that the Trust has effective systems in place for governance; therefore it was important for Trust Board to have discussion on the report and agree a way forward.

Discussion on the report ensued in which some Non-Executive Directors expressed their concerns about how the review was conducted with no involvement of the Non-Executive Directors until the draft report was already written, the quality of the report and its current status. Mrs Magwood also raised the fact that the review included quality improvement and information governance and, as Lead Director for both areas, she was not effectively informed nor involved. Mrs Toal highlighted the importance of the final report accurately reflecting the Terms of Reference that were developed. The Chair responded that the focus of the Terms of Reference was on clinical and social care governance. The Terms of Reference were subsequently circulated to Non-Executive Directors following the meeting by way of reminder. Both the Chief Executive and the Medical Director apologised if there were any misunderstandings in the report or in the process that was used.

The importance of the Chief Executive using the Trust's finite resources well in terms of time, money and people in addressing some of the recommendations was highlighted. A reviewer from outside Northern Ireland as opposed to the Leadership Centre was also suggested.

Following discussion, it was suggested that Non-Executive Directors would forward any inaccuracies they felt required to be corrected, to the Chair's office. The Chief Executive agreed that he would then meet with the author of the report to ensure that the

Executive Summary

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

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

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

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

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

Summary of Recommendations **Appendix 1**

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

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

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

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

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

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

4.15 Clinical Audit

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

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

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

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

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

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

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

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

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

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

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

HSC Business Services Organisation

Southern Health & Social Care Trust

Board Effectiveness 2018/19

nqa. ISO 9001 Registered Quality Management

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.

	trained needs will be considered
Responsible Manager	Chair and Chief Executive
Implementation Date	31st 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 29th August 2019
Responsible Manager	Chair and Chief Executive
Implementation Date	31st August 2019

6 Inquiry into Hyponatreamia 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 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	31st October 2019

No	Question	*Circle / highlight as appropriate*					Comment
3	**ROLES, RESPONSIBILITES 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%	

has also received from the Audit Committee an internal audit report on Mr O'Brien's private practice where governance matters related to this Committee.

45.4 In my view, knowing what I know now, the Trust Board and the Governance were not kept appropriately informed in the period 2016 – 2020. This included explicitly detailing the patient safety risk arising as a result of the demand:capacity mismatch. Since Dr O'Kane, as Medical Director, raised matters at the Trust Board in August 2020, I believe that the Trust Board and the Governance Committee has been kept appropriately informed. The Governance Committee has also been kept informed in regard to improvements being made in reporting, in particular in respect of the MHPS process and professional governance.

Learning

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

46.1 Looking back across my tenure, through the lens of what has evolved to my knowledge since 2020, it is clear to me now that the Trust's governance systems were not fit for purpose.

46.2 At the center of this unfitness is what appears to me to have been a lack of triangulation of information and/or a culture of working in silos. Separate processes were being undertaken with no joining up of the intelligence – MHPS, Appraisal, and Serious Adverse Incident investigations. There was also an unhealthy churn in the key roles of CEO, Medical Director, and Acute Director over the period 2016 – 2020, which did not help matters.

46.3 I did not raise any specific concerns about the governance systems at the time. However, I did raise the below areas for consideration because I believed that

result of underinvestment in resources and in equipment. A business case by the Interim Director of Performance, Lesley Leeman, was put in place for a new scanner as a result of this escalation and previous discussion within SLT. The issue in Stoke services was that staff from Daisy Hill were redeployed during Covid into the Intensive Care Unit in Craigavon. A commitment was given to rebuild the team and an action plan was put in place by the Director of Acute Services, Mrs Melanie Mc Clements to address the areas of concern that I had raised. *Please see:*

12. 20220210 Approved Governance Committee Minutes
13. CSCG Report to Governance Committee 10 February 2022 (Quarter 3)
14. Appendix 1 - HCAT Report Oct - Dec 2021
15. Approved Performance Committee Minutes 01.12.22
16. 20221205 E to EM and MOK re Cardiology Discussion and Performance Committee
17. 20221205 E to EM and MOK re Cardiology Discussion and Performance Committee A1
18. 20220310 Approved Performance Committee Minutes
19. 20220523 - Email - M O'Kane to EM & PL re Stroke Services
20. 20220523 - Email - M O'Kane to EM & PL re Stroke Services A1

10. How do you ensure that the Board is appraised of both serious concerns as well as current Trust performance against applicable standards of clinical care and safety? What is your view of the efficacy of these systems?

10.1 I provide challenge and scrutiny at Trust Board, the Governance Committee and the Performance Committee by reading detailed reports on patient safety and risk and asking the relevant Directors questions about performance and remedy/action to be taken if required. When I have serious concerns, I have escalated them to the Chair and the Chief Executive in my role as Chair of the Performance Committee – outlined in Q. 9. I raise concerns verbally at meetings, formally in minutes and by e mail in written correspondence.

10.2 I think there is a more robust system around Clinical and Social Governance since Dr O Kane commissioned the Clinical and Social Care Governance Review in 2019. Prior to 2019 since my appointment in January 2017, in my view, there was a less developed approach to governance where there were separate reports to the Governance Committee on specific areas such as Information and Medicines governance which gave assurance. Governance is, however, a dynamic process where there needs to be continuous improvement and I think it has become more effective with the introduction of the CSCG report to the Governance Committee which brings all this

information together in a summary report so that we can see trends and patterns about areas that we should be concerned about. There are a number of reports presented to the Governance Committee on Clinical and Social Care Governance, SAIs, Raising Concerns, Clinical Audit, Standards, Mortality, Litigation, MHPS, Judicial Review which now provides a more systematic approach to Patient Safety and Risk. The information is triangulated and interrogated at the Committee by members to ascertain if the data/statistics and their trends/patterns are giving us cause for concern. A good example is the CSCG report presented to the Governance Committee in May 2023 by the Medical Director, Dr Stephen Austin, which brought information on Complaints, Incidents and SAIs in a summary report which clearly summarised areas of concern/risk/challenge.

10.3 As a NED, I rely on the information that is brought to the Board through the reports from SLT at Trust Board, Governance and Performance Committees. The Directors are responsible at an operational level for governance in their Directorates and the Board relies on SLT to bring good quality information on areas of risk and patient safety as well as their concerns. *Please see:*

21. Governance Committee Agenda 11th May 2023
22. 20230504_CSCG Governance Committee Paper Final_120523
23. 20211116 Confidential Governance Committee Minutes

11. How did the Board assure the HSCB and the Department of Health that the governance structures in place are effective (or otherwise)? Please provide examples.

11.1 Each Directorate has its own governance lead. Directors and governance leads meet with commissioning leads in HSCB/SPPG in regular monitoring meetings to report on both delivery of services and governance. As a NED, I am not involved in these meetings and I have no input into these meetings.

11.2 There are regular accountability meetings between the Chair, the Chief Executive and the Permanent Secretary in DOH. As a NED, I am not involved in these meetings and I have no input into these meetings. *Please see:*

24. 20230125 SHSCT Mid-Year Accountability Meeting

12. How did the Board assure itself regarding governance issues (i) throughout the Trust generally and (ii) within urology services in particular?
The Board assures itself regarding governance issues

Stinson, Emma M

From: Devlin, Shane <[redacted]>
Sent: 01 February 2019 10:37
To: Brownlee, Roberta; Mullan, Eileen
Cc: Comac, Jennifer; Judt, Sandra; Wright, Elaine; OKane, Maria
Subject: RE: Govern mtg/papers

Hi Roberta / Eileen

This is an issue that we discussed at SMT this week when reviewing the papers. I have asked for a line by line explanation for each one that was over 10 days. This will be discussed at the Governance committee as I am not content with this area.

Thanks

Shane

From: Brownlee, Roberta
Sent: 01 February 2019 09:35
To: Mullan, Eileen; Devlin, Shane
Cc: Comac, Jennifer; Judt, Sandra; Wright, Elaine
Subject: Govern mtg/papers

Eileen/Shane

Just working through the Govern papers for meeting next week. You probably have noted, as I have mentioned before, under litigation the number listed under Maternity & Women's health. If I recall previous papers referenced this as well.
Also noting the SAIs reported between 1/1/18 and 31/12/18 that the high graph "blue" shows 10 - 60 days or more. I appreciate this area is under discussion. At a tragic maternal death, before Shane came into post, you will recall Eileen, TB especially NEDs concern the length of time for reporting same and who and how escalated to CX (in Stephen's time as CX). This created a lot of debate then. Has the reporting mechanism improved since that TB meeting?

Roberta

canteen area. I "walked the walk as well as talking the talk" - I was a visible Chair. I liked to meet all grades of staff and made time to stop and have a brief chat.

I never formally or informally discussed urology services or Mr O'Brien with any member of SMT.

In all my years as Chair I never met with Mr O'Brien formally and have no notes of any meeting.

I never remember any of the Urology Consultants speaking to me formally re Urology services. I knew many of the Urology staff, but none came to me formally. I would have visited the canteen often during my tenure and met many staff including staff from the Urology Dept, during my travels. No one ever spoke to me formally or informally about clinical issues about Mr O'Brien.

It was only when Dr Richard Wright (then Medical Director) walked into my office (2016/2017 year- when Francis Rice was Interim Chief Executive) to inform me that concerns that had been raised about Mr O'Brien. Dr Wright did not go into any detail of the concerns during that discussion (referred to later in my statement). Then, in July 2020, Shane Devlin Chief Executive came to my office and said there were concerns being investigated regarding Mr O'Brien. Shane mentioned it was to do with storage of patients records not having been triaged and followed up in a timely manner. No further detail from my recollection was shared at that time.

No other member of the SMT, any other Urology staff ever raised any concerns with me formally or informally. The Leadership walks from my recollection had not picked up any Urology clinical concerns.

8. How is the Board informed of concerns regarding patient safety and risk?

Normally concerns regarding patient safety and risk would be brought to the attention of the Board via the CX or relevant SMT member to the Confidential Governance meeting or the Confidential Board meeting. The Governance Committee is a sub-committee (delegated schemes to Sub Committees) of the Board and Chaired by a NED. Meetings were held every three months.

15. Is the Board appraised of those departments within the Trust which are performing exceptionally well or exceptionally poorly and how is this done? Is there a committee which is responsible for overseeing performance, where does it sit in the managerial structure and hierarchy and how does the Trust Board gain sight of these matters?

Yes. The Board was provided monthly with a performance report that showed via traffic light system of "red, amber and green" (green indicating areas of high performance to red which indicated non - compliance or high risk) of all areas in each Directorate via the Director of Performance.

Information about performance of departments is fed into the Board through the various Sub-Committees of the board, chaired by the relevant NED. A new Performance Committee (Chaired by an NED) was established, from memory, in 2019 to enable more time and challenge on every aspect of performance reporting. This was a Sub Committee of the Board. The Board would scrutinise the reports and ask questions. This performance report showed how the areas are performing but did not alert clinical issues.

The Urology waiting lists for first referrals was listed and the report did indicate "long waiters" outside of the timeframe. The Director of Performance reported to the Board monthly of her regular meetings with the Commissioner (HSCB) of these pressures. There was theatre pressures and work force pressures adding to the issues. No clinical concerns are reported on the Performance report. The Board would have no other means of gaining sight of these issues unless the CX Directors of Medicine, Performance and Nursing brought this to the Board attention.

16. What was the Board's attitude to risk and risk management? What processes were in place to assist the Board in identifying and responding to risks related to clinical concerns and patient safety?

O'Brien's practices and Mr. O'Brien using his connection to the Chair to his advantage, were other features or causes of what went wrong within Urology services. On occasions, Mr. O'Brien in conversations with me and other members of the team would advise that he had spoken with the Chair directly to advise her of the capacity issues within Urology Services and he would have told us that she had assured him that she would sort this out, for example, that she would work on getting the urologists more theatre time. He would have advised of the times that he had met and spoken with Mrs Brownlee at social functions and that he had made her fully aware of what was happening in Urology. He also mentioned on a number of occasions that she was involved and supported the work of CURE (Craigavon Urological Research and Education), which is a limited company set up by a number of urological staff to provide funding (raised through fundraising) to allow for urology staff to do research and training and attend courses, and of which Mrs Brownlee had been a Director and she had also been actively involved in fund raising. As previously mentioned, I believe she was involved in asking at least two members of Trust staff who were actively trying to manage and address concerns regarding Mr. O'Brien to step back (Mr. Mackle and Mrs Gishkori). Although I am not aware of any other incidents, this outside influence always concerned me because, like the mentioning of his legal connections, Mr. O'Brien also referenced this connection in his conversations and, in my opinion, the purpose may have been to make others feel intimidated by the knowledge that he was influential with someone who held a senior position in the Trust's senior management." **WIT 26300 - 26301**.

Please respond in full to both (i) and (ii) to indicate where you agree or disagree with what Ms. Corrigan has reported concerning your actions, providing all relevant details, as appropriate.

All NEDs (excluding myself) sat on this Committee because of its important function. The Governance Committee reported into the Board and minutes were presented by the Chair for approval. The Chair of Governance would always have provided a verbal update to the Board if anything of significance had arisen during the Governance meeting. The Chair of Governance Committee after every meeting always held a formal meeting with me, the Chief Executive and the Board Assurance Manager and the written update was provided. This feedback meeting was normally held within 10-14 days after the Sub Committee meeting. If something arose between Board meetings regarding patients' safety or adverse risk of a serious nature, then the CX would have phoned to tell me or spoke to me in person. Then I would have phoned the NED to keep them informed. SAI notification to DoH/HSCB would be seen via my office on most occasions unless a director forgot to copy me in on alerts.

I also introduced Leadership walks by NEDs to all areas across the Trust looking for evidence that what we heard in the Board was happening on the frontline. These Leadership walks enabled testing of the systems, opportunity to meet all grades of staff, listen and be a visible Board. This further completed the Governance circle.

The NEDs had to complete four visits per year planned with input by each Director and my personal assistant. A Leadership tool was developed with the input of previous Chief Executive with all Governance headings. These walks were planned and could have taken 2-4 hours to complete depending on which site was visited. It was a formal process, and the returned documents came back to me and the Chief Executive and then brought quarterly to the Governance Committee. These were excellent visits and highly rated by frontline and management staff. Action plans may have had to be developed because of the visit and again this came from the Director via the Chief Executive's office.

At the Governance Committee each time it held a meeting the Risk Register was an agenda item for discussion. The Risk Register also came to the Board from recollection six monthly. Again, from my recollection I never recall anything to do with Urology

Southern Health and Social Care Trust

LEADERSHIP WALK – GUIDANCE TOOL FOR NON EXECUTIVE DIRECTORS

Name:	Roberta Brownlee
Visit To:	Thorndale Unit (Urology), Craigavon Area Hospital
Date and time of visit:	23 May 2012 at 10.30 am
Accompanied By:	Kate O'Neill, Urology Specialist Nurse

** Please note: you may not wish to complete all questions during your visit – the following are suggested questions.*

1.

a. What works well for you?

Small select unit. Very personalised for patients. We engage well with the patients. Many patients afraid – need a lot of reassurance. Small effective team and very adaptable. Highly skilled and competent team. Specific nurses who lead in different areas and development opportunities are available and accepted. Good communication. Good flexible and responsive staff. Supportive Consultants.

b. **What doesn't work well?**

Short of middle grade doctors for support (Registrar level). *There is a recognised shortage of middle grade doctors nationally within Urology. The Trust has advertised on a number of occasions without success. However we have recently advertised and we have had three applicants – interviews due to take place mid-August and we are hopeful that we will be successful in appointing. Also last year we only were successful in getting one registrar through training but from August 2012 we are getting 2 Registrars which will assist with this support. Last week we were advised that the Trust had secured funding from Board Liaison Group for an additional Specialty Doctor and we are hopeful that we will appoint another doctor from the interviews in August.*
Limitations of the size of the building. *These limitations have been recognised and there are plans being put in place to move the 'Thorndale Team' to main outpatients.*
Small team so if one staff member off sick impacts greatly. *As part of the Review of Adult Urology there is funding for a further 2 Specialty Nurses and we have been involved in discussions on how best to utilise this funding. Also the Unit depends on the General Practitioner with Specialist Interest (GPwSI) and when he is off sick this impacts on the activity. However it is hoped to address this through the appointment of more Specialty Doctors.* **Two patients and staff raised concerns of no car parking spaces. The length of walk for older patients and their family members**. *It is anticipated that both these points will be addressed through the move from the current location to main outpatients.*

2.

a. What would you like to change or see different?

Expansion of the team *this is in process with the additional 2 new Consultants and 1 replacement Consultant commencing 1 August, 1 September and 1 October. Also the appointment of the 2 new Specialty Doctors, 2 Specialty Nurses and the successful securement of 2 Registrars*
***Non-stock and requisitions – the process i.e. consumables – e.g. can these be stock items to enable more cost effective purchasing? I have asked for this to be looked at on several occasions – to date no response.** *This is currently with Head of Purchasing and Supplies. Although we have been advised that the items alluded to can only be moved to stock items once they have gone through the tendering process which is governed by BSO. A list and appropriate documentation has been completed in preparation of this tendering process.*

b. What challenges do you face?

Expansion of the area 'South'. Limited medical cover. Not always a medical member available in this unit. *As per above this will be addressed with the additional medical staff (Consultants, Specialty Doctors, Registrars) that are coming to the Trust. The plan is that one or more of these will be based each day in Thorndale Unit.*

****Access to the main hospital for emergencies is not possible – what we have to do is call 999 to get Emergency Department. Needs to be noted for future reference. The present link corridor not passable**** *the corridor was planned to link the Thorndale Unit with the main hospital but the only access was through the Paediatric Outpatients area which has security risks in that only staff can use this when paediatric outpatients is not taking place. Also part of the corridor is open so therefore not suitable if accessible for patients during inclement weather. This issue will be addressed when the Unit is incorporated in main outpatients.*

c. Have you any ideas for improvement?

Privacy at reception – for phone calls. *This will be addressed when the Unit moves to main outpatients as they will have a 'closed in' reception area*. **Formalisation of link corridor – how to use – great corridor but of no benefit.** *It has been very difficult to progress the use of this corridor due to child protection issues. We have been able to use it for moving equipment through from main hospital to Thorndale Unit.*

d. Have you made any improvements you are particularly proud of?

- One stop clinic - Haematuria and prostate diagnosis – these patients seen within 1 or 2 weeks and offered biopsy on the day of visit. Most flexible cystoscopy done on same day of clinic.
- Decontamination purposes – used to only have one probe now bought 4 and formalised a protocol for decontamination– excellent outcomes – Band 7 lead the MDT approach to safe practice, completing this task is nursing auxiliary.
- Harmonisation of prostate biopsy service – Band 7 used the opportunity of her post graduate diploma in specialist nursing to standardize all patients to get appropriate local analgesia.

3.

a. How many commendations have you received in the past 3 months?

Feedback from community services very good and have many commendations. Staff impressed with high levels of satisfaction. Could patient satisfaction survey and the questionnaires be completed at this unit?

b. How many complaints have you received in the past 3 months?

None.

c. What are you doing to respond to/learn from the issues raised?

If any complaints I would share locally and listen and learn. Engage with all staff.

4. How do you engage with users?

We do 1:1- we have used service users to improve haematuria documentation. Daily engagement with all patients and ask for feedback before they leave the clinic. Open honest 1:1. Availability of documentation used.

5. Do you have regular team meetings?

a. What**'s on you**r team meeting agenda?

Band 7 goes to Sisters meeting weekly – I find this excellent. Good links with the wards. I bring back and share information weekly. Formal meetings 2-3 times per year. We look at Assistant Director meeting outcomes, HR, Training, Governance and Infection Prevention Control.

6. Any staffing issues?

Only middle grade doctors. *As per response to 1 (b).* No other staffing issues.

7. **Is your Team's mandatory training up**-to-date?

Basic life support up-to-date.
M&H – 100%
Fire Awareness – all staff booked for May 12 – all previously trained.
Infection Control – annual – 100% up-to-date. Excellent and up-to-date. Good opportunity for development.

8. Do you have arrangements in place for regular supervision?

I do this twice yearly with staff (one Band 7 responsible for this) and KSF completed by other Band 7.

9. Tell me about your safety audits (on dashboard/other)

Bedpan/fridge/hand hygiene audits – learning outcomes shared with staff for display in patient waiting area.

10. Is there a good understanding of when and how to report an incident/error?

Good understanding by staff. Sharing Datix report/process to all other staff.

11. What areas of risk are you concerned about in your ward/facility/team?

None raised but highlighted isolation from main hospital. Could have two collapses per month and have to go via 999 call. *This is a recognised concern and one of the reasons to having Thorndale relocated to main outpatients*.

12. When you escalate risks that are beyond your control, do you get a timely response?

No concerns – can raise concerns and gets a timely response.

13. Are you getting the support you need to manage risks that you are accountable for?

Yes – no issues.

14. Do you have any problems with infection control (if applicable)? (Non Executive Directors to comment on environment and general observation for infection control)

None. Fresh and new unit. Extremely clean. Spoke to three patients and all very complimentary of the service provided. Commended staff's friendliness, helpfulness and privacy.

15. When had you last an MRSA; MSSA; C. Diff or other problem?

None.

16. Any other comments? (*Record any additional information noted during visit*)

This is an excellent facility. Very person centred. Patients like the privacy. Spoke to two S/Ns and audio typist. Both S/Ns highly skilled nurses – no concerns raised. Confirmed the high quality outcomes. Phone area very open and poor privacy. *To be addressed and to be taken into account when Thorndale is relocated*. Staff have had 'other teams' come to look at Thorndale as it appears Urology may move from this Unit. *The discussions about a potential move were only at a very early initial stage and had been tentatively discussed with the Urologists and Specialty Nurses and nothing had been agreed or that there would be a definite move. However, the other team that have been provisionally told that there may be a potential for them to move to Thorndale if Urology moved went to visit the Unit without notifying, Assistant Director/Head of Service and arrived unannounced. However, Head of Service addressed this immediately with the Staff in Thorndale*. Staff not really aware of any planned changes. Staff need to be kept informed and involved in the planning e.g. Urodynamics Room – extremely hot and no air conditioning. If Urology moving to another area the name 'Thorndale Unit' needs to go with this specialty because of how and why it was named this. It's important that this request is noted at this stage please. *The proposed move has been discussed with Consultants and Specialty Nurses and they all had been given an opportunity to advise on any areas that they wanted to have included. This is still only at the planning stage and it will not be progressed without their involvement including a clinical room suitable for urodynamics/biopsies etc. We have also noted the request to keep the Thorndale name for the area when it is relocated.*

Signature _____ Date _____

** This report should be completed within 7 days of your visit and returned to the Chair**'s Office. The Chair's PA will then forward to the** Chief Executive and person(s) who conducted/assisted in your walk-around.*

Southern Health and Social Care Trust

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LEADERSHIP WALK – GUIDANCE TOOL FOR NON EXECUTIVE DIRECTORS

Name:	Geraldine Donaghy. NED
Visit To:	Thorndale Unit (Urology) Craigavon Area Hospital
Date and time of visit:	Monday 5th March at 11.30am
Accompanied By:	Jenny McMahon Urology Nurse Specialist

Key Issues:

- **Ongoing development of services**
- **Ongoing development of nursing skills**
- **Challenges of meeting cancer targets**
- **Equipment needs (enhance training potential)**

Director's Response:

**** Please note: you may not wish to complete all questions during your visit – the following are suggested questions.***

1.

a. What works well for you?

I visited the Unit on Mon 5th March and was accompanied by Urology Nurse Specialist Jenny McMahon. [redacted] Personal Information redacted by USI .

Thorndale Unit is now located within the main hospital block which has removed the isolation felt when the unit was located at the back of the hospital. The Unit has been designed to allow the smooth running of one stop assessment and review clinics with 5 consultation rooms and 2 treatment rooms. CAH is the only hospital within the region to offer a service whereby when appropriate patients may have USS scanning and procedures completed in one visit. Delegates from the DOH and other Trusts have visited the unit to explore if they could replicate this service design. From speaking with the Nursing, Admin and one of the Consultants, it was evident that there was an excellent team spirit in the Unit with openness to cooperate in all areas of the service delivery. Excellent systems of communication have been developed and in evidence including efforts to keep patients informed throughout their attendance at the clinic (which often stretched over a whole day).

b. What doesn't work well?

The staff were conscious of the distress for patients when difficulty was experienced in getting patients admitted as an emergency in a timely manner due to bed pressures. In general when theatre lists are cancelled or reduced, this often results in a noticeable increase in the volume of calls from patients / carers expressing anxiety regarding delays to treatment. This problem was sympathetically managed by staff who maintained good communication with patients when these situations arise.
As a small nursing team and while sickness episodes are not common, they have significant impact on the ability to cover both Thorndale Unit and the Stone Treatment Centre which the Unit has management responsibility for.
Workforce issues are generally stable although with an ever increasing workload, additional staff are needed. Increased incidences in Prostate & Renal Cancers have resulted in a case being made for an additional nurse to do follow up and the Unit is hopeful this will happen. Currently there is a Consultant Urologist vacancy and ongoing dependency on Locum Consultants continues.

2.

a. What would you like to change or see different?

- With the support of the management structure we continue to discuss further opportunities for nursing staff development in the provision of new services e.g. Prostate cancer review, Erectile Dysfunction clinics, Renal cancer follow up
- Improved flexible cystoscopy equipment to allow further training for nurse endoscopy
- Improve succession planning for the future of the service

b. What challenges do you face?

- Difficulties remain in meeting the cancer targets for first appointment and first definitive treatment
- Lengthy waiting time for what are considered to be non-urgent urological surgery, however many of these patient are experiencing significant impact on their quality of life while awaiting procedures

Concerns were expressed by both nursing and medical staff on these challenges. In some cases Non urgent waiting times extended to a 4 year wait. It was suggested that proposed new guidelines due to be rolled out on treating prostate cancers would create added pressures on waiting times for non urgent cases.

c. Have you any ideas for improvement?

- Ongoing support for staff development
- Further development of nurse provided services
- Additional equipment & suitable equipment to facilitate training & additional work .

The Unit noted a clear need for additional equipment/scopes & Videoscopes in particular which would facilitate improved diagnosis and staff training due to staff in training being able to observe the site of the problem on video. The Line Manager I was informed was actively pursuing funds. I mentioned the E&G Funds as a possibility to pursue?

6. OPERATIONAL PERFORMANCE

i) Performance Report (ST 179/09)

Mrs Clarke presented the report summarising the Trust's performance in August 2009 against Priority for Action (PfA) 2009/10 standards and targets and key performance indicators of corporate performance. She stated that the Trust continues to perform strongly across a range of areas, namely Timely Hospital Discharge; Mental Health and Learning Disability Resettlement and Cancer. Members were advised of an improved performance in relation to complaints responded to within 20 working days, routine diagnostics and family group conferences.

Mrs Clarke drew members' attention to a number of risk areas, namely i) Inpatient/Daycase Access target; ii) Renal dialysis via fistula and iii) Unallocated child care cases. In relation to i), Mrs Youart advised that the Trust had undertaken a review of urology services and this had highlighted a capacity gap. This is a regional issue and a regional review of urology services is underway. Referring to renal dialysis via fistula, Mrs Youart stated that there should be an improved performance in the second half of the year as a result of medical staff being trained to undertake fistula creation. As regards unallocated childcare cases, members noted the management actions taken to mitigate the risk of unallocated child care cases.

Mrs Clarke took members through the changes in the Clinical and Social Care Quality section of the report. The Chairman asked about a peer group benchmark for Crash Call rates. She also asked if clinical outcome indicators could be incorporated into the Performance Report. Mrs Clarke advised that the Trust continues to work with CHKS on clinical indicators.

The Board of Directors approved the Performance Report (ST 179/09)

ii) Finance Report (ST 180/09)

Mr McNally presented the Financial Performance Report for the period ending 31 August 2009. He advised that the Trust is reporting a cumulative deficit of £3.1m for the five month period ended 31st August 2009 with an in month marginal surplus of

Southern Health and Social Care Trust

Minutes of a meeting of the Board of Directors held on Thursday, 24th September 2009 at 10.00 a.m. in Dungannon Council Offices

PRESENT:

Mrs A Balmer, Chairman
Mrs M McAlinden, Acting Chief Executive
Mrs R Brownlee, Non Executive Director
Mr E Graham, Non Executive Director
Mr A Joynes, Non Executive Director
Mrs H Kelly, Non Executive Director
Mrs E Mahood, Non Executive Director
Dr R Mullan, Non Executive Director
Mr B Dornan, Director of Children and Young People's Services/Executive Director of Social Work
Dr P Loughran, Medical Director
Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing
Mr S McNally, Acting Director of Finance

IN ATTENDANCE:

Mrs P Clarke, Acting Director of Planning and Reform
Mr K Donaghy, Director of Human Resources and Organisational Development
Dr G Rankin, Director of Older People and Primary Care Services
Mrs J Youart, Director of Acute Services
Mrs S Cunningham, Southern Area Manager, Patient and Client Council
Mrs J Holmes, Board Secretary
Mr P Toal, Communications Manager
Mrs S Judt, Committee Secretary (Minutes)

1. CHAIRMAN'S WELCOME AND APOLOGIES

The Chairman welcomed everyone to the meeting. Apologies were recorded from Mrs D Blakely, Non Executive Director.

governance issues until 2017 year. We were made aware by the Director that an action plan was in place and being monitored. I do not recall attending a Board meeting where urology clinical issues of a high-level risk were brought to the Board to be informed. The Board was aware of the long waiting lists in Urology (but was assured by CX of a review for a Regional Strategy for Urology services due to long waiting in all other Trust areas being undertaken by the DoH).

Along with other services like Radiology, Endoscopy, Unscheduled Care - to name a few - Urology came to the attention of the Board as a service under pressure. I do not remember Urology ever coming to the Board as a single agenda item. We did know of the long waiting lists as this was referenced on the performance reports along with many other specialities.

13. How did the Board monitor and quality assure the governance actions and action plans of the Trust? If possible, please illustrate your answer by reference to examples of Board monitoring and quality assurance throughout the Trust and most particularly within urology?

As previously mentioned, action plans came to the Board regularly as an update and NEDs/myself always asked for an update either three or six monthly on progress and monitoring. I recall (18/19 year) some serious issues coming to the Confidential Board agenda (the Mental health facility Bluestone Unit as an example) the Director would have provided a paper and talked to members in detail regarding this. The paper also provided an action plan which was time bound. In this case I mention an independent team outside of SHSCT was asked to complete a review and present a report of their findings to the Board. This happened and an action plan was further developed and monitored by the Director who in turn brought in a timely manner reports to the Board of progress to ensure completion and improvements achieved.

Aside from an update that Mr O'Brien was under investigation in 2017 and details provided, Urology from my memory never came to Trust Board again until to Summer

Southern Health and Social Care Trust

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REPORT SUMMARY SHEET

Meeting: **Date:**	**Trust Board** **30th August 2012**
Title:	**Monthly Performance Management Report**
Lead Director:	**Paula Clarke, Director of Performance and Reform**
Corporate Objective:	• Provide safe high quality care • Maximise independence and choice for our patient and clients • Support people and communities to live healthy lives and to improve their health and wellbeing. • Make best use of resources. •
Purpose:	**For approval**
Summary of Key Areas:	***High level context:*** This report reviews performance at the end of July 2012 against the Commissioning Plan standards and targets and provides an assessment of current performance. The report highlights a number of areas of risk predominantly with respect to elective access and the associated requirement to meet interim targets set by the HSCB, to maintain standards monthly and to re-achieve at least the end of March 2012 position by the end of September 2012.

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	related to future provision of Catheterisation Laboratories has not been concluded and therefore, investment proposals cannot be finalised. Performance risks are predominantly in day cases with presenting pressures in out-patients and cardiac investigations. Interim additional capacity has been brought on stream via a modular catheterisation laboratory however full use of this facility has not been possible due to the inability to recruit a locum Consultant operator and access times continue to increase. • **Urology** – The performance risks in in-patients, day cases and urodynamics result from an established capacity gap for which recurrent investment has been committed. Current in-house capacity is entirely absorbed in managing red flag referrals and urgent cases. The Trust has appointed 3 Consultant Urologists, starting in August; September; and November however the impact of this capacity will not manifest until into quarter 3 and 4. In the interim, capacity has been accessed from the Independent Sector however they are unable to provide all of the capacity required to achieve access standards. • **Oral Surgery and Ophthalmology** – These services are provided on an outreach basis to the Trust by Belfast and South-Eastern Trusts. Local action continues to seek to develop a local ophthalmology service through the appointment of 2 consultants. Capacity gaps for these specialties are being assessed regionally with no resolved position. In the interim the Trust continues to use the Independent Sector to provide the additional capacity required which presents risk in the longer term with a small provider base of IS providers in Northern Ireland. • **Allied Health Professionals** – The Regional demand and capacity exercise is concluding and will potentially recommend additional resources for physiotherapy to address access gaps however a resolved position has not been reached in relation to paediatric OT and SLT and in physical/sensory and learning disability OT and physiotherapy. Whilst

			• Trust anticipates a rolling backlog in reviews until recurrent demand/ capacity gaps have been addressed. • Of the total waits, 88% of those waiting have been waiting from 1 April 2012. • The largest volumes of waits are in Urology and ENT with the longest waits in Urology. • Work continues to cleanse lists and Specialist Nurses are working with relevant consultants to screen urgent reviews and longest waiters • Whilst some funding has been provided in 2012/13 to address review backlog, capacity to put in the place the additional capacity required is limited by availability in specialties that have capacity gaps and require to utilise capacity to maintain access times for new referrals also. • Health and Social Care Board has agreed funding to address review consequences of new in-house additional capacity being delivered in 2013/14.		
2	Achievement of statutory functions/duties: Care Management Processes. Risk includes: • Level of Older People and Primary Care Residential Home/Nursing Home/Domiciliary clients Annual Reviews not completed. • The Trust should have robust care management communication processes in place and	• Monthly monitoring of reviews undertaken by Head of Service/Assistant Directors • Group established to examine operational management of the annual review process • Delegated Statutory Functions Report • Monthly reporting to Trust Board (from August 2013) • Annual meeting with Heath & Social Care Board Director of Social Care/Children's Services	• Domiciliary Care Reviews – monthly reporting exercise underway to identify the number of reviews carried out and those outstanding. • Reviews completed by 31/7/2013: Domiciliary Care: 75.3% Nursing Homes – 80% Residential Homes – 84% Overall completion rate – 77% 24.7% have been waiting longer than a year to have their reviews carried out	Older People and Primary Care	**HIGH**

		EXTERNAL MONITORING: 7. **Monthly** Elective and Unscheduled Performance meetings with Health and Social Care Board ACTION PLANNING: 8. Implementation plans in place to reduce access times, where demand remains static, and additional ***recurrent*** capacity has been invested/ approved via IPT 9. Periodic plans developed aligned to ***non-recurrent*** allocations of available funding for elective access via HSCB 10. Operational plans under development to maintain red flag waiting time standards and reduce urgent waiting times to the acceptable clinical timescale. However, routine waiting times will increase as a consequence of the management of the red flag and urgent waiting times.	from 2014/15 in Quarter 1 of 2015/16. • SMT permission granted for additionality in April 2015 to continue to address previously identified risk areas that were funded via non-recurrent allocations in 2014/15. Spend from April to be re-couped from 2015/16 non-recurrent allocations. • Further non-recurrent funding for Independent sector capacity was made available in November for specific regionally agreed speciality areas for OP/IP/DC. In response, the Trust has established additional capacity in Q4 2015/16 for pain management, general surgery and orthopaedics. c) Key areas of risk identified within the Acute Services Directorate have been **partially addressed** with non-recurrent funding and part year effect recurrent investments in : • Symptomatic Breast Clinic • CT and • Endoscopy . d) Remaining areas of risk highlighted to Health and Social Care Board formally include:- a. Haematology (New OP) b. Urology (OP Review Backlog)		

Southern Health and Social Care Trust

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CORPORATE RISK REGISTER

August 2016

	b*) Planned Patient Backlogs** • Acute only On-going risk with a significant volume of patients waiting ***past their clinically indicated review timescale in Outpatient and AHP services.	list and the processes for monitoring; escalation; and actioning of these reviews, that have been clinically agreed and communicated with the Consultants.	• In 2016/17 some additional review patients were prioritized for additional capacity from the £700k non recurrent allocation; however total volume of those waiting beyond clinically indicated dates has started to increase again. The Trust will continue to re-direct internal resources to areas of greatest risk as funding becomes available or as operationally feasible throughout 2016/17. Operational process are in place to ensure patients requiring clinically urgent review are prioritised. **b) Planned Patient Backlog** As at 1st August 2016, there were a total of 1560 patients on the planned treatment backlog. The longest waiting patient dates back to October 2014 and relates to Urology. 79% (1237) of the planned treatment backlog relates to Endoscopy with the longest substantial wait from January 2015. Non recurrent funding received in 2015/16 and allocated for 2016/17 is insufficient to meet the demand for new and planned repeat endoscopy. Priority is given to red flag, urgent and planned patients initially, then routine waits.		

Data source: BOXI CH3 Universe, run date 16/05/16

ref 5 (i)- OP NEW CONS LED UROLOGY REG SPEC WAITS (SUBMISSION)

SOUTHERN HEALTH AND SOCIAL CARE TRUST

Number of Patients Waiting on a Consultant Led First Outpatient Appointment for Regional Urology Specialty by Consultant and Waiting Time Bands AS AT: #REF!

Sum of Total Waiting	Weeks Waiting										
Consultant Name	**0-9Wks**	**9+ to 13Wks**	**13+to 18Wks**	**18+ to 21Wks**	**21+ to 26Wks**	**26+ to 31Wks**	**31+ to 36Wks**	**36+ to 41Wks**	**42+ to 52Wks**	**52+Wks**	**TOTAL**
YOUNG	114	3	63	22	16	45	47	11	78	74	473
O'BRIEN	40	67	34	1	61	43	42	6	63	51	408
SURESH	73	46	4	39	45	31	31	11	40	65	385
GLACKIN	86	35	25	46	19	20	3	42	22	80	378
O'DONOGHUE	73	53	48	4	55	41	25	16	17	26	358
HAYNES	71	9	29	0	32	37	37	27	35	76	353
GENERAL UROLOGIST	120	36	24	11	18	24	19	17	26	48	343
UROLOGY CONSULTANT	40	2	0	0	0	0	0	0	0	0	42
A HAEMATURIA CONSULTANT	2	0	0	0	0	0	0	0	0	0	2
BROWN	1	0	0	0	0	0	0	0	0	0	1
TOTAL	**620**	**251**	**227**	**123**	**246**	**241**	**204**	**130**	**281**	**420**	**2743**

Produced by Directorate of Performance and Reform, Informatics Division, Information Team

Data source: BOXI CH3 Universe, run date 13/05/20

ref 5 (i)- OP NEW CONS LED UROLOGY REG SPEC WAITS (SUBMISSION)

SOUTHERN HEALTH AND SOCIAL CARE TRUST

Number of Patients Waiting on a Consultant Led First Outpatient Appointment for Regional Urology Specialty by Consultant and Waiting Time Bands AS AT: **30/04/2020 (Run date 13/05/20)**

Consultant Name	0-9Wks	9+ to 13Wks	13+to 18Wks	18+ to 21Wks	21+ to 26Wks	26+ to 31Wks	31+ to 36Wks	36+ to 41Wks	41+ to 52Wks	52+Wks	TOTAL
A UROLOGIST (E)	273	184	133	83	151	152	123	77	152	363	1691
GENERAL UROLOGIST	113	55	53	32	55	55	39	11	47	204	664
HAYNES	4	2	3	0	1	2	0	1	1	389	403
GLACKIN	16	8	9	0	3	2	0	0	1	311	350
YOUNG	9	8	5	1	5	0	4	1	3	304	340
O'DONOGHUE	3	8	8	2	4	1	4	2	0	275	307
O'BRIEN	3	2	3	0	3	2	4	3	7	217	244
SURESH	0	0	0	0	0	0	0	0	0	54	54
JACOB	0	0	0	0	0	0	0	0	0	15	15
TYSON	0	0	0	0	0	1	0	0	1	1	3
BROWN	0	0	0	0	0	0	0	0	0	2	2
HUGHES	1	0	0	0	0	0	0	0	0	0	1
TOTAL	**422**	**267**	**214**	**118**	**222**	**215**	**174**	**95**	**212**	**2135**	**4074**

Produced by Directorate of Performance and Reform, Informatics Division, Information Team