HEALTH & SOCIAL CARE TRUST

REGIONAL REPORTING TEMPLATE FOR DELEGATED STATUTORY FUNCTIONS REPORT

Draft Proposal of Template for consideration by Directors of Social Work, Board and Trust and the Acting Chief Social Services Officer.

REPORTING TEMPLATE INDEX

SECTION 1 - QUALITATIVE

Number 1 – 2.8 to be completed by Executive Director of Social Work

Number 3 – 3.9 to be completed by Social Work Leads of each Directorate

SECTION 2 – QUANTITATIVE (Including Performance Indicators)

(Section 1 to 2.8 to be completed by Executive Director of Social Work)

1. Introduction

2 GENERAL

Executive Director of Social Work:

……..

2.1 Statement of Controls Assurance – Compliance with NISCC Requirements

2.2 Accountability arrangements from frontline staff to Executive Director on Trust Board with responsibility for professional social work

2.3 Executive Director of Social Work's General Statement of Controls Assurance setting out the Trust's performance in-year against the Discharge of Statutory Functions.

2.4 Summary of areas where the Trust has not adequately discharged Delegated Statutory Functions

2.5 Progress report on Actions taken to improve performance, including financial implications.

2.6 Highlight which, if any, of the areas requiring further improvement and if they have been included in the Trust's Corporate Register

2.7 Report on the Trust's Compliance in relation to other statutory agencies such as RQIA, NISCC

2.8 Set out the systems, processes, audits and evaluations undertaken internally or externally identifying emerging trends and issues which shape the Directors conclusion about Trust performance.

3. GENERAL NARRATIVE

Mental Health/Primary Care & Older People/ Learning Disability/Physical Disability/Childrens Services including Mental Health & Disability.

Directorate:-

3.1	**Named Officer responsible for professional Social Work**

3.2	Supervision arrangements for social workers

3.3	**Set out Systems, processes, audits, reviews and evaluations undertaken internally and externally during the year, measuring performance against statutory functions, identifying emerging trends and issues.**

3.4	Report on Directorate's compliance with other statutory agencies such as NISCC, RQIA (in relation to social work)

3.5	Summary of difficulties or issues in regard to the ability to discharge Delegated Statutory Functions

3.6	Provide a progress report in relation to remedial action to improve performance including financial implications

3.7	Indicate if the issues above are included in your Directorates Risk Register

3.8	Any identified training issues

3.9	SUMMARY

QUANTITATIVE DATA

2.The Mental Health (NI) Order 1986
Article 4 (4) (b) Article 5 (1)Article 5 (6)Article 18(5) Article 18(6)Article 115

2.1.a	Number of Applications for Assessment by:		
	Nearest Relative		
2.1.b	Approved Social Worker		
	Commentary		
2.2	ASW Response Times (measured from within one hour of requested time of arrival)		
	Commentary		
2.3	Number of Social Circumstance Reports completed following detention		
		Total Number of Reports completed	Number of completed reports which were completed within 14 days
2.3.a	by nearest relative		
2.3.b	by Social Worker		
	Commentary		
2.4	Number of Guardianships accepted by Trust:		
2.4.a	New Applications		
2.4.b	Renewal Applications		
	Number of Guardianships accepted by a nominated other person		
2.5	Numbers referred to Tribunals		
	Commentary		

2.6	**Number of newly Approved Social Workers during year**	
	Number of Approved Social Workers removed during year	
	Number of Approved Social Workers at year end (who have fulfilled Requirements consistent with quality standards)	

Commentary

Number of Adult Protection Referrals *(see Appendix 1 for guidance notes on performance indicators)*	
Definition: The percentage of referrals for vulnerable adult investigations within the various programmes of care	
Related Indicators: Number of protection plans implemented	
Exclusions: ***None***	
	HSCT
<u>NUMERATOR</u> No of vulnerable adult referrals within the year	
Elderly – POC 4	
Mental Health – POC 5	
Learning Disability – POC 6	
Phy Disability – POC 7	
<u>DENOMINATOR</u> The relevant base population for each programme of care.	
Elderly – POC 4	
Mental Health – POC 5	
Learning Disability – POC 6	
Phy Disability – POC 7	
%	
Elderly – POC 4	
Mental Health – POC 5	
Learning Disability – POC 6	
Phy Disability – POC 7	
.....Health & Social Care TRUST %	

ADULT PROTECTION PLANS IN PLACE
(see Appendix 1 for guidance notes on performance indicators)

Definition: The percentage of Vulnerable Adult Referrals who have a protection plan implemented**.**

Related indicators:
Number of Adult Protection Referrals

	HSCT
NUMERATOR No of Protection Plans in each Programme of Care initiated.	
Elderly – POC 4	
Mental Health – POC 5	
Learning Disability – POC 6	
Phy Disability – POC 7	
DENOMINATOR No of vulnerable adult investigations where the completion date of the investigation falls between 1 April and 31 March inclusive.	
Elderly – POC 4	
Mental Health – POC 5	
Learning Disability – POC 6	
Phy Disability – POC 7	
%	
Elderly – POC 4	
Mental Health – POC 5	
Learning Disability – POC 6	
Phy Disability – POC 7	
……..HEALTH AND SOCIAL CARE TRUST %	

Outcome:

Corporate Parenting Report (cc3/o2)

Please Note: ***Information for this section will be contained in the Corporate Parenting Report (CC3/02)***

3 Children (NI) Order 1995
Article 18 (2)Schedule 2 Para 1, Article 18 (2)Schedule 2 Para 5(2) ,Article 18 (2)Schedule 2 Para 9, Article 27 (1)(2),Article 27 (1)(2), Article 27 (8), Article 35,Article 36 (1) Article 44,Article 45 (1)(2) ,Article 45 (3)(5)(6)(7)(8), Article 108 (1), Article 118, Article 130,Article 174 ,Article 175, Article 177

CHILDREN IN NEED		
3.1	**How many Children in Need are there in your area?**	
	Trend analysis and commentary	
3.2	**Religion of Children in Need**	
3.3	**Ethnic Origin of Children in Need**	
3.4	**Number of children assessed as having a disability**	
3.5	**How many children have been referred for assessment of Need**	
3.5.a	**Childcare**	
	Learning and Physical Disability	
3.6	**How many children are currently Awaiting an assessment of need (unallocated cases including disability)**	
	Trend analysis and commentary	
3.7	**How many children in need are currently awaiting assessment or treatment with child and adolescent mental health services**	
	Trend analysis and commentary	

3.8	**What preventative action is being taken by the Trust to ensure that children in need are not involved in offending behaviour** ***(narrative by Head of Service)***

3 Children (NI) Order 1995
Article 18 (2)Schedule 2 Para 1, Article 18 (2)Schedule 2 Para 5(2) ,Article 18 (2)Schedule 2 Para 9, Article 27 (1)(2),Article 27 (1)(2), Article 27 (8), Article 35,Article 36 (1) Article 44,Article 45 (1)(2) ,Article 45 (3)(5)(6)(7)(8), Article 108 (1), Article 118, Article 130,Article 174 ,Article 175, Article 177

3(b) CHILD PROTECTION		
3b.1	**How many children are on the Child Protection Register**	
3b.2	**How many of these children have a learning disability**	
3b.3	**How many of these children have a physical disability**	
3b.4	**Religion on the children Protection Register**	
3b.5	**Ethnic origin of children on the Child Protection Register**	
3b.6	**How many registrations have there been during the year**	
3b.7	**How many de-registrations have there been during the year**	
3b.8	**What percentage of registrations are re-registrations**	
3b.9	**For children on the register, how long have they spent on the register**	
3b.10	**How much time is spent on Child Protection** **Gateway** **Family Intervention Service** **Looked After Children**	
3b.11	**Commentary on Trends of Child Protection Register**	
	Trend Analysis and commentary	

3b.12	**Commentary on length of time children spend on register, particularly >1 year**
	Trend Analysis and commentary
3b.13	**Commentary on what measures are being taken to tackle overdue case conferences/length of time on register**
	Trend Analysis and commentary

Duration of time on the Child Protection Register *(see Appendix 1 for guidance notes on performance indicators)*	
Definition: 1. The percentage of children whose names have been on the child protection register continuously for 2 years or more as at 31 March as a total of the number of children on the register; and 2. The percentage of children as at 31 March whose names had been on the register continuously for 2 years or more and were removed from the Child Protection Register	
Related Indicators: Re-registrations on the Child Protection Register	
Exclusions: **None**	
Outcome: Living in safety and with stability	
Number of Children on Child Protection Register as at 31 March	
Number of children as at 31 March who were on the Child Protection Register continuously for 2 or more years	
Number of children during the year whose names were removed from the register	
Number of children during the year whose names were removed from the register who on the day of de-registration had been on the register for 2 or more years	
The percentage of children whose names have been on the child protection register continuously for 2 years or more as at 31 March as a total of the number of children on the register	
The percentage of children as at 31 March whose names had been on the register continuously for 2 years or more and were removed from the Child Protection Register during the year u	

	HSCT
NUMERATOR 1. No of children whose names were on the register for 2 or more years.	
DENOMINATOR 1. Total number of children on the child protection register	
%	
NUMERATOR 2 . No of children whose names were removed from the register who had been on the register for 2 or more years.	

DENOMINATOR 2. Total number of children whose names were removed from the child protection register.		
%		

Comments

3 Children (NI) Order 1995		
3c Looked After Children		
3c.1	**How many Looked After Children in your Trust are under Care Orders or an accommodated basis**	
3c.1.1	**Number of Looked after children with host families**	
3c.1.2	**Number of Looked After children in respite care**	
3c.2	**Religion of Looked After Children**	
3c.3	**Ethnic origin of Looked After Children**	
3c.4	**Number of Looked After Children by type of placement, i.e. fostercare, residential, secure accommodation, with family, other**	
3c.5	**What facilities – statutory, voluntary and private are available to care for these Looked After Children i.e. how many places in residential homes, foster care placements**	
3c.6	**How many placement moves has each Looked After Children had (excluding respite)**	
3c.7	**How many Looked After Children are awaiting assessment or treatment with child and adolescent mental health services**	
3c.8	**How many children are also on Child Protection Register**	
3c.9	**Has each Looked After Children been allocated a social worker *(Narrative)***	

3c.10	**Is each Looked After child being visited by a social worker at least once a month (narrative)**	
3c.11	**Is the case of each Looked After Children reviewed in line with statutory requirements *(narrative)***	
3c.11.1	**No. of Looked After Children Reviews held during the year**	
3c.11.2	**No. of these Looked After Children Reviews which were outside of statutory timescales**	
3.c.12	**For children accommodated by the Trust under Article 21 of the Children Order, what arrangements has the Trust in place to ensure that it has the appropriate degree of parental responsibility to care for these children *(narrative)***	
3.c.13	**Is there an adequate supply of placements for children to enable placement choice *(Narrative)***	

3.c.14	**How many exceptions to the normal fostering limit were made to foster care approvals in order for a child to be placed in an emergency in the last 12 months** ***(narrative)***	
3.c.15	**What is the formal scheme of delegation that specifies who can agree such an exemption** ***(Narrative)***	
3.c.16	**How many children are deemed to be in an inappropriate placement given their assessed needs** ***(Narrative)***	
3.c.17	**Do all looked after children have a permanency plan by the time of their first 3 month statutory LAC Review**	

3.c.18	**Can foster carers get access to support 24 hours a day throughout the year** ***(narrative)***	
3.c.19	**What action is being taken to monitor and reduce the number of placement moves experienced by Looked After Children** ***(narrative)***	
3.c.20	**How many Looked After Children are involved in offending behaviour and what is being done in partnership with other agencies to reduce this** ***(narrative)***	

3.c.21	**What action is being taken to address the health needs of Looked After Children** ***(narrative)***	
3.c.22	**What progress are children making at school and what are their examination results**	
3.c.23	**How many looked after children are currently suspended or expelled from school**	
3.c.24	**Since the last report how many children have been notified to the police as having run away from residential or foster care**	
3.c.25	**Number of childminders and any issues (narrative)**	
	Number of new registrations	
	Number of de-registrations	
	Number of outstanding applications	
3.c.26	**Number of children accommodated by ELB for 3 months or more by category**	

MAHI - STM - 097 - 5140

PERFORMANCE INDICATORS FOR SOCIAL CARE STATUTORY FUNCTIONS 08/09

STABILITY OF PLACEMENT OF LOOKED AFTER CHILDREN *(see Appendix 1 for guidance notes on performance indicators)*	
Definition: The percentage of looked after children as at 31 March who had 3 or more separate placements over any 6 month period in the preceding year	
Related Indicators: Long term stability of looked after children Permanency - % of looked after children placed for adoption and the timescales	
Exclusions: Planned respite (up to 28 days at a time) Holidays Hospital admissions ***These exclusions would not be considered to be a change in placement resulting in instabilities.***	
Outcome: **Living in Safety and with Stability**	
Number of looked after children as at 31 March that had 3 or more separate placements (over any 6 month period in preceding year)	
Total number of looked after children as at 31 March	

	HSCT
NUMERATOR No of LAC at 31 March that had 3 or more separate placements over a six month period.	
DENOMINATOR No of LAC on 31st March 2009.	
%	

Comments

Long Term Stability of Looked After Children *(see Appendix 1 for guidance notes on performance indicators)*	
Definition: The percentage of children as at 31 March who had been looked after continuously for at least 2 ½ years, who were currently in a foster placement where they had spent the last 2 years	
Related Indicators: Stability of placements of looked after children	
Exclusions: Children looked after at any time during that period under an agreed set of short term placements A child placed for adoption with their existing foster carers is not counted as a change of placement	
Outcome: Living in safety and with stability	
Number of children who had been continuously looked after at least 2 ½ years as at 31 March	
The number of those who were in a foster placement as at 31 March	
Of the number of those in foster placement at 31 March, how many had been with the same foster carer continuously for at least 2 years	
Percentage of children as at 31 March who had been looked after continuously for at least 2 ½ years, who were currently in a foster placement where they had spent the last 2 years	

	HSCT
<u>NUMERATOR</u> No of children in foster placement, who have been with the same foster carer continuously for at least 2 years	
<u>DENOMINATOR</u> No of children looked after continuously for at least 2.5 years	
%	

Comments	

3d CHILDREN (LEAVING CARE) ACT (NI) 2002
Article 34E, Article 34F

3d.1	**Number of young people allocated a personal advisor**	
3d1.1	**Number of young people awaiting a personal advisor**	
3d.2	**Number of young people with a pathway plan**	
3d.3	**Number of young people who meet the criteria but do not have a pathway plan**	
3d.4	**How many young people have left care during the year**	
3d.4.1	**Where did these young people go to live**	
3d.5	**How many young people who left care at age 16 or over are still in touch with their social worker, carer or other approved person**	
3d.6	**What progress do young people make after leaving care – current activity education/employment/training**	
3d.7	**How many care leavers are employed/unemployed**	
3d.8	**How many care leavers are themselves parents**	
3d.9	**How many care leavers are homeless or living in bed and breakfast arrangements and what action is being taken to provide these young people with supportive housing *(narrative)***	

OVERALL SUMMARY OF ISSUES RAISED WITHIN CC3/02

Adoption Legislation

4 Adoption (NI) Order 1987		
Article 3(as amended by HPSS Order 1994), Article 11		
4.1	**Number of Prospective Domestic Adopters awaiting assessment**	
4.2	**Number of Prospective Inter-country adopters awaiting assessment**	
4.3	**Number of children freed for adoption awaiting an adoptive family placement**	
4.4a	**Number of Looked After Children who were made subject of an adoption order**	
4.4b	**Number of Looked After Children placed for adoption (*i.e. freed, consent, permanency panel match, in adoptive placement)***	
4.5	**Details of recruitment, assessment, training, support for prospective adopters**	
4.6	**Details of Post Adoption Support**	
4.7	**Number of children referred for permanency planning**	

4b ADOPTION (INTERCOUNTRY ASPECTS) ACT (NI) 2001		
4b.1	**Number of inter-country applications and outcomes (total)**	
4b.2	**Number adoption orders granted**	
4b.3	**Number of adoption orders pending**	
4b.4	**Number of adoption orders approved**	
4b.5	**Number of applications waiting for assessment**	

5 CHRONICALLY SICK AND DISABLED PERSONS (NI) ACT 1978;	
5.1	**Details of patients <65 in hospital for long term (>3months) care who are being treated in hospital accommodation for >65**

6 DISABLED PERSONS (NI) ACT 1989 *Note: 'disabled people' includes individuals with physical disability, sensory impairment, learning disability*		
6.1	**Number of referrals to Physical/Learning/sensory Disability** ***(source: SOSCARE)***	
	Number of cases allocated	
6.2	**Number of assessments of need carried out**	
6.3	**Types of need that could not be met:**	
6.4	**Number of assessments of disabled children ceasing full time education**	

7 HEALTH AND PERSONAL SOCIAL SERVICES (NI) ORDER 1972;
Article15, Article 36 [as amended by Registered Homes (NI) Order 1992]

7.1	Number of Article 15 (HPSS Order) Payments	
7.2	Number of people in residential or nursing care	

8 CARERS AND DIRECT PAYMENTS ACT 2002

8.1	**Number of Adult carers receiving individual carers assessments**	
8.1.b	**Number of Carers receiving a service**	
8.2	**Number of young carers assessed**	
8.2.b	**Number of young carers receiving a service**	
8.3	**Number of people receiving direct payments**	
8.4	**Number of carers receiving direct payments**	

Commentary

Service Users in Receipt of Direct Payments *(see Appendix 1 for guidance notes on performance indicators)*	
Definition: The percentage of eligible users who are in receipt of direct payments in each programme of care at 31 March	
Related Indicators: No. of Carers in Receipt of Direct Payments	

	HSCT
NUMERATOR No of service users in receipt of direct payments in each Programme of Care .	
Children – POC 3	
Elderly – POC 4	
Mental Health – POC 5	
Learning Disability – POC 6	
Phy Disability – POC 7	
DENOMINATOR No of service users who are in receipt of services in each Programme of Care who fall within the eligibility criteria.	
Children – POC 3	
Elderly – POC 4	
Mental Health – POC 5	
Learning Disability – POC 6	
Phy Disability – POC 7	
%	
Children – POC 3	
Elderly – POC 4	
Mental Health – POC 5	
Learning Disability – POC 6	
Phy Disability – POC 7	

Commentary

Carers Assessment *(see Appendix 1 for guidance notes on performance indicators)*	
Definition:Percentage of new Service Users/carers who have been offered a carers assessment	
Definition:Percentage of new Service Users/carers who have undertaken a carers assessment	

	HSCT
<u>NUMERATOR</u> No of completed individual carers needs assessments in each Programme of Care .	
Children – POC 3	
Elderly – POC 4	
Mental Health – POC 5	
Learning Disability – POC 6	
Phy Disability – POC 7	
<u>DENOMINATOR</u> No of new service users receiving a service by Programme of Care.	
Children – POC 3	
Elderly – POC 4	
Mental Health – POC 5	
Learning Disability – POC 6	
Phy Disability – POC 7	
%	
Children – POC 3	
Elderly – POC 4	
Mental Health – POC 5	
Learning Disability – POC 6	
Phy Disability – POC 7	
HEALTH AND SOCIAL TRUST %	

Commentary

APPENDIX 1

PERFORMANCE INDICATORS FOR SOCIAL CARE STATUTORY FUNCTIONS 2008 - 09

INTRODUCTION

The attached indicators have been agreed for the year 08/09 in relation to the monitoring of social care delegated statutory functions.

A small number of indicators have been agreed for both Children's Services and Adult Services. Trusts are expected to include specific information on these indicators within their statutory functions reporting for the period April 08 – March 09.

These indictors will be accepted as indicators for safe and effective care in respect of the designated social service to which they refer.

The indicators relate to specific evidence based outcomes that are known to improve the quality of life of children and adults in respect of social services. It is envisaged that reporting on them over time will give a clear indication of improved quality outcomes and areas that require a particular focus to improve quality outcomes.

It is anticipated that these indicators will be added to over the coming years.

MAHI - STM - 097 - 5156

Stability of Placement of Looked after Children

Definition

The percentage of looked after children at 31 March who had 3 or more separate placements over any 6 month period in the preceding year.

Related Indicators

- Long term stability of children looked after.
- Permanency – % of looked after children placed for adoption and the timescales

Calculation Details

Calculate as numerator/denominator as a percentage

Numerator Definition

The number of looked after children at 31 March that had 3 or more separate placements over a six month period within the previous year.

Denominator Definition

The total number of looked after children on 31st March

Denominator Exclusions

- Planned respite (up to 28 days at a time)
- Holidays
- Hospital admissions

These exclusions would not be considered to be a change in placement resulting in instabilities

Measurement Period length

Six monthly at 30 September and 31 March
To be reported upon annually

Definition of Terms

Looked after Child
A child looked after by an authority is a child who is (a) in the care of the authority or (b) who is provided with accommodation by the authority, for a period of more than 24 hours. (Article 25 (1) (a), (b) and 25 (2) Children NI Order 1995

Data Collection & Analysis Tools

Information can be collected through

- Corporate Parenting Returns
- Permanency Plans

Rationale for Indicator

This indicator is an important measure of the stability of care that a child has experienced. On the whole stability is associated with better outcomes. Proper assessment of a child's needs and an adequate choice of placements to meet the varied needs of different children are essential if appropriate stable placements are to be made. Inappropriate placements often break down and lead to frequent moves. The circumstances of some individual children will require 3 or more separate placements during a a six month period if they and others are to be kept safe, but more can be done to reduce the number of moves.

Outcome
Living in safety and with stability

'Our Children – Our Pledge' A Ten Year Strategy for Children and Young People In Northern Ireland 2006-2016, OFMDFM

Long Term Stability of Looked after Children

Definition

The percentage of children at 31 March who had been looked after continuously for at least 2½ years, who were currently in a foster placement where they had spent the last 2 years

Related indicators

- Stability of placements of looked after children

Calculation Details

Calculate as numerator/denominator as a percentage

Numerator Definition

Of the children who had been continuously looked after for at least 2 ½ years, the number who were in a foster placement, and who had at the 31st March been with the same foster carer continuously for at least 2 years.

Denominator Definition

The number of children looked after at 31st March who had been looked after continuously for at least 2 ½ (i.e. for more than 913 days inclusive of 31st March)

Denominator Exclusions

- Children looked after at any time during that period under an agreed set of short term placements.

- A child placed for adoption with their existing foster carers is not counted as a change of placement.

Measurement Period length

To be reported upon annually

Definition of Terms

Looked after Child
A child looked after by an authority is a child who is (a) in the care of the authority or (b) who is provided with accommodation by the authority, for a period of more than 24 hours. (Article 25 (1) (a), (b) and 25 (2) Children NI Order 1995

Data Collection & Analysis Tools

Information can be collected through

- Corporate Parenting Returns
- Permanency Plans

Rationale for Indicator

To increase the long-term stability of children who remain in care for significant periods of time. Stability is associated with better outcomes. Placements break down because they are not sufficiently well-matched to children's needs, or of sufficient quality, or because they are not well supported. Placement breakdown has a significant impact on children's wellbeing and their friendships, as well as disrupting their education and the continuity of access to other key services.

Outcome

Living in safety and with stability

'Our Children – Our Pledge' A Ten Year Strategy for Children and Young People In Northern Ireland 2006-2016, OFMDFM

Duration of time on the Child Protection Register

Definition

1. The percentage of children whose names have been on the child protection register continuously for 2 years or more at 31 March as a total of the no of children on the register; and

2. The percentage of children at 31 March whose names had been on the register continuously for 2 years or more and were removed from the child protection register during the year.

Related Indicators

- Re-registrations on the child protection register

Calculation Details

Calculate as numerator/denominator as a percentage

Numerator Definition

1. The number of children whose names were on the register at 31 March and who have been continuously on the register for 2 or more years.

2. The number of children who names were removed from the register who on the day of de-registration had been on the register for 2 or more years.

Denominator Definition

1. The total number of children whose names were on the child protection register on 31st March

2. The total number of children whose names were removed from the register during the year

A child may be counted more than once

Denominator Exclusions:

- None

Measurement Period Length

Six months at 30 September and 31 March
To be reported upon annually

Data collection & Analysis Tool:

Information can be collected through

- Corporate parenting returns
- ACPC statistical returns

Rationale for Indicator

This indicator should help to measure whether children and their families are receiving the services necessary to bring about the required changes in the family situation and to monitor performance in working towards the outcomes outlined in the child protection plan. This indicator reflects the underlying principle that professionals should be working towards specified outcomes.

Outcome

Living in safety and with stability

'Our Children – Our Pledge' A Ten Year Strategy for Children and Young People In Northern Ireland 2006-2016, OFMDFM

Number of Adult Protection Referrals

Definition

The percentage of referrals for vulnerable adult investigations within the various programmes of care

Related Indicators

- Number of protection plans implemented

Calculation Details:

Calculate as numerator/denominator as a percentage

Numerator Definition

The number of vulnerable adult referrals within the year
(1st April – 31st March)
There will be a separate numerator for each of the programmes of care.

Denominator Definition

The relevant active caseload for each programme of care

- Elderly
- Mental health
- Physical & Sensory Disability
- Learning disability

Denominator Exclusions

- None

Measurement Period Lengths

To be reported upon annually

Definition of Terms

Adult Protection Referral
If an issue of concern re abuse/neglect/exploitation meets the criteria for vulnerable adult procedures is raised by a staff member with the relevant line manager and needs further action to establish the level of risk or to deal with the identified risk then it is an adult protection referral. Referrals can be identified from any location.

Vulnerable Adult
A person aged 18 yrs or over who is, or may be, in need of community care services OR is resident in a continuing care facility by reason of mental or other disability, age or illness OR who is, or may be, unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation. (Regional guidance)

Data Collection & Analysis Tools

Information can be collected through

- Local returns to Boards
- Annual Statutory Functions Monitoring Report

Rationale for Indicator

This indicator should help to measure the level of adult abuse being notified and thereby assist in reviewing the services available to respond to such situations.

Outcome

Living safely without fear of violence or abuse in any form

'Safeguarding Vulnerable Adults – Regional Adult Protection Policy & procedural Guidance' DHSSPS, 2006.

Adult Protection Plans in place

Definition

The percentage of Vulnerable Adult referrals who have a Protection Plan implemented.

Protection Plan *– "an agreement written or verbal, made with vulnerable adults in order to increase their resilience or mitigate any possible risk. It may be as a result of preliminary interview, post-strategy discussion or as an outcome of formal investigation....Plans will often include a combination of statutory support services, responses within the vulnerable adult's informal network and personal protection measures. But measures in even one of the domains can be viewed as a protection plan, provided it is the result of informed consent by the vulnerable and notified to a designated Officer."*

Related Indicators

Number of Adult Protection Referrals.

Numerator Definition

Number of Protection Plans in each Programme of Care initiated, where the start date, of the Protection Plan, falls between the 1 April and 31 March, inclusive, whether or not the Protection Plan is still in place at 31 March.

Denominator Definition

Number of Vulnerable Adult referrals between the 1 April and 31

March, inclusive.

There will be a separate Denominator for each of the following

Programmes of Care

- Elderly
- Mental Health
- Physical & Sensory Disability
- Learning Disability)

Denominator Exclusions

- Referrals which have been screened out.

Definition of Terms

Adult Protection Referral
If an issue of concern re abuse/neglect/exploitation meets the criteria for vulnerable adult procedures is raised by a staff member with the relevant line manager and needs further action to establish the level of risk or to deal with the identified risk then it is an adult protection referral.

Vulnerable Adult
A person aged 18 yrs or over who is, or may be, in need of community care services OR is resident in a continuing care facility by reason of mental or other disability, age or illness OR who is, or may be, unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation. (Regional guidance)

Data Collection & Analysis Tools

Information can be collected through

- Local returns to Boards
- Annual Statutory Functions Monitoring Report

Rationale for Indicator

This indicator helps to measure the effectiveness of adult protection arrangements. It supports the principles of the regional policies and procedures that an agreed plan of action is essential to safeguard the well-being of vulnerable adults.

Outcome

Living safely without fear of violence or abuse in any form

'Safeguarding Vulnerable Adults – Regional Adult Protection Policy & procedural Guidance' DHSSPS, 2006.

MAHI - STM - 097 - 5167

Service Users in Receipt of Direct Payments

Definition

The percentage of eligible users who are in receipt of direct payments in each programme of care at 31 March

Related Indicators

- Carers in receipt of direct payments

Calculation Details:

Calculate as numerator/denominator as a percentage

Numerator Definition

The number of service users in receipt of direct payments in each Programme of Care.

There will be a separate numerator for each of the following Programmes of Care

- Children
- Elderly
- Mental Health
- Physical & Disability and Sensory Disability
- Learning Disability

Denominator Definition

The number of service users who are in receipt of services in each Programme of Care who fall within the eligibility criteria as defined in Paragraph 1.1 of "Direct Payments Legislation and Guidance for Boards and Trusts" DHSSPS April 2004, at 31st March within current caseload and thus assessed as needing a service.

There will be a separate denominator for each programme of care.

Denominator Exclusions

Those identified in paragraph 1.4 of "Direct Payments Legislation and Guidance for Boards and Trusts" DHSSPS April 2004, at 31st March

Measurement period length

Every three months (i.e. 31 March, 30 June; 30 September; 31 December)
To be reported upon annually

Definition of Terms

Direct payment
Cash payments given to persons in lieu of services that would otherwise have been arranged for them by HSS Trusts so that they may arrange the provision of their own services. (2002 legislation)

Carer – for the purposes of direct payments
A carer is any person aged 16 or over who provides, or intends to provide, a substantial amount of unpaid and informal care to another person on a regular basis (this includes those with parental responsibility for a disabled child). Direct payments can be used to support the carer in their caring role or help maintain the carers' own health and wellbeing.

Data Collection & Analysis Tools

Information can be collected through

- CC8 returns to DHSSPS quarterly
- Annual Statutory Functions Monitoring Report

Rationale for Indicator

Direct Payments offer the individual user or carer greater flexibility in how their support is provided and ensure that their care and support package is directly responsive to their individual needs and wishes.

Outcome

Enabling people to take control over their lives by increasing choice, promoting independence and providing more flexible responses to assessed need.

'Policy & Practice Review Report', p3, DHSSPS, 2005.
'Direct Payments Legislation and Guidance for Boards and Trusts' DHSSPS, 2004

Carers & Direct Payment Act (NI) 2002

MAHI - STM - 097 - 5170

Carer's Assessments

Definition

The percentage of new service users/carers who have

a) been offered a carers assessment

b) a carer's assessment undertaken

Calculation Details

Calculate as numerator/denominator as a percentage

Numerator Definition

The number of completed individual carer's needs assessments in each programme of care, completed during the period of 1st April – 31st March inclusive.
There will be a separate numerator for each programme of care

Denominator Definition

The number of new service users receiving a service during this period 1st April to 31st March inclusive
Separate denominators for each programme of care

Denominator Exclusions

- Service users living permanently in residential and nursing homes.

Measurement Period Length

Every three months (quarterly)
To be reported upon annually

Definition of Terms

Carer
People who, without payment, provide help and support to a family member or friend who might not be able to manage without this help because of frailty, illness or disability. Carers can be adults caring for other adults, parents caring for ill or disabled children or young people(16+years) who care for another family member. (Regional Policy – 2006)

Carer's assessment
Assessment of the circumstances of a person, who is providing substantial and regular care to a member of family or friend, in order to determine whether the carer is eligible for support; determine the support needs of that carer; and if those needs can be met. (Regional Guidance – 2005)

Data Collection & Analysis Tools

Information can be collected through

- CA1 return to DHSSPS
- Annual Statutory Functions Monitoring Report

Rationale for Indicator

Support for carers is a key part of support for vulnerable people. Support for carers also enables carers to continue with their lives, families, work and contribution to their community. This measure provides a measurement of engagement with, and support to, carers.

Outcome

Enabling Carers to maintain their role for as long as they wish and it is appropriate and safe for them to do so.

‘Caring for Carers – Recognising and Supporting the Caring Role’, DHSSPS, 2006 – http://www.dhsspsni.gov.uk/ec-dhssps-caring-for-carers.pdf
‘Carers and Direct Payments Act (NI) 2002 – Carer’s Assessment and Information Guidance’, DHSSPS, 2005 – http://www.dhsspsni.gov.uk/ec-carers-assessment-information-guidance.pdf

BELFAST HEALTH & SOCIAL CARE TRUST

REGIONAL REPORTING TEMPLATE FOR DELEGATED STATUTORY FUNCTIONS

For Year end 31 March 2021

CONTENTS SHEET

1 EXECUTIVE SUMMARY

Executive Director of Social Work:

The Role of Executive Director of Social Work has been held by Mrs Carol Diffin from 1st September 2018.

……..
Please provide a high level summary overview which must include:

This Report provides an overview of the Trust's discharge of its statutory functions in respect of services delivered by the social work and social care workforce (the social care workforce). It addresses the assurance arrangements underpinning the delivery of these services across the individual Service Areas, outlines levels of compliance with the standards specified in the Scheme for the Delegation of Statutory Functions (Revised April 2010) (the Scheme for Delegation) and identifies on-going and future challenges in the provision of such services.

1.1 Executive Director of Social Work Statement of the Governance arrangements in place for safe and effective social work and social care services across the Trust

The Executive Director of Social Work is accountable for assurance of Trust organisational and governance arrangements underpinning the discharge of social care statutory functions and for the discharge of such functions by the Trust's social care workforce. An unbroken line of professional accountability runs virtually from the individual practitioner through the Service professional and line management structures to the Executive Director of Social Work and onto the Trust Board.

The Executive Director of Social Work:

- Provides professional leadership to the Trust's social care workforce.
- Provides expert advice to the Trust Board on all matters pertaining to the discharge of statutory functions.
- Is accountable for the assurance of all issues pertaining to the social care workforce's compliance with professional and regulatory standards.
- Is accountable for ensuring that appropriate arrangements are in place to discharge the Trust's statutory social care functions and for the assurance of same.
- Is required to report directly to the Trust Board on the discharge of these functions. The Annual Statutory Functions and six-monthly Corporate Parenting Reports are presented to Trust Board for consideration and approval.
- The Executive Director of Social Work is responsible for the completion of a quarterly update report to the Assurance Committee on the work of the Social Care Committee, including the work of the Social Care Steering Group (Divisional Social Workers) and the Adult and Childrens Safeguarding Committees respectively.

During this reporting period the Trust's social care workforce has been located across three Directorates: Adult Social and Primary Care, incorporating Older People's Services and Adult Learning Disability Services (including Muckamore Abbey Hospital); Women & Specialist Hospitals, incorporating Mental Health Services; and Childrens Community Services.

Each of the operational Directorates have established Divisions mirroring the former service delivery units and have established Senior Leadership Teams, which have accountability for Divisional service delivery, performance and governance arrangements. The Divisional Social Workers have assumed the responsibilities for professional Social Work practice as members of their Divisional Senior Leadership Team and accountably for the range of social care governance and service delivery functions.

Throughout the reporting period, the Divisional Social Workers have had a key organisational role in providing assurance with regard to the discharge of statutory functions. They have responsibility and are accountable for:

- The professional leadership of the Division's social work and social care workforce.
- The assurance of arrangements for the discharge of statutory functions relating to the delivery of statutory social care services by the Divisional workforce as detailed in the Regional Scheme of Delegation.
- The provision of expert advice to the Divisional Leadership Team on matters pertaining to the social work and social care workforce and the discharge of statutory social care functions.
- The establishment within the Division of arrangements to ensure an unbroken line of accountability for the discharge of statutory functions by the social work and social care workforce through the Divisional Social Worker to the Executive Director of Social Work.
- The establishment of arrangements and ongoing responsibility for the completion of the Divisional Interim and Annual Statutory Functions Reports.
- The establishment of arrangements to facilitate the completion of other reporting requirements (both internal and external) relating to the discharge of statutory functions.
- The establishment and assurance of Divisional arrangements to ensure the social work and social care workforce's compliance with NISCC's regulatory requirements.

The Trust's Assurance Framework outlines the overarching corporate mechanisms and related processes, which provide assurance as to the effectiveness of the systems in place to meet the Trust's objectives and to deliver appropriate outcomes.

The Trust has in place a Social Care Committee. The Committee Chair is Ms Anne O'Reilly, Non-Executive Director. There are three other members of the Committee who are also Non-Executive Directors, Ms Miriam Karp, Dr Martin Bradley and Mrs Nuala McKeagney. The Committee is

authorised by the Trust Board to review the Annual and Interim Statutory Functions Reports, the six-monthly Corporate Parenting Reports and miscellaneous other reports pertaining to the discharge of statutory functions prior to their presentation to Trust Board.

The Social Care Steering Group (membership of which is made up of the Divisional Social Workers and the Adult Safeguarding Lead) is a sub-committee of the Social Care Committee with responsibility for the monitoring of and reporting to the Committee on the discharge of statutory functions.

The Trust has a Children's Safeguarding Committee, which has responsibility for providing assurance to the Trust Board, via the Social Care Committee that appropriate and effective Trust-wide arrangements are in place to facilitate the discharge of its statutory responsibilities to safeguard the welfare of its childhood population. Membership of the Committee is drawn from senior operational and professional staff from each of the Trust's Divisions/Directorates and is chaired by the Executive Director of Social Work.

The Trust also has an Adult Safeguarding Committee, which mirrors the remit and structures outlined in respect of the Children's Safeguarding Committee from an adult safeguarding perspective.

The Trust's Risk Management Framework outlines the organisational arrangements underpinning the identification/assessment, ongoing management and review of risks and the related Trust Risk Register structures and processes. Each Service has its local Risk Register, which serves to populate Directorate and Trust's Corporate Risk Registers and Principal Risk Registers respectively. Directorate and corporate governance structures afford the mechanisms for the ongoing management and review of risks across the respective Registers.

The Trust's Adult Social Services Professional Social Work Supervision Policy (January 2014) and the Regional Supervision Policy Standards and Criteria (Revised November 2013) provide the framework for the delivery of professional social work supervision to social work staff in adult and children's services. The Trust's Supervision Policy and Procedures for Social Care Staff in Adult Services October 2011 outlines the processes and standards informing supervision delivery to social care staff. The Trust has achieved satisfactory compliance with the standards specified in the Revised Guidance for Registrants and their Employers NISCC July 2010 in relation to the supervision of AYE staff.

Compliance with supervision standards is monitored on an ongoing basis through Service and Trust-wide audit processes.

During this reporting period the Executive Director of Social Work was tasked by the Trust Board to undertake a review of Social Care Governance arrangements within the Trust. This work commenced in September 2020 and is focusing on the following areas:

- Strengthening the role of the Executive Director of Social Work within the Trust
- Developing the Executive Director Social Work role in respect of the social care workforce
- Developing a quality management system for social work and social care
- Improving the Trust's response to adult safeguarding issues

This review will be completed in the first quarter of the next reporting period.

1.2 Statement of the Executive Director of Social Work's assessment of the Trust's performance in effectively and efficiently delivering Delegated Statutory Functions during the reporting period

At the time of reporting last year the region was preparing for the peak of the first wave of the Covid 19 pandemic and the first period of lockdown had just commenced on 24th March 2020. The past year has been one of unprecedented challenge for the health and social care system as a whole as the pandemic has surged/peaked on three different occasions followed by periods of recovery and rebuild. Staff across the Trust have worked tirelessly to deliver services to the most vulnerable and have had to be flexible, agile and creative in how they have done so, adopting new ways of working and communicating whilst at the same time providing direct care to those most at risk and in need.

Despite these challenges, the Trust has continued to prioritise the safe discharge of its statutory functions and it is my professional opinion that the Trust has overall achieved satisfactory compliance with the requirements specified in the Scheme for Delegation.

The individual Service returns provide detailed commentaries on the levels of compliance, areas of difficulty, achievements and emerging trends in relation to the delivery of statutory services.

The Trust has co-operated fully with the Regulation and Quality Improvement Authority (RQIA) in the discharge of its functions and worked hard to address any concerns raised.

The Trust is compliant with NISCC's Code of Practice for Employers. With regard to the registration of the workforce, the Trust has arrangements in place to monitor and assure compliance with registration requirements. During the course of the reporting period, it became apparent that these arrangements required to be strengthened in respect of a cohort of social care staff. All issues of non-compliance have been identified and addressed and the learning will be shared across the Trust. The Trust is engaged in regular formal and informal contacts with NISCC.

As at 31 March 2021, the Trust had achieved full compliance with NISCC registration across all sectors of its social care staff.

1.3 Comment on the Trust's progress in delivering the 2019/2020 local DSF Plan (further detail to be provided for each Programme of Care at Section 2.6)

This has been a challenging year for the Trust in the context of the the delivery of services during a pandemic. Despite the impact of having to respond to the pandemic, progress has been made by each Programme of Care with their local DSF Action Plans, which are detailed in the individual service areas summaries.

The key areas of progress are as follows:

Older Peoples Programme of Care

Domiciliary Care
The Trust continues to have an overreliance on the independent sector for the provision of domiciliary care and is continuing to work towards a reform of its own statutory Homecare Service. Over the past year there has been a significant and sustained reduction of more than 65% in the level of unmet need across this division.

Continuing Healthcare
The Trust recently received the outcome of a NIPSO investigation, which concluded a finding of maladministration against the Trust for failure to implement a Continuing Health Care policy in line with the 2010 Care Management Circular. This finding has brought clarity for the Trust in respect of the regional position on this matter.

Implementation of the Mental Capacity Act
Some progress has been made within Older Peoples PoC in respect of the assessment of the legacy cases although the ongoing challenges in meeting the May 2021 deadline will be discussed in the next section.

Mental Health Programme of Care

Completion of ASW reports within 5 days
The service has always strived to complete its ASW reports within 5 working days. This year only 2 reports were not completed within this timescale compared to 26 reports last year. This is a significant improvement during a time when the service was under considerable pressure due to the pandemic.

Amalgamation of primary care and the recovery services
This work has continued over the past year. Progress has been made in completing a caseload waiting tool for the community teams and many of the social work vacancies have been filled.

Learning Disability

Domiciliary care

The number of cases on the waiting list for domiciliary care packages has continued to decrease, with further work being undertaken to increase capacity by May 2021.

Implementation of the Mental Capacity Act

Whilst some progress has been made in respect of the legacy cases the service still has a significant number of deprivation of liberty assessments to complete due to a lack of capacity across the division. All staff have been trained in the MCA and a steering group has been established along with a database to monitor progress.

Iveagh delayed discharges

The number of delayed discharges had reduced from 4 to 2 by the end of the reporting period and the Trust has been involved in a number of Judicial Proceedings (JR) taken in respect of these delays over the past year. The settlement reached in respect of a number of these JR proceedings has required the Trust to enhance the Operational Policy of Iveagh to ensure that escalation arrangements for delayed discharges are explicit. It has also required to HSCB to establish a standing forum to monitor the issue of delayed discharges.

Resettlement of patients from Muckamore Abbey into the Community.

The Trust has continued to be very active in planning for the resettlement of its patients with 6 successful discharges during the reporting period and 3 further patients on trial leave at the 31st March 2021. Planning continues in respect of the 16 remaining Belfast Trust patients.

Adult Safeguarding in Muckamore Abbey Hospital

A significant amount of work has been undertaken in respect of the Safeguarding Improvement Notice that was issued my RQIA in 2019 with the result that it was lifted in April 2020. The detail of the work undertaken is outlined in Section 2.5 of the Learning Disability Report and details the following: the development of new materials to support staff to understand their responsibilities in respect of adult safeguarding; the embedding of safeguarding into everyday core business through safety briefings, weekly ASG meeting; the development of an extensive data set providing information regarding safeguarding incidents, use of seclusion and use of restraint; and the introduction of regular audits.

Workforce

The Division has been successful in recruiting to some key social work posts such as the service manager with responsibility for adult safeguarding, hospital and community teams and the adult safeguarding lead post. The service also secured agreement for the recruitment of a professional social work band 8a post, which will support the Divisional Social Worker in strengthening the governance arrangements for social work and social care in this Division once appointed. Agreement has also been secured to recruit a number of designated social work team leader posts who will also undertake the role of DAPO given the challenges of recruiting sufficient DAPOs in this

division. Recruitment is also underway to recruit senior practitioner posts to fulfil the role of DAPO and band 6 posts to undertake the role of IO.

Children's Community Services

Detention under the MHO/delayed discharges from Iveagh and development of appropriate community placements
During the course of the year, the Directorate had two delayed discharges in the Iveagh Centre. One of these children was discharged to the care of his parents and has since transitioned to Adult Learning Disability Services. The second child remains in the Iveagh Centre. The Trust submitted two business cases to the HSCB in respect of packages of care required to meet the assessed needs of these young people and these continue to be discussed between all relevant parties. Both delayed discharges have been the subject of JR proceedings with a settlement reached in respect of one child and a contested hearing proceeding in respect of the other. The Trust has continued to work with the HSCB in respect of the dearth of appropriate resources for this service user group and a Framework for Children with Disability is currently being finalised by the HSCB, which will hopefully address some of the deficits in service provision.

In respect of assessments undertaken under the Mental Capacity Act the service has made good progress and aims to have all assessments completed by the deadline May 2021.

Personal Advisors
Whilst some progress was made initially during the reporting period in addressing the waiting list for personal advisors this has not been sustained due to ongoing staffing issues and the impact of Covid. Further detail will be provided in Section 1.4.

Early Years Inspections
As a result of Covid the inspection of early years facilities was paused during the first lock down and an action plan put in place to address this backlog by the end of September 2020. This action plan had not taken account of the subsequent second and third periods of lockdown and therefore progress was not achieved as outlined. The service worked within the agreements outlined by the DOH and HSCB. This will be addressed more fully in Section 1.4.

1.4 Identify the areas where the Trust has not adequately discharged their statutory functions and the actions taken to address this (further detail to be provided for each Programme of Care at Section 2.7)

The following is an overview of a number of areas, which have generated particular challenges in relation to the discharge of statutory functions over the reporting period. The individual Service reports provide additional commentary on these themes.

Implementation of the Mental Capacity Act (NI) 2016 Phase 1 (MCA)

The Mental Capacity Act has continued to be implemented across the Trust, although the challenges associated with providing services during the pandemic, along with workforce issues across the professions, has meant that the Trust has not made as much progress in respect of the legacy cases as it had hoped. Older Peoples and Learning Disability services have all reported that they will not meet the requirements by the May deadline given the volume of assessments to be completed and the challenges of rebuilding services. The Trust, along with the other four Trusts have highlighted their concerns to the DOH in respect of meeting this extended deadline. The Services continue to keep a focus on this work and to prioritise the completion of these assessments. Additional staff where possible, will be brought into support the existing teams to complete this work where this is possible.

Domiciliary Care

Whilst progress has been made in reducing the number of cases requiring domiciliary care packages across both Older Peoples and Learning Disability Services there continues to remain a level of unmet need in both of these areas. 290 individuals were awaiting care packages at the end of the reporting period. Priority continues to be given to support those individuals needing to be discharged from hospital rather than those already in the community. This represents a significant risk to service users and carers, in terms of unmet assessed need and additional carer stress. All unmet need cases are risk assessed and there continues to be arrangements in place for the prioritisation of high-risk cases. Further work is being undertaken to improve how the packages are provided and this will hopefully address some of the capacity issues and address user experience.

ASW Workforce

Recruitment and retention of ASW staff to populate the Trust's ASW rota has continued to be a challenge and whilst the Trust has managed to maintain this rota during the reporting period this was only possible with the early recruitment of 8 ASW candidates who were appointed by August 2020 under the Coronavirus Act (2020) with modifications to the MHO. Issues that continue to impact on the ability to interest staff to undertake this role are linked to the following:

- the additional pressures this role places on staff on top of their core role and
- the regular and significant delays they experience when requiring out of Trust beds resulting in lengthy assessments which in turn impacts on their work life balance and their health and safety

The Trust is exploring the development of an ASW hub to provide support to staff when on the rota, along with a formal on call rota to support staff when they are working beyond their normal hours. In

addition the Trust has invested in a patient conveyancing contract to reduce the waiting times for service users and has also continued to work with RESWS to agree transfer of some patients where the admissions process is likely to be significantly delayed.

Annual Reviews for Older People

The Older Peoples service has a significant backlog in relation to the completion of statutory annual reviews for both care homes and domiciliary settings. Whilst all non-essential reviews were stood down with agreement from the DOH during the pandemic, the backlog presents significant risk in respect of timely engagement and review of service users by the service and the ability of the service area to be assured in relation to the quality of care experienced by service users. The service has developed an action plan for restarting these reviews although it is anticipated that this will not be completed until December 2021.

CREST

All long term permanent care home cases are now managed within CREST within BHSCT. The work of this team has been impacted on by ongoing staff vacancies within the team, the disproportionate impact of the Mental Capacity Act on current cases and the need to restart the annual reviews. This has now been placed on the Trust's Principle Risk Register with actions being undertaken to improve staffing levels and ensure prioritisation of high risk cases.

Timely recording and closure of historic hospital social work cases

During the Covid period, due to the additional pressures to discharge patients in a very timely manner and also the number of staff being redeployed from some of the hospital sites, the service struggled to manage timely recording and historical case closures. An action plan has been put in place to address this as the service rebuilds and it is hoped that all historical cases will be closed by July 2021.

Adult Safeguarding

The Trust has continued to prioritise Adult Safeguarding during the reporting period and has placed this area of work on its Principle Risk Register given the concerns that have been highlighted by RQIA over the past year in respect of a number of facilities eg Shannon Clinic, Meadowlands, Valencia. An action plan has been developed by the Adult Safeguarding Committee to address these deficits in respect of the following: staff awareness of safeguarding policy and procedures, training of the workforce, recruitment of specialist adult safeguarding positions in some divisions, supporting the shared learning across the Trust where practice has improved e.g. Outpatients and Muckamore Abbey Hospital and collation of timely data.

The Trust has experienced challenges with regard to the recruitment of staff to specialist posts such as DAPOs and IOs particularly from within the Learning Disability Programme of Care. To address some of these deficits it has been agreed that the recruitment of future Team Leader posts within this service will now be designated SW posts, who will also undertake the role of DAPO. Currently there are additional pressures on the existing resource to the extent that demand is greater than the capacity of the ASG staff and this has caused ASG staff to be under significant stress which in turn impacts on retention of staff to these posts.

Community Placements for adults with a Learning Disability

Due to a lack of community infrastructure, the Adult Learning Disability service area continues to have difficulty finding suitable accommodation for its service users with complex and challenging needs resulting in delayed discharges from Muckamore Hospital. The service has undertaken a number of pieces of work to address this deficit: regional procurement for complex cases, development of an accommodation plan through to 2023, developing a business case for a Supported Living Development.

Children's Community Services

Personal Advisors

At the end of the last reporting period the Trust reported that it had 103 young people who did not have a personal advisor. An action plan was put in place and the Trust had hoped to have reduced this number significantly during the course of the year. Unfortunately due to a number of factors such as: the increased number of young people remaining in care; the impact of having to respond to the pandemic and the broader workforce challenges the total number at the period end is 83.The Trust will continue to work towards decreasing this number over the next few months as it begins to rebuild its services.

Unallocated cases/Statutory Visits/Statutory Reviews

The Directorate continues to make good progress in working to reduce the number of unallocated cases across Gateway, Family Support and Children with a Disability services. The Trust has recruited to the 9 senior practitioner social work posts that were funded through an IPT to address the issue of unallocated cases across these service areas and is currently out for recruitment of the permanent band 4 positions.

The Directorate has not been able to ensure that all looked after children have had an allocated social worker consistently throughout the year and has reported that 65 children over the course of the year did not have an allocated social work at some point and 35 young people remaining without a named social worker at period end. Despite the \trust agreeing to fund at risk an additional team to respond to the growing numbers of looked after children remaining in care it has been

unsuccessful in recruiting and retaining enough staff to ensure this new team is populated. Further work is underway to review caseloads across the Directorate to see if there is any scope to realign team structures. In addition, the Trust continues to proactively address recruitment and retention challenges.

94 statutory reviews did not take place within regulatory timescales mainly linked to the impact of Covid on the workforce and families, resulting in delays requiring to be facilitated to ensure all necessary staff and family members were able to attend. In addition, some reviews were delayed due to staff vacancies. The Directorate can report that all outstanding Reviews have now been completed and as part of its rebuild plan will ensure that these Reviews are undertaken within timescale as we move forward.

Placement Moves

Whilst the overall number of children who have experienced a move of placement has decreased from 179 last year to 117 during this reporting period, the number of children experiencing 2 or more moves has remained constant.

Challenges remain in respect of matching children with the most appropriate placement when they initially are admitted into care. The growing numbers of children remaining in care for longer and the growing complexity of their needs means it is harder to meet their needs through the more traditional placements. This is across residential and fostering services. The residential Children's homes within BHSCT have remained at full capacity with no vacancies and on a number of occasions they have had to work out with their Statement of Purpose. The Trust has had to maintain its Home for 8-12 year olds such is the demand for placements for this group of children. Children and young people coming into care are presenting as very challenging due to their complex situations and the impact of trauma. The Directorate has continued to roll out a Trauma informed approach across residential, fostering and LAC services supported by TSS and this is beginning to impact positively on placements and staff.

The past year has been a particularly difficult one in respect of the recruitment of foster carers due to the usual methods of recruitment campaigns having to be paused due to the pandemic.

The Trust continues to look at a range of initiatives to support placements and minimize the need for a young person to move and these are outlined in Section 2.7 of the Children's Community Services Report.

Delayed Discharges from Iveagh / development of appropriate community placements

The Trust has one child who remains as a delayed discharge in the Iveagh Centre at the end of the reporting period. The Trust continues to

work with the DOH and HSCB to secure full approval for the capital and revenue funding required to meet this young persons assessed needs and to provide an appropriate community placement.

The Trust continues to be concerned at the lack of strategic direction with regard to the provision of a range of appropriate community placements for children with complex disabilities. During the reporting period the Trust has had to place two children with complex disabilities in its short breaks Home due to the lack of appropriate long term placements available both in the Trust and across the region. This has had a direct impact on the Trust's ability to provide residential short breaks to a range of families whose children are assessed as benefiting from these short breaks. The Trust has worked closely with the other Trusts and the HSCB to develop a framework for the provision of services to support this group of service users and their families. The Trust would request that the completion of this Framework is prioritised by the HSCB so that progress can be made in how these children and their families have their needs met in the most appropriate way.

Early Years Inspections

At the end of the last reporting period the Trust had a total of 89 Inspections outstanding and an action plan had been put in place to address them within the first half of the year. Unfortunately this plan did not take into account that the Covid pandemic would continue all year with a second and third surge. In line with DOH/HSCB regional direction these Inspections moved to a staggered inspection process from December 2020 with observation visits being deferred until March 2021 when Inspections resumed. At the end of the reporting period the Trust had a total of 355 inspections outstanding and an action plan had been established outlining how these would be addressed.

1.5 Comment on the Trust's current workforce arrangement for both the professional leadership of delegated statutory functions and the operational delivery of service

As outlined in Section 1.1 the Executive Director of Social Work provides professional leadership to the Trust's social care workforce. She is also accountable for ensuring that appropriate arrangements are in place to discharge the Trust's statutory social care functions and for the assurance of same. Within Children's Community Services the 2 Co-Director posts are designated social work posts which ensures the delivery of statutory functions across all areas of children's social work. Within ACOPs, Learning Disability and Mental Health Services the Director and Co-Director posts are non designated social work posts but they hold operational responsibility for the delivery of the Trust delegated statutory functions.

The Trust has four Divisional Social Workers who are key members of the Divisional teams. They are responsible for providing professional leadership of the Division's social work and social care workforce and for

providing expert advice to the Divisional Leadership Team on matters pertaining to the social work and social care workforce and the discharge of statutory social care functions. They are also responsible for the establishment within the Division of arrangements to ensure an unbroken line of accountability for the discharge of statutory functions by the social work and social care workforce through the Divisional Social Worker to the Executive Director of Social Work.

Each of the Divisional Social Workers is responsible for highlighting any issues in relation to the social work and social care workforce to the operational managers within the Divisional teams, their Director and to the Executive Director of Social Work. The Executive Director of Social Work has regular meetings with the divisional social workers to ensure the delivery of statutory functions across the Trust and also meets with the relevant Directors to discuss any issues arising that impact on the delivery of statutory functions.

The Trust has participated in the Regional Review of the Social Work workforce led by the DOH and awaits the completion of the final report.

The challenges of recruiting and retaining a social work and social care workforce are highlighted in each service areas report particularly at band 5/6 with the exception of Older Peoples Programme of Care. The need to encourage and support social workers to progress through to team leader posts and further up the line management structure will be a priority over the next few years. This is key to ensuring that social work has a strong voice at all levels of the organisation.

The Trust remains concerned at the high level of vacancies, particularly in Children's Community Services and also in relation to some of the key specialist posts ie ASW, DAPO and IO despite proactively going out to recruit. Additional support was provided by the Learning and Development team to the AYEs who graduated and commenced work early due to the pandemic and the Trust is keen to continue with this model going forward to support the retention of staff in these high turnover areas. The Executive Director of Social Work has also commenced a workforce strategy for social work and has identified four key areas of work: Ensuring sufficient capacity; Creating interest in social work as a profession; Creating the environment and Supporting the workforce. This work will continue in the next reporting period.

Despite these challenges the workforce has to be commended for remaining agile and flexible in how they provided services throughout this time adopting new ways of working using virtual methods; use of technology; use of PPE; additional reporting within the Trust to ensure that regional guidance and Action Cards were adhered to; redeployment of staff to ensure staffing levels remained at a level to operate key services for children young people families, vulnerable older people, those with mental health and learning disabilities.

The impact of the past year's pandemic on our staff cannot be underestimated and will continue as the Trust moves to rebuilding services over the next year.

The resilience and creativity of Social Work and Social Care Staff throughout this past year is a testament to their commitment to the needs of the most vulnerable in society and the strong desire to promote service users rights whilst ensuring their welfare and safety remains paramount. Throughout this past year staff worked tirelessly, to ensure that services continued to be delivered to the most vulnerable whilst they were challenged in how to keep themselves and their own families' safe.

I would wish to place on record my thanks to the social work and social care workforce in BHSCT for their commitment to providing safe, effective and compassionate services to our most vulnerable during what has been a very challenging and unprecedented year.

Carol Diffin
Executive Director of Social Work

Date 14th May 2021

2. PROGRAMME OF CARE SUMMARY

Programme of Care / Directorate:- Older People's Services

2.1	Named Officer responsible for professional Social Work
2.1a	**Accountability Arrangements - Please provide a copy of your Organisational Structure from Assistant Director to Band 7 Staff** Ms Tracy Reid is the Divisional Social Worker for Adult, Community and Older People's Services. The Divisional Social Worker has responsibility for professional issues pertaining to the social work workforce within the service area of Adult, Community and Older People's Services (ACOPS). This includes the areas of Community Social Work, Hospital Social Work, Adult Protection Gateway Team and singleton Social Workers across multi-disciplinary teams in Older People's Services. Within ACOPS, key working responsibilities and statutory duties to Older People in long-term care are discharged by the Care Review and Support Team (CREST). This is a multi-disciplinary team, with the current majority of key workers coming from a Social Work background. Ms Reid is accountable to the Executive Director of Social Work for the assurance of organisational arrangements underpinning the discharge of statutory functions related to the delivery of Social Work services within the Service Area. The responsibility of the Divisional Social Worker is outlined in section 1.1 An unbroken line of accountability for the discharge of statutory functions by the social work workforce, runs from the individual practitioner through the service area professional structures to the Executive Director of Social Work and onto the Trust Board. There is an ongoing audit process in place to assure the line of accountability within the service areas and the service area is compliant with its responsibilities. The service area can confirm that there are no current breaks in the professional line of accountability. **Highlight any vacancies and the action taken to recruit against these.** There are no vacancies within the line of accountability for the discharge of statutory function
2.1b	**Please highlight key Social Work Workforce planning issues, including recruitment, retention and professional roles (ie. ASW, DAPO, JP). Information provided should include level and type of vacancies and any vacancy control systems in place.**

Recruitment and Retention

During this reporting period, Community Social Work teams continued to work towards stabilising the social work workforce, and have demonstrably reduced dependency on agency and temporary staffing. In 2016 Community Social Work began a transformational process to transition from a high dependency on social care staff, to develop a workforce model to ensure that there were sufficient levels of professional staff to deliver statutory and professional duties to older people. The service area is pleased to report that it will have achieved its objective of a service composition of 70% Social Work staff and 30% non-professional Social Care staff by the end of April 2021. A recruitment day for Social Workers was held on 12th December 2020 resulting in the appointment of 19 permanent Social Workers across eight community teams. The service area can report that all posts within the management and professional structure for Community Social Work are filled.

The Care Review and Support Team (CREST) has been significantly impacted by vacancies over this reporting period and this continues to impact upon the service areas ability to meet its statutory duties. Since the inception of the service CREST has struggled to retain the required staffing model. The current staffing model is for 20 WTE Band 6 Practitioners. There are presently 8 vacant Band 6 posts (40%) and 2 vacant Band 7 posts (50% vacancy). The service area has undertaken a scoping exercise for voluntary staff re-deployments to the service, to provide support to the team. However, this has not achieved the desired impact. There is an active rolling recruitment campaign in place. The service area is pleased to report that 5 WTE Band 6 posts have been offered, with staff due to commence in early June 2021. Interviews for Band 7 posts are due in April 2021. The desirable skill mix, for the team would be 40% Social Work, 40% Nursing and 20% either or AHP. The team currently has a skill mix of 20% Nursing and 80% Social Work. The service has particularly struggled to recruit nurses to the team and this continues to be an area of focus. The impact of chronic vacancies, caseload demand and Mental Capacity Act, upon the ability of the service to meet its statutory duties is contained within the Trust's principle risk register and is discussed further in section 2.7.

There are no immediate work force issues within Hospital Social Work. The service has remained stable in the current reporting period. There has been a successful recruitment campaign in the current reporting period and the service has markedly reduced its dependence on temporary and agency staff, with 93% of Band 5/6 Social Work staff in permanent posts. With current recruitment activity, it is anticipated that the service will have 96% of its Band 5/6 posts permanently filled by June 2021. All management positions at Band 7, 8A and 8B remain stable and filled. This marks a reversal in the trend of poor retention in Band 7's, which had affected the service over more recent years.

Workforce planning

There are no vacancy controls across the service area

The service area recognises the challenges of recruitment and retention of Social Workers in a changing workforce environment, where job opportunities outweigh the number of qualified professionals. Whilst the Division has been able to make progress in relation to stabilising Community and Hospital Social Work, there is an increasing demand for Social Work across the Division, which the Division is struggling to meet. This is particularly evident in intermediate care, where there has been significant growth during the pandemic, with additional staff required in both home and bed based services. Also the growth in a Discharge to Assess model and a prioritisation of carer support in intermediate care will require additional Social Work investment. Attempts to re-deploy Social Work staff from other areas has proved challenging as staff can be reluctant to move and there is a concern in de-stabilising areas which are only recovering from chronic periods of instability and the impact of the pandemic.

The Trust held a Social Work Workforce Workshop in December 2020 in an attempt to explore and address these challenges across all areas of Social Work. A number of task and finish groups are currently in place with the aim to generate ways to attract staff to the Trust, encourage career progression and increase retention of staff. The service area also is committed to participating in and supporting the Social Work Regional Recruitment exercise commencing in April 2021.

Professional roles

a) Designated Adult Protection Officer (DAPO)

All Social Work Band 7's and 8a's in ACOPS are trained as DAPO's. The service areas currently have an adequate number of trained DAPOs. ACOPS take a Divisional approach to DAPO provision and where there are challenges in identifying a DAPO in a specific area, a DAPO will be sourced from across the Division. This was evident during the first surge of the pandemic where the Adult Protection Gateway Team provided DAPO support to those areas, that were struggling to meet their requirements. Staff are supported in their role through a regular DAPO Support Forum.

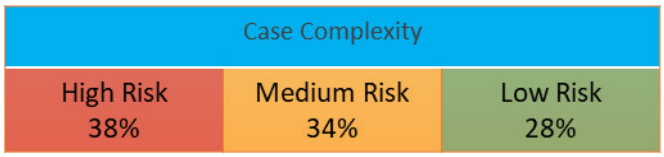
a) Investigating Officers (IO)

All Band 6 Social Workers in ACOPS are trained as IO's. The service areas currently have an adequate number of trained IOs and there are sufficient numbers of Investigating Officers in place to respond to adult safeguarding referrals across the Division. However, within the Adult Protection Gateway Team, there is an ongoing review into the service model and there may be a requirement for additional recruitment of Investigating Officers. ACOPS take a Divisional approach to IO provision and where there are challenges in identifying an IO, an IO

	will be sourced from across the Division. Staff are supported in their role through a regular IO Support Forum. **b) Achieving Best Evidence (ABE) Interviewers** There are 8 staff members within ACOPS who are ABE interviewer trained and this is sufficient to meet the demand within the service area. It is noted within this reporting period there has been very low numbers of ABE interviews required. Staff are supported in their role through an ABE support forum. **c) Approved Social Worker** There are currently five Approved Social Workers in Older People's Services who conduct this role as part of a day time ASW rota. While this is an excellent resource within the teams, there is no easement for caseload and ASW staff incorporate this duty into their work plan. The Trust is in ongoing discussion with the Department of Health regarding future workforce planning in relation to the ASW role and funding of same. **d) Mental Capacity (Northern Ireland) Act 2016** The service area is significantly challenged by the end of May 2021 deadline for completion of legacy assessments under the Mental Capacity Act. This MCA work has greatly increased the workload of teams and the risks associated with this are further discussed in section 2.7. A key aspect of this risk is due to the limited number of sufficiently experienced Social Work qualified staff who are trained to undertake Trust Panel Applications. Recruitment has not addressed these pressures, as the majority of newly recruited staff are either newly qualified or without sufficient experience, thereby are ineligible to undertake the role. Whilst this is a role that can be undertaken by professions other than Social Workers, the release of these staff to undertake this role, has not been possible due to specific pressures related to the pandemic. Staff within the service area are being supported through workshops, individual mentoring, cases discussions and robust quality assurance systems in the completion of the MCA assessments.
2.2	**Supervision arrangements for social workers**
2.2a	**Please confirm that the Trust is fully compliant with the Regional Supervision Framework Yes** **If not, outline the remedial action taken to address this** The service area has a range of systems in place to ensure compliance with the Regional Supervision Framework. The delivery of this framework, is supported by an adequate number of professional supervisors and line managers who operate to this framework. During the surge periods of the pandemic the service area has been

	challenged in meeting full compliance with the supervision standards in relation to frequency. OPS compliance with supervision at the end of this reporting period was 73%. The top three reasons for supervision exception is annual leave, work pressures (particularly in the hospital setting) and sick leave either for supervisor or supervisee. Where a supervisor is on long term sick leave alternative arrangements are put in place. The service areas continue to comply with the Trust's monthly supervision exception reporting arrangements. Supervision compliance is reviewed on a monthly basis by the Divisional Social Worker through the Social Work Senior Leaders Assurance Group and by the Collective Leadership Team through the monthly Divisional governance and assurance arrangements. The service area has also recently established a centralised online electronic system for the reporting of supervision exception, registration compliance and annual appraisals. This enables increased visibility by senior managers into local compliance within teams. The service area has an annual supervision audit arrangement in place. The supervision audit for this reporting was delayed due to the pandemic but is currently ongoing, with completion due by June 2021. Areas of focus for improvement include: - improving the opportunities for reflection - mutual supervision agenda setting - improving how risk is discussed/analysed within the supervision setting. The Service area is working to both improve the experience of the supervisee through the planned piloting of a new template to guide supervision with an emphasis on case file audits. The Service area is also considering the implications of the regional draft supervision policy, as a way of shaping new and innovative to deliver supervision.
2.2b	**Please confirm if the Programme of Care is utilising a Caseload Weighting tool: No** **If not, outline how the Programme of Care is managing current capacity, demand and workforce availability** Service areas have implemented differing local arrangements, across their teams for the management of current capacity, demand and workforce availability. However, the Division would welcome a regionally agreed caseload weighting tool and awaits further guidance in relation to this. Caseloads within Community Social Work have been traditionally very high, with a mix of low level social care cases and high risk statutory cases. In response to COVID 19, the service area implemented a risk

stratification tool, which identified high levels of high and medium risk cases across all Community Social Work.



Given the prevalence of high risk cases in the team and that 40-45 % of the team were not professionally social work qualified, caseloads for Social Workers had risen to approximately 90- 100 cases, with high levels of low risk unallocated cases emerging as a risk. This was also exacerbated by the inability of Community Social Work to transfer its cases to CREST, due to staffing vacancies within CREST. As a consequence community Social Work was put on the Divisional Risk Register as High Risk. As out workings of the risk reduction, additional Social Care Co-ordinator posts were uplifted from a Band 4 to a Band 5/6 Social Work post and a significant number of cases were transferred to CREST. This has had a significant positive impact on Community Social Work teams, enabling the reduction in individual Social Work caseloads to a safer, more manageable size. Social Workers now have an average caseload of 48 service users and professionally qualified staff undertake all assessment and statutory review activity. Community Social Work has been able to reduce the level of risk within the team to medium and anticipates further reduction, with the full completion of the recruitment process.

Community Social Work is currently undertaking an improvement project to add a case risk indicator on Paris. This work will help the service understand and analyse caseload complexity.

As highlighted previously, CREST has experienced chronic vacancy issues in recent years and this had delayed the transfer of cases from Community Social Work and Physical and Sensory Disability into CREST. The outworkings of this was a disparate caseload, with no central visibility of the level of risk associated with individual cases and a spread of nursing home intelligence across multiple teams. Therefore, as a way to manage and centralise the risk associated with these workforce pressures, the Senior Management Team agreed that the cases were best sitting in a central place, with consistent risk management arrangements and responses. This would also relieve the Community Social Work service who had been carrying additional workload pressures since 2017. Therefore all long term permanent care home cases will be managed within CREST, once the transfer process is completed. As a consequence, individual practitioner case load numbers have risen from 70 to126 over last 9 months, which represents a 44% increase in caseload size. This is very challenging for the team, due to current staff vacancies, the disproportionate impact of the Mental Capacity legacy and current cases, and the need to restart non-essential reviews as part of the COVID rebuild.

	Whilst ongoing recruitment within CREST will help to alleviate some of these pressures, this is an area of significant concern and has been raised on the Trust's Principal Risk Register. CREST was established to provide an improved quality of care experience through relationship based assessment and review, with improved sense making of risks within care homes and a focus on MDT working. The Trust will not be able to meet this vision without significant additional investment. As part of the risk management arrangements for CREST the following safeguards are in place: • all cases are risk assessed • high risk cases are aligned to practitioners • medium to low risk case are managed on a day to day basis by duty system - which has led to high levels of unallocated cases • There are systems in place to prioritise case and workload at daily safety huddles, which is led by Senior Practitioner • A fortnightly meeting led by Assistant Service Manager to review allocation, referrals, data in relation to duty system and data regarding incidents • Governance process in place to review care homes on a weekly basis and incidents. • Service continuity plan in place As stated in 2.1(b) there is an ongoing rolling recruitment drive in place and voluntary re-deployment has been explored. An IPT has been developed by the Trust, which sets out the expansion necessary to address this issue. The Hospital Social Work Service does not possess a formal Caseload Weighting Tool, however the service area would welcome any regional guidance in relation to this. Managers actively review equity of casework for the Social Workers within the respective acute and general hospital sites. The centralisation of referrals through the Community Discharge and Social Work Hub continues to significantly improve visibility of Social Work referral and demand across acute hospital sites. Working with Intermediate Care services, the service area has in place an allocation system. A Band 7 Social Work Lead, who screens all referrals to the Hub and ensures that the most appropriate professional takes forward the case, oversees this system. This also ensures that high risk statutory cases in hospitals involving adult safeguarding, child protection, self neglect, mental incapacity, addiction and domestic violence are better identified as discrete social work referrals. This is a significant improvement from historical practices where prioritisation was often only understood within the context of discharge activity. This improved screening has continued to reduce the number of inappropriate referrals to Hospital Social Work and this is reflected in Data Return 1. Furthermore, it has improved the visibility and awareness of the statutory social work role across the wider system, who have traditionally only understood the social work role in terms of discharge.

2.3	**Report at high level on any audits, research, outcome reports or evaluations undertaken during the reporting period, that relate to delegated statutory functions (bullet points only). Please ensure reference is made to the inclusion of service user involvement.**
	Care Management a) The Trust has made progress with actions to respond to the recommendations of the BSO care management audit of 2019, which has included the reissuing of Care Management Standards, updating of and standardisation of care planning, risk assessment and review pro-forma, with full implementation of these on PARIS. Furthermore there has been additional training for staff and the development of additional tools to support them in their role. However, due to the impact of the pandemic a number of actions have been difficult to achieve full compliance in, due to restrictions in access to residents in care homes. This is an area of focus for the Division as part of the restarting of non-essential reviews. Outstanding recommendations include: - All care plans should be signed by the service user - Risk management plans should be in place for all service users - Financial capacity should be assessed and documented as part of the assessment process b) BSO undertook a financial audit in relation to one care home of concern during this reporting period, which included a focus on the management of service users' finance. This identified some learning for the Trust and as a consequence of this a number of actions have been taken: - the development of a new draft financial policy for the Division in relation to supporting residents monies - the delivery of further training for staff from DLS in understanding their responsibilities in relation to supporting residents in the management of monies - issuing of additional guidance to staff c) The ACOPS governance team have begun a monthly audit of all admissions to care homes, to ensure compliance with care home admission processes. These have included a focus on the assessment and care planning for service users in interim placements. This audit activity has continued to demonstrate improvements, particularly in the areas of evidence of assessments and compliance with the completion of Trust care plans. The audit identifies the requirement for service areas to strengthen their evidence of: - the articulation of human rights issues considerations - service user and carer consultation, at the point of admission.

This is an ongoing area of focus for identified service areas and is being addressed with staff through a number of fora.

d) The CREST service completes routine care management audits. These audits evidence that the CREST practitioners have achieved very high compliance in the review of changing needs of the residents. Overall, there is strong evidence of a holistic review of their needs being captured within reviews. Audits evidence strong consideration of the individuals capacity to participate in the review and strong evidence that resident's human rights are considered throughout all the reviews undertaken.

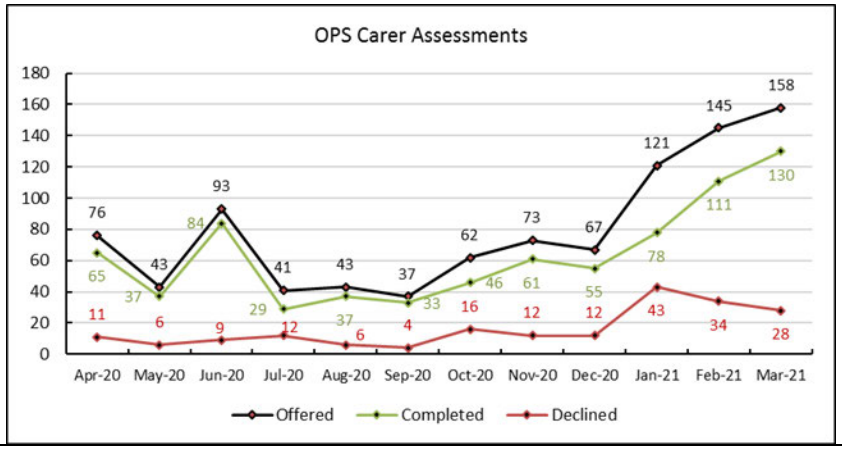
Carers

a) Remote Carers Assessment and Support Pilot

The significant impact on carers during Covid-19 was very evident and service areas have noted heightened anxiety amongst carers about infection, the suspending of care packages with increased burden on carers and the impact of long term restrictions on visiting in care homes. During the first surge of Covid 19 Community Social Work teams struggled to respond to service demands for carers assessments due to staff absence and Covid restrictions. There were 167 outstanding referrals for Carers Assessments at end of September 2020 across Community Social Work teams. The service area identified the need for an improved timely response to the needs of carers, yet recognised carers anxiety about unnecessary footfall into their homes. In response. the service implemented a remote carers assessment and support pilot where 1.5WTE Social Work resource was targeted to respond to referrals for Carers Assessments, piloting the facilitation of carers assessments by telephone or MS Teams. The pilot commenced in October 2020 with a six-month evaluation at the end of March 2021.

Outcomes from the pilot have included:

- reduced delay in awaiting carers assessment
- positive feedback and increased satisfaction from carers who found this approach to be more accessible
- increased uptake in carers assessments by carers:



b) Improving the Wellbeing of Carers

Community Social Work, as part of Safety Quality Belfast (SQB) with carers, commenced a service improvement project in December 2020. The aim was to improve the wellbeing of carers. The primary driver was to minimise the impact of the pandemic and support mental wellbeing. The project recognised the need to reach out to carers in a different way due to the pandemic restrictions. A Happy App was utilised, online questionnaires and fortnightly support groups with carers were facilitated on MS Teams. The evaluation demonstrates that carers who took part in support groups felt more supported, less isolated and more informed. Furthermore they benefited from the online group activity as an opportunity to chat with others in caring role. Community Social Work is currently working with the Trust Carers Co-ordinator to identify a new menu of online supports to carers, aimed at reducing isolation and improving well being.

c) Supporting Care Partners

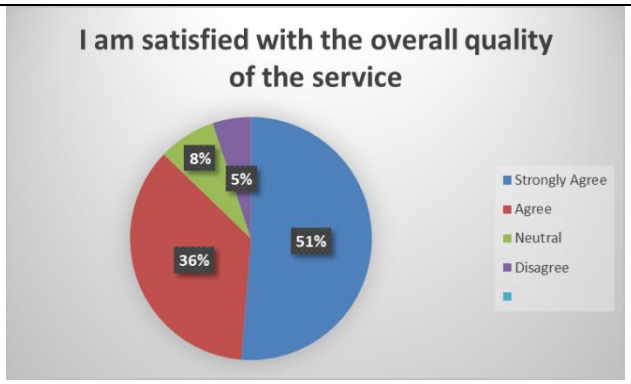
As part of the regional guidance to progress and support implementation of the care partner arrangements within care homes, CREST facilitated 2 engagement forums with care homes and families. The purpose of this has been to explore shared understanding of the care partner role; enable shared learning as to families experience of undertaking the care partner role and an articulation of the positive impact this had had on their relative. Crest Team has driven this initiative within locality care homes and this collaboration has led to a more successful implementation of care partner arrangements across Belfast locality homes.

Support to Care Homes

During the reporting period the CREST team engaged with care homes as to their level of satisfaction with the support provided by the CREST team:

87% of returns agreed or strongly agreed that they were satisfied with the overall quality of the service
79% agreed that the Input from CREST has improved the quality of care delivered to their residents.

92% of responses stated that they strongly agreed or agreed that the remit of CREST was clear to them
Overall, 90% of returns felt that the Input from CREST has been helpful in informing the care of the Residents in their care.



Hospital Social Work

In 2020, Hospital Social Work engaged with the Trust Learning and Development Department and the HSC Leadership Centre to undertake an extensive "Listening Exercise" with hospital Social Workers as part of a review of the current service delivery model. Participants included those at Bands 5/6, 7 and 8A. The outworkings of this are now integrated into a Hospital Social Work action plan for the incoming reporting period, with a focus on strengthening professional standards and governance.

Hospital Social Work is a core member of a newly established divisional Care Management Service User Experience Group. This group will carry through learning from the monthly Care Home admissions work, examine service user, carer and family experiences of discharge planning and transitions in community placements. This group will also scrutinise adverse incidents associated with service user experiences of discharge planning and community transitions. The group will develop service wide responses and shared learning initiatives to promote improved patient / service user experiences.

Data Quality Improvement

The implementation of a new Quality Management System within the Trust has led to significant work being undertaken across service areas in relation to the development of accurate and contemporaneous data reporting systems for social work and social care. This purpose of this is to support quality, safe and effective care and improve data driven decision making. Within this reporting period this has been a key focus for both Social Work and Social Care. Examples of this include:

- The development of new monthly safety and quality data sets for EMI Residential Homes and Supported Housing facilities
- The development of high value datasets and dashboards by CREST, evidencing key performance indicators aligned with safety, effectiveness, experience and equitable delivery of service across the independent commissioned care sector.
- Community Social Work has focused on developing new data sets to report monthly on the number of annual reviews completed and outstanding, monitor unallocated cases and caseload risk stratification. This is due for implementation in May 2021.
- The development of new Social Work Assurance Data Set to

	support and measure compliance with professional standards
2.4	**Programme of Care to advise of any significant judgements and/or decisions derived from Serious Adverse Incidents, Case Management Reviews, Mental Health Review Tribunals, Judicial Reviews or RQIA Inspection and/or Review activity during the reporting period, that directly relates to the Trusts discharge of their statutory functions.**
	Serious Adverse Incidents In May 2020, significant concerns arose in relation to Clifton Nursing Home's ability to respond to its Covid-19 outbreak in respect of its leadership and governance arrangements, and its infection prevention and control approach. As a consequence of this, the Trust in collaboration with HSCB, RQIA, DOH and PHA decided that they no longer had confidence in Clifton Nursing Home to undertake the necessary measures to safeguard residents and therefore considered moving residents to alternative suitable accommodation. An interim Care Home provider was identified to provide day to day management of the home and the need to move residents was averted. A Serious Adverse Incident was reported by the Trust on 1 June 2020 in light of the serious concerns and events that had arisen. This is a Level 3 SAI with an independent chair and review team. A draft report is expected by the end of April 2021. Clifton Nursing Home remains as a home of concern on the Trusts Care Home Escalation Framework. Whilst sustained improvements in infection prevention and control arrangements and the environment have been evidenced over the last 9 months, there is an ongoing transition process in operational management arrangements to Kathryn Homes. This also includes the commencement of a new manager within the Home. During this period of transition, in addition to a weekly presence in the home, the service area is undertaking monthly monitoring visits and oversight meetings, which will remain in place to ensure sustained change. Within this reporting period the service areas of Community Social Work and Adult Protection Gateway Team completed a Level 2 SAI, which arose as a consequence of a failure of the service areas to prevent a perpetrator having further access to a victim. The case has highlighted a number of areas for training and development including: - staff requiring a greater understanding of interface with PSNI - staff requiring additional training on the meaning of bail conditions, and the need at times to challenge the decisions of other professions in order to protect clients - the need to balance the out workings of criminal proceedings with the best interest of vulnerable service users - there is also learning regarding how the Service area works to engage the Human Rights of service users for their benefit

RQIA Inspection

During this reporting period, 3 of the Trust's Supported Housing facilities have been inspected, all of which received excellent reports and no Quality Improvement actions were required. Furthermore, all 4 Residential Homes for people with dementia have underwent inspections, which resulted in 4 QIP's in total. These QIP's in the main, related to environmental issues. The Trust has outdated EMI Residential buildings which are in need of modernisation and renovation. The Trust is currently seeking ways to secure funding for the modernisation of these facilities. Killynure Residential Home is currently decanted to allow for works to modernise the Home to commence.

NIPSO

Community Social Work has had one very significant set of NIPSO findings during this reporting period. The matter concerned maladministration, in relation to the failure to implement a Continuing Healthcare policy in line with the 2010 Care Management Circular. The area of Continuing Healthcare has been a challenging issue and the service areas welcome the development of a new regional position in relation to this matter.

NISCC

During this period the service area has identified weaknesses within the assurance processes for NISCC registration, in the statutory homecare service. As a result this Division is undertaking a Serious Event Audit methodology with NISCC and Human Resources. The out workings of this, will be to complete a review of the NISCC registration assurance processes across the Division, to make any recommendations for the wider Trust and to develop an action plan to implement identified improvements.

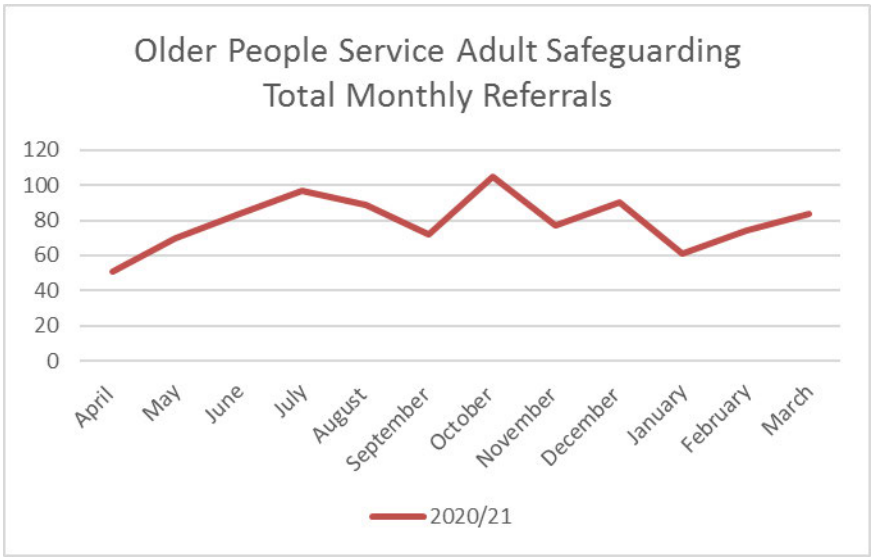
Courts and Tribunal Service

It has been a challenging year for the service areas as we continue to adjust to the implementation and impact of the Mental Capacity Act. Staff are continuing to work through complex cases and liaising with the Department of Legal Services to determine the best pathway to support our clients and understand how the law applies to particularly complex situations. The service areas are still required in some cases to seek the authority of the High Court to act in those areas where Phase 1 of the MCA does not as yet provide that authority. This has been in those cases where the Trust are undertaking a range of interventions on behalf of a person who lacks the capacity to make decisions for themselves.

The service areas also note, that in those cases where there has previously been a Declaratory Order in place that the High Court has, where there is no longer controversy in respect of a person's care, been directing that it is reasonable to have those cases managed under MCA

	going forward. The Court is reassured that the independence of the Review Tribunal Service now provides the independent oversight to a person's care arrangements, where there is a Deprivation of Liberty inherent in the care arrangements. However, for a number of cases, it is not exceptional to be required to have in place concurrently, a Declaratory Order, a Trust Panel Application and an intensified care management process. Whilst this reflects the intensity of work that can be involved in the management of Older People with complex physical, social and behavioural needs, it is also important to note that the court service has also been very complimentary to the service area on a number of occasions, in relation the quality of reports provided and case law being explored. Virtual hearings have been established as routine, within the Court Service and staff have responded well to this. **Office of Care and Protection (OCP)** The service area have contributed to the Office of Care and Protection consultation process, regarding their review of their referral mechanism for safeguarding referrals. During the pandemic the OCP sought assurances that staff remained in place and were available to respond to concerns raised to the court or by the court, regarding the management or mis-management of a person's money/assets. A direct referral route through the Principal Social Worker was established and this has been very effective in providing a proactive and responsive approach to this interface with the OCP.
2.5	**Advise on any challenges in the provision of Safeguarding services that have arisen in this Programme of Care during the reporting period and actions taken to mitigate any difficulties.**
	The Adult Protection Gateway Team (APGT) continues to operate a dual system consisting of duty function to screen and co-ordinate adult safeguarding referrals for the Division and an investigation function. APGT has operational responsibility for adult protection investigations for Older Peoples Programme of Care and Physical and Sensory Disability. Within this reporting period OPS received 954 Adult Safeguarding referrals, of the total referrals received 46% of referrals were screened out, 22% of referrals met the threshold for an Adult Protection Investigations to be commenced and for 10% Alternative Safeguarding responses were implemented. 21% of referrals were transferred to community teams within OPS for an adult safeguarding investigation. This continues to represent a significant over reporting of inappropriate referrals and requires a significant investment of resource, in relation to the level of screening required to manage referrals safely. In the forthcoming reporting period it is the intention of the service area to undertake an improvement project to better understand reporting behaviours and to identify ways to reduce inappropriate referrals, using Quality Improvement methodology.

The impact of the pandemic was particularly felt in the first quarter of the reporting period, and resulted in a significant drop in adult safeguarding referrals, as highlighted below. This was particularly noted in relation to referrals from the Care Home sector, where referrals over this reporting period, have reduced by 43% to the previous year.



However, conversely PSNI referrals increased significantly over the reporting period 2020/21, with an increase of 203% in referrals noted form the previous year. However, many of these were noted to be welfare referrals as a result of the pandemic as opposed to allegations of abuse.

In response to the emerging patterns as the pandemic progressed, Older People's Services put in a number of mitigations, which included:

- In the early months of the pandemic, the service area established weekly Adult Safeguarding huddles with all ACOPS service areas to monitor changing patterns in referrals, to ensure timely remedial action was taken and to seek assurances that sufficient staffing was available to respond to referrals

- Updated data sets have been established to support trends analysis for ACOPS referrals and facilities

- All Trust Care Home referrals were centralised through a single point and Care Homes were reminded through letter and fora that they must continue to report Adult Safeguarding incidents

- Trends/ analysis of Care Homes Adult Safeguarding referrals discussed at weekly commissioned services governance meeting

- MARAC structures were supported to be maintained within the Division during surges

- Social media messaging and podcast was developed for sharing across Trust platforms to raise awareness of Adult Safeguarding

- Specific areas were targeted to raise awareness of Adult Safeguarding, through focused communication strategies including the development of new awareness posters. These were areas that were likely to have contact with service users and families during lockdown. These included Emergency Departments, NIAS, GP's, Domiciliary Care and District Nursing.

- Adult Safeguarding training was targeted at staff who were being redeployed into new roles as a consequence of the pandemic

- Concerns in relation to referral patterns were added to the Divisional risk register and were escalated to the HSCB Regional AS Group

During this reporting period the Division has commenced an improvement project, to assure the full implementation of Adult Safeguarding arrangements across the Division, considering arrangements not just within Social Work services but also across all areas where care is delivered. This considers key factors including: training of staff, awareness of reporting procedures, systems for analysing referral patterns, ensuring discussion of adult safeguarding at live governance, safety huddles and briefings, and quality assuring information held in all teams. This has been an extensive piece of work with a baseline audit conducted across 12 service areas. The outcome of this audit will form the basis of a Divisional Improvement Plan, which will include the establishment of a Divisional Adult Safeguarding Governance Group. To support the Division in this work we have appointed in March 2021, a new Adult Safeguarding Service Manager, who will not only manage the Adult Protection Gateway Team, but will also take forward a number of key improvement areas.

Another improvement focus is the undertaking of an audit of adult safeguarding responses and investigations, for adults who are at risk of harm, but are not in need of protection. It remains a risk across the Division that there are no regional standards for the management and investigation of adults at risk of harm. In the continued absence of this, the Division is commissioning a piece of work to support standardisation and consistency, through the development of local guidance.

Adult Safeguarding in Hospitals has had an acute focus for the Division in this reporting period. Within both Valencia and Meadowlands, RQIA identified concerns in relation to staff's ability to recognise and analyse adult safeguarding issues and trends. This led to 2 significant pieces of work in relation to the training and development of staff and the development of systems across both wards, to raise awareness of adult safeguarding and to capture activity. Whilst staff responded well to the improvement, it did highlight deficits within other professions in relation to their awareness of adult safeguarding issues, which is similar across the wider hospital system. The Adult Safeguarding Champion for the Trust is currently leading on a piece of work to develop additional training resources and action plan, to support hospital based staff to discharge fully their responsibilities in relation to safeguarding

	vulnerable patients. Furthermore, Hospital Social Work continues to work closely with other hospital professionals in promoting children and adults safeguarding awareness. Hospital Social Work is currently developing a communication and engagement strategy with hospital wards to promote domestic violence and safeguarding awareness. Within this reporting period, the service area have noted increased delays with PSNI investigations, and the PSNI have advised that this is as a consequence of the impact of the pandemic. However, this has an impact on service user's confidence in the process as well as causing additional distress.

2.6 Progress Update on DSF Plan

This Section is for the Programme of Care to record their progress with the actions identified at the beginning of this reporting period (cross reference with section 1.3)

2.6	Issue/Action Agreed at DSF meeting in October 2020	Progress Update at 31st March (as per update meeting on 8 March 2021)	RAG
Older People's Service			
	Issue: Adult Safeguarding - Decrease in the number of Joint Protocol cases **Update at DSF meeting – 5.10.20** Whilst the Trust continued to make Adult Safeguarding referrals to PSNI under the Joint Protocol guidance, the police are increasingly advising it will be a single agency response. This is a regional issue and as such will require engagement with PSNI to address. This alongside other challenges in Adult Safeguarding need to be taken forward regionally through the NIAS forum. Action: • Trust to continue to liaise with PSNI and address concerns regarding decline in JP investigations. • Regional response and engagement with PSNI through NIAS forum	The Trust continues to make Adult Safeguarding referrals to PSNI under the Joint Protocol guidance, but it remains the issue that the police are increasingly advising it will be a single agency response. As previously stated this is a regional issue and as such will require further engagement with PSNI and will be taken forward through the newly-established Interim Adult Protection Board. The Gateway Team continue to liaise with PSNI on a case by case basis to determine whether the threshold for Joint Protocol is met. The PSNI are members of both the Transformation Board and the Interim Adult Protection Board and therefore going forward there will be opportunities to discuss and agree the way forward regarding the Joint Protocol **Update from Meeting on 8 March 2021:** • Regional approach noted	

Issue: Domiciliary Service Provision **Update at DSF meeting – 5.10.20** Home Care in OPPC requires reform. There have been a number of reforms over the years but they have not achieved the aim of improving the service and managing the flow from hospital discharge. Until the Reform is successfully implemented there will continue to be an over reliance on the private sector. Trust advised the procurement process is restrictive and impacts on the progress of reforming the service **Action**: • Wider Regional Review and Reform of Domiciliary Care is underway, and will be kept under review during the next reporting period (2020/2021).	It remains the position of the Division (OPS and PSD) that there continues to be an over dependence on the independent sector for the provision of domiciliary care. However there has been a significant and sustained of >65% reduction in the level of unmet need across the Division at the end of this reporting period The Division has established an oversight group for the purpose of moving forward with the reform of Statutory Homecare. However, some identified key activities have been delayed due to the operational challenges associated with COVID. The Division await further regional reform and will implement as required any new recommendations arising from this.	
Issue: Continuing Healthcare CHC **Action:** The Trust awaits Department of Health Policy Guidance Update at DSF meeting – 5.10.20 Current policy position as outlined in the Care Management Circular sets out expectations on the Trust in relation to CHC. Trust confirmed there is no equality of	The service area have recently been found to have failed to put in place an operational policy for the purpose of assessing Continuing Health Care needs. The Trust welcomes the clarification of a regional position in relation to this matter and this significantly reduces this risk.	

access due to lack of clarity. HSCB acknowledged that whilst the Policy does not have sufficient detail, it does confirm that the Care Management Circular sets out expectations on the Trust in relation to provision of CHC. **Action:** • HSCB to follow up Ministerial approval on the Guidance	**Update from Meeting on 8 March 2021:** • DoH revised circular awaited Raised at fortnightly Directors Meetings (DoH in attendance)	
Issue: Mental Capacity Act **Update at DSF meeting – 5.10.20** Medical staff have been recruited and ongoing recruitment is taking place to increase capacity. Trust confirmed this issue is on their risk register. Trust confirmed there are 'cross Trust' issues which are presenting practical difficulties. This is a challenge across all programmes of care. An early alert has gone to DoH. Trust confirmed they will not be able to meet the December deadline. **Action** • Trust to confirm actual numbers of backlog and action plan • Regional discussion and agreement to any extension to the December deadline	Older People's Services has been challenged in the availability of sufficiently experienced/ qualified staff to meet the scale of the demand arising from legacy cases. Although progress has been made, there are still significantly high levels of legacy cases, that require assessing for Trust Panel Application process. Within this service area, suitably qualified staff have been redeployed to prioritise this work and overtime rates had been offered, but staff have been reluctant to take up this offer. As of reporting, it is recognised that this programme of care will not meet its obligations in relation to MCA by May 2021. This has been recorded on the Trust's principal risk register and an early alert has been sent to the Department of Health	

	Update from Meeting on 8 March 2021: This remains an area of very high risk for the Trust. CEx is aware of the concerns	

Rag Rating:
Green - Complete
Amber - Partially Complete
Red - Not complete

Where the RAG status is Amber or Red, please include further detail in Section 2.7 of this template.

2.7 Discharge of Delegated Statutory Functions

This section enables the Trust to provide more details on the issues identified by the Executive Director at Section 1.4

2.7	Summary of areas where the Trust has not adequately discharged their Delegated Statutory Functions for this Programme of Care.	Please outline remedial action taken to address this situation and any proposed future action.
	Older People & Adults Issues	
1)	**Domiciliary Care** Older Peoples Services continues to be over dependent on the independent sector for the provision of domiciliary care. Whilst there has been a significant reduction in the level of unmet need across the Division, on 31 March 2021, 278 service users were awaiting care packages, this equated to 1588.75hrs. This represents a significant risk to service users and carers, in terms of unmet assessed need and additional carer stress.	Weekly reporting systems are in place for the monitoring of unmet need. All unmet need cases are risk assessed and there continues to be arrangements in place for the prioritisation of high-risk cases. The new brokerage system has had a positive impact on the ability of the service to broker care in a more efficient and timely way. A working group has been established to support a number of key improvements including implementing a move away from designated call times to bandings, to address split packages and improve service user experience.
2)	**MCA** The inability of Older People's Services to meet full compliance by 31st May 2021 with MCA is a significant challenge for the service area and Trust. The inability to reach this target within target also presents a significant risk to service users, the service area and trust. This risk is recorded on the Trust's Principle Risk Register	The service areas continues to bring a focus and priority to this work. In addition to Trust Panel Applications there are also increasing numbers of Rule 6 reports that are required However, given the staffing limitations highlighted, the service area has been forced to significantly reduce its statutory review activity in care homes. This is an unsustainable position for the Trust and a re-priorisation of staff towards care home reviews has been risk assessed as a priority. An early alert has been raised to the Department of Health and this is recorded on the Trusts Principal Risk register. The Service area will endeavour to continue to progress new MCA work, but is significantly concerned about its ability to progress legacy work

3)	**Annual reviews** The service areas have significant non-compliance in relation to statutory annual reviews for both care home and domiciliary settings. This is due to the impact of Covid restrictions on visiting and the DOH directing the standing down of non-essential reviews in April 2020. In January 2021, the Chief Social Worker wrote to the Trust to advise that care reviews should recommence using a risk-assessed approach. This presents a significant risk in terms of timely engagement and review of service users, and the ability of the service area to be assured in relation to the quality of care experienced by service users.	Service areas have in place action plans in place for the re-starting of reviews, using a risk based approach and this has commenced in the later part of this reporting period. Given that the service area has such a significant caseload who are in receipt of commissioned care, as referenced in data return 1.4, this recovery exercise in addition to normal business, is anticipated to take until December 2021.
4)	**CREST** Significant challenges in relation to support and review of residents in care homes. All long term permanent care home cases are now managed within CREST. However, as a consequence individual practitioner case load numbers have risen from 70 to126 over the last 9 months, which represents a 44% increase in caseload size. There is also significant levels of un allocated low risk cases within the Team. This is very challenging period for the team, due to current staff vacancies, the disproportionate impact of the Mental Capacity legacy and current cases, and the need to restart non-essential reviews as part of the COVID rebuild. The lack of staff resource to carry out annual reviews, routine monitoring, or meet standard of monthly visits to aligned care homes presents risk to service users and weakens the Trust's assurance of safe care delivery and governance oversight in homes.	This is recorded on the Trust's Principal Risk register as an extreme risk. As part of the risk management arrangements for CREST the following safeguards are in place: • all cases are risk assessed • high risk cases are aligned to practitioners • medium to low risk case are managed on a day to day basis by duty system - which has led to high levels of unallocated cases • There are systems in place to prioritise case and workload at daily safety huddles, which is led by Senior Practitioner • A fortnightly meeting led by Assistant Service Manager to review allocation, referrals, data in relation to duty system and data regarding incidents • Governance process in place to review care homes on a weekly basis and incidents.

	.	• Service continuity plan in place As stated in 2.1(b) there is an ongoing rolling recruitment drive in place and voluntary re-deployment has been explored. An IPT has been developed by the Trust which sets out the expansion necessary to address this issue. The Trust will be seeking the support of HSCB in addressing the funding required.
5)	**Historical Case Closures in Hospital Social Work** During the Covid period 2020/21, the service area has struggled to manage timely recording and historical case file closures in the hospital. This was exacerbated by a number of Hospital Social Workers being temporarily redeployed to alternative hospital and intermediate care sites under Covid contingency planning. This was to support effectiveness, experiences, equity and safe and timely Social Work discharge planning and Mental Capacity assessments. This presents a significant risk to Trust assurance processes and delays in recording and closures can impact on timely information sharing.	In response, the hospital Social Work leadership group has implemented a robust action plan. This plan includes: • Adopting new procedures and processes similar to other HSC Trusts to streamline case closures • Greater use of protected time for Band 5/6 staff members to complete recording and case closures • Creation of site specific centralised filing system (May 2021) • Weekly interrogation of PARIS reporting by Band 4 Information Officer • Band 6 Administration manager to provide fortnightly dashboard on case closures to the Service Manager for Social Work • Fortnightly Social Work and Administration management meetings to review the action plan This target to have all historical cases closed by 1 July 2021

PROGRAMME OF CARE DATA RETURNS 1 – 6 AND 9

DATA RETURN 1 – PoC / Directorate: Older People's Services

1 GENERAL PROVISIONS			
		<65	65+
1.1	How many adults were referred for assessment of social work or social care need during the period?	0	4975
1.2	Of those reported at 1.1 how many adults commenced receipt of social work or social care services during the period?		2913
1.3	How many adults are in receipt of social work or social care services at 31st March?		7293
1.3a	How many adults are in receipt of social work support only at 31st March (not reported at 1.4)? *There is no consistent reporting mechanism currently in place within PARIS to accurately reflect the number of cases which are Social Work only. The Service Areas continue to work with the with the Business Service Unit to resolve this data point.*		*N/A*
1.4	How many care packages are in place on 31st March in the following categories:		*4237*
	i. Residential Home Care *The service area has refined how this data point is captured and now reflects the actual number of people in a residential home on the date of 31 March 2021, using a census approach. Within the first ¾ of this reporting period there has been a significant decline in the number of new placements in residential homes, with recovery in the final quarter*		562
	ii. Nursing Home Care *The service area has refined how this data point is captured and now reflects the actual number of people in a nursing home on the date of 31 March 2021, using a census approach. Within the first ¾ of this reporting period there has been a significant decline in the number of new placements in nursing homes, with recovery in the final quarter*		1331
	iii. Domiciliary Care Managed		3185
	iv. Domiciliary Non Care Managed		363
	v. Supported Living	*7*	96

	A significant number of voids have emerged during this period and is understood to be linked to the impact of Covid.		
	vi. Permanent Adult Family Placement		N/A
1.4a	For all those listed above in 1.4 provide assurance that the Care Management process is being applied in accordance with the DHSSPS Care Management HSC ECCU/1/2010 Circular. YES *However, whilst the service area has given significant focus to improving compliance with the Care Management circular, full compliance in this reporting period was not achievable due to the impact of COVID, particularly in relation to review activity and signing of pro-formas. The Service Area has an audit cycle in place which is focused on the Care Management process for people who are in Care Homes to support the improvement of the quality of application of the process.*		
1.5	Number of adults provided with respite during the period	*PMSI return*	*PMSI return*
1.6	Number of adults known to the Programme of Care in receipt of Centre based Day Care *We have interpreted this data point as being the number of people registered with the day centre on 31 March 2021. PSD attendees will be recorded PSD return and not as a composite figure for ACOPS.*		
	- Statutory sector	*n/a*	566
	- Independent sector - *The Service Area do not have an electronic mechanism to capture this information. The Connected Community Hub contract with the IS Day Centre and manage this as manual count*.		210
1.6a	Number of adults known to the Programme of Care in receipt of Day Opportunities *This number is achieved through a manual count.*		264
1.7	Of those at 1.6 how many are EMI / dementia		
	- Statutory sector		103
	- Independent sector		N/A
1.8	This is intentionally blank		

1.9	How many of this Programme of Care clients are in HSC Trust funded social care placements outside Northern Ireland?		2

DATA RETURN 1 – General Hospital – OPS - HSW BCH, NICC, MPH, IMC

1 GENERAL PROVISIONS - HOSPITAL				
		<18	18-65	65+
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the period?	8	1162	1835
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the period?	8	1162	1835
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?	Under 18 = 0 18 -65 = 34 65+ = 403 Total 437		

Age is at date of referral for 1.1 and 1.2
Age at 31st March for 1.3

*This is a manual count taken on the 31st March 2021. Paris system reports considerably higher open caseloads for HSW as at the 31st March 2021 due to impact of historical open caseload.

<18 return is 8 and 18-65 is 1162 – should this be included in Older People's Services
The service area has always reported the total numbers for Hospital Social Work in this way, as the service is managed by Older People's Services. Whilst it is noted that this year the HSCB has requested a disaggregation between Acute and Non-Acute settings, it was not noted that these figures should be reported across different programmes of care. This would be extremely challenging, as in relation to under 65's some of these service users will be known to PSD, some Mental Health, some Learning Disability and some are not required to be known to any community service. We would not have the ability through our IT system to disaggregate these. All 18 - 65's would not automatically transfer to the PSD report.

DATA RETURN 1 – Acute Hospital (general setting) OPS - HSW MIH and RVH

1 GENERAL PROVISIONS – ACUTE HOSPITAL (GENERAL SETTING)				
		<18	18-65	65+
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the period?	30	1469	3886
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the period? (assessment is to include screening). **Please note it is expected that the response for sections 1.1 & 1.2 will be the same**	30	1469	3886
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?	Under 18 = 7 18 – 65 = 51 65+ = 131 Total 189		

Age is at date of referral for 1.1 and 1.2
Age at 31st March for 1.3

*This is a manual count taken on the 31st March 2021. Paris system reports considerably higher open caseloads for HSW as at the 31st March 2021 due to impact of historical open caseload.

<18 return is 30 and 18-65 is 1469 – should this be included in Older People's Services or are these overall figures for Acute?

These are the overall figures for acute
As above:
The service area has always reported the total numbers for Hospital Social Work in this way, as the service is managed by Older People's Services. Whilst it is noted that this year the HSCB has requested a disaggregation between Acute and Non-Acute settings, it was not noted that these figures should be reported across different programmes of care. This would be extremely challenging, as in relation to under 65's some of these service users will be known to PSD, some Mental Health, some Learning Disability and some are not required to be known to any community service. We would not have the ability through our IT system to disaggregate these. All 18 - 65's would not automatically transfer to the PSD report.

DATA RETURN 2 – PoC / Directorate _OPS - SEE FULL RETURN IN PH&D DATA

2 CHRONICALLY SICK AND DISABLED PERSONS (NI) ACT 1978;			
		<65	65+
2.1	Details of patients less than 65 in hospital for long term (>3months) care who are being treated in hospital ward for over 65		X
2.2	Number of adults known to the Programme of Care who are:		
	Blind		N/A
	Partially sighted		N/A
2.3	Number of adults known to the Programme of Care who are:		
	Deaf with speech		N/A
	Deaf without speech		N/A
	Hard of hearing		N/A
2.4	Number of adults known to the Programme of Care who are:		
	Deaf Blind		N/A

DATA RETURN 3 – PoC / Directorate __OPS_____

3 DISABLED PERSONS (NI) ACT 1989 ***Note: 'disabled people' includes individuals with physical disability, sensory impairment, learning disability***		
3.1	Number of referrals to Physical/Learning/Sensory Disability during the reporting period.	N/A
	Number of Disabled people known as at 31st March.	N/A
3.2	Number of assessments of need carried out during period end 31st March.	N/A
3.3	Number of assessments undertaken of disabled children ceasing full time education.	N/A

DATA RETURN 4 – PoC / Directorate OPS

4 HEALTH AND PERSONAL SOCIAL SERVICES (NI) ORDER 1972;
Article15, Article 36 [as amended by Registered Homes (NI) Order 1992]

4.1	Number of Article 15 (HPSS Order) Payments	47
	Total expenditure for the above payments	£5774.81
4.2	Number of TRUST FUNDED people in residential care	432
4.3	Number of TRUST FUNDED people in nursing care	894
4.4	How many of those at 4.3 received only the £100 nursing care allowance?	437

DATA RETURN 5 – PoC / Directorate OPS

5 CARERS AND DIRECT PAYMENTS ACT 2002

		16-17	18-64	65+	n/k
5.1	Number of adult carers offered individual carers assessments during the period.	**0**	**571**	**321**	**153** **includes 83 not recorded on Paris**
5.2	Number of adult individual carers assessments completed during the period	**0**	**500**	**259**	**90** **includes 83 not recorded on Paris**
5.2a	Number of adult individual carers assessments declined during the period and the reasons why.	**0**	**71**	**62**	**62**
5.3	Of the total at 5.2 in how many of the assessments were the carers, caring for disabled children?	**n/k**	**n/k**	**n/k**	**n/k**
5.4	Number of adult carers receiving a service @ 31st March	**0**	**302**	**179**	**3**

5.5	Number of young carers offered individual carers assessments during the period.	**0**
5.6	Number of young carers assessments completed during the period	**0**
5.7	Number of young carers receiving a service @ 31st March	**0**
5.8	(a) Number of requests for direct payments during the period 1st April – 31st March *(Interpreted as same figure as new approvals)*	**66**
	(b) Number of new approvals for direct payments during the period 1st April – 31st March	**66**
	(c) Number of adults receiving direct payments @ 31st March	**245**
5.9	Number of children receiving direct payments @ 31st March	**0**
5.9.a	Of those at 5.8 how many of these payments are in respect of another person? *(unable to accurately disaggregrate from Paris Data)*	**n/k**
5.10	Number of carers receiving direct payments @ 31st March *(unable to accurately disaggregrate from Paris Data)*	**n/k**

5.11	Number of one off Carers Grants made in-year.	**701**

Note: sections 5.8, 5.9 and 5.10 are to be reported as mutually exclusive.

Commentary

There has been an overall decrease in the number of carers assessments offered(100) in this reporting period, in line with a general reduction of referrals across the service areas, as a consequence of the impact of Covid. However, a number of improvements have been noted across the service areas in relation to Carers:

-There has been a significant improvement in the uptake of carers assessments (229) during this reporting period. This marked improvement has been assisted by the implement of a remote carers assessment project during Covid, which has been well received by carers and has significantly reduced delays in access to carers assessments. As a consequence of this improvement work there is a significant reduction in the number of carers assessments declined. The main reasons for decline in OPS are

1. A4 – The carer feels they do not need any support.
2. A8 – The care would not give a reason or no reason recorded.

The service area is pleased to report that in this reporting period we have increased the number of carers grants being paid, for additional carer support, by 196

In addition as a response to Covid, the service areas offered additional emotional support to bereaved carers and carers of residents in care homes.

DATA RETURN 6 – PoC / Directorate _____OPS_____

6 SAFEGUARDING ADULTS

6.1	Number of safeguarding adult referrals within the period	**954**
6.2	Number of safeguarding adult referrals within the period broken down by the following categories of abuse: (a) Financial (b) Institutional (c) Neglect (d) Physical (e) Psychological/ Emotional (f) Sexual (g) Exploitation	**a. 136** **b. 9** **c. 118** **d. 318** **e. 115** **f. 51** **g. 6**
6.3	Number of investigations commenced within the period	**206** Adult Protection **208** Adult Safeguarding **Total 414**
6.4	Number of investigations completed within the period *Interpreted as number of adults in need of protection cases closed*	**217**
6.5	Number of care and protection plans commenced within the period	**211**
6.6	Number of care and protection plans in place on 31st March PMSI do not collect 'care and protection plans in place on 31st March'	Not required

No. of referrals in 6.1 is 954 but in 6.2 categories total 753. A difference of 201
This is the number of referrals received by the Adult Protection Gateway Team (APGT)
Over this reporting period, BHSCT APGT received 201 APP1's (Adult Protection referrals) for OPS which did not have a category of abuse, as these were screened as inappropriate referrals. However as the Gateway Team received the referrals on an APP1 form, this the data is reflected in section 6.1 Whilst the BHSCT added an additional line 'Inappropriate' to the HSCB return template section 4, to record the inappropriate APP1's, section 6.2 of this template did not provide this option and this is why there is a difference in figures.

PLEASE ENSURE A SEPARATE RETURN IS COMPLETED FOR EACH PROGRAMME

DATA RETURN 9 – PoC / Directorate _OPS_____

9 The Mental Health (NI) Order 1986
Article 4 (4) (b) Article 5 (1) Article 5 (6) Article 18(5) Article 18(6) Article 115

Admission for Assessment Process Article 4 and 5		**TRUST ASW**	**RESWS ASW**
9.1	Total Number of Assessments made by ASWs under the MHO This figure is significantly lower than last year. OPS figures are collated by Mental Health Services who manage the ASW rota. The Mental Health Statutory Functions Report notes 40 assessments not specified to programme of care some of which may be in the older age profile but not known to OPS.	19	
9.1.a	Of these how many resulted in an application being made by an ASW under (Article 5.1b)	16	
9.1.b	How many assessments required the input of a second ASW (Article 5.4a)	0	
9.1.c	Number of applications made by the nearest relative (Article 5.1.a)	0	
9.1.d	Can the Trust provide assurance that they are meeting their duties under Article 117.1 to take all practical steps to inform the nearest relative at least 7 days prior to discharge.	YES – mandatory templates are completed along with each ASW risk assessment which captures this information electronically.	

Use of Doctors Holding Powers (Article 7)		
9.2	How many times did a hospital doctor use holding powers?	7
9.2a	Of these, how many resulted in an application being made?	7

ASW Applicant reports		
9.3	Number of ASW applicant reports completed	16
9.3.a	*Confirm if these reports were completed within 5 working days* YES – the reports are completed electronically and the confirmation of completion date is a mandatory field.	

Social Circumstances Reports (Article 5.6)		
9.4	Total number of Social Circumstances reports completed. *This should equate to number given at 9.1c. If it does not please provide an explanation.*	0

9.4.a	Confirm if these reports were completed within 14 days? **YES / NO** If no, please explain	0

Mental Health Review Tribunal		
9.5	Number of applications to MHRT in relation to detained patients	1

Guardianships (Article 18)		
9.6	Number of Guardianships in place in Trust at period end	1
9.6.a	New applications for Guardianship during period (Article 19(1))	0
9.6.b	How many of these were transfers from detention (Article 28 (5) (b))	1
9.6.c	How many were Guardianship Orders made by Court (Article 44)	0
9.6.d	Number of new Guardianships accepted during the period (Article 22 (1))	0
9.6.e	Number of Guardianships renewed during the reporting period (Article 23)	1
9.6.f	Number of Guardianships accepted by a nominated other person	0
9.6.g	Number of MHR hearings in respect of people in Guardianship (provide total number)	1
9.6.h	Total number of Discharges from Guardianship during the reporting period (Article 24)	1

Discharges as a result of an agreed multi-disciplinary care plan	1
Lapsed	
Discharged by MHRT	
Discharged by Nearest Relative	
Total	1

Approved Social Worker (ASW) Register		
9.7	Number of newly appointed Approved Social Workers during period The Trust continues to take a corporate approach to ASW provision and this is reported in the Mental Health Statutory Function Report.	
9.7.a	Number of Approved Social Workers removed during period The Trust continues to take a corporate approach to ASW provision and this is reported in the Mental Health Statutory Function Report	
9.7.b	Number of Approved Social Workers at period end (who have fulfilled requirements consistent with quality standards)	

	The Trust continues to take a corporate approach to ASW provision and this is reported in the Mental Health Statutory Function Report	

9.8	Do any of the returns for detention and Guardianship in this section relate to an individual who was under 18 years old? NO If yes, please provide number and advise on any issues presenting	
9.9	How many times during the reporting period has the Trust notified the Office of Care and Protection under Article 107? Please advise of any issues. This figure is collated through a combination of electronic and manual count. The service area will work to provide greater precision in respect of the number of referral to the Office of Care and Protection. The Service area continue to have to fund private financial capacity assessments in most cases. Sourcing and accessing these assessments continues to present a challenge for staff. DLS continue to support training of OPS staff annually to support staff understanding of their statutory responsibilities in respect of the management of service user finances.	40

The Mental Health Order (NI) 1986 as amended by The Criminal Justice (NI) Order 1996.SArticle 50A(6). Schedule 2A Supervision and Treatment Orders.		
9.10	Number of supervision and treatment orders, (where a Trust social worker is the supervising officer) in force at the 31st March	0
9.11	Of the Total shown at 9.10 how many have their treatment required as: (a) Treatment as an in-patient (b) Treatment as an out patient (c) Treatment by a specified medical practitioner	
9.12	Of the total shown at 9.10 how many include requirements as to the residence of the supervised person (excluding in-patients)	
9.13	Of the total shown at 9.10 how many of these supervision and treatment orders were **made** during the reporting period. Please advise of any issues presenting	

2. PROGRAMME OF CARE SUMMARY

Programme of Care / Directorate:- Physical & Sensory Disability

2.1	Named Officer responsible for professional Social Work
2.1a	**Accountability Arrangements - Please provide a copy of your Organisational Structure from Assistant Director to Band 7 Staff** Ms Tracy Reid is the Divisional Social Worker for Adult, Community and Older People's Services. The Divisional Social Worker has responsibility for professional issues pertaining to the social work and social care workforce within the Service Area. She is accountable to the Executive Director of Social Work for the assurance of organisational arrangements underpinning the discharge of statutory functions related to the delivery of Social Work and Social Care services within the Service Area. The role of the Divisional Social Worker is outlined in section 1.1 An unbroken line of accountability for the discharge of statutory functions by the social care workforce runs from the individual practitioner through the Service Area professional structures to the Executive Director of Social Work and onto the Trust Board. **Highlight any vacancies and the action taken to recruit against these.** There are no vacancies within the line of accountability for the discharge of statutory function.
2.1b	**Please highlight key Social Work Workforce planning issues, including recruitment, retention and professional roles (ie. ASW, DAPO, JP). Information provided should include level and type of vacancies and any vacancy control systems in place.** The service area is pleased to report that there are minimal professional social work vacancies in the service area with two social work vacancies at the end of this reporting period. The service area can also report that staffing has remained very stable with a low turnover of staff at practitioner or managerial level. **Professional Roles** **a) Designated Adult Protection Officer (DAPO)** The service area has in place sufficient numbers of DAPO's to meet its current responsibilities in relation to Adult Safeguarding responsibilities.

	b) Investigating Officers The service area has in place sufficient numbers of IO's to meet its current responsibilities in relation to Adult Safeguarding responsibilities. **c) Approved Social Worker** The Trust takes a corporate position in relation to the Approved Social Worker role and this is reported on within the Mental Health Statutory Function report. Physical & Sensory Disability has one Approved Social Worker. **d) Mental Capacity Practitioners** The service area has sufficient numbers of suitably qualified practitioners in place to meet its requirements for the Mental Capacity Act.
2.2	**Supervision arrangements for social workers**
2.2a	**Please confirm that the Trust is fully compliant with the Regional Supervision Framework Yes/No** **If not, outline the remedial action taken to address this** During periods of surge in the pandemic, supervision took place in group settings. However this was for a short period before individual supervision sessions were resumed. There are arrangements in place to monitor compliance with supervision, through a monthly exception reporting arrangement. This ensures that the service manager maintains oversight of compliance with supervision. In Physical & Sensory Disability at March 2021, there was one episode of non-compliance due to maternity leave. The service area is subject to the Adult, Community and Older People's supervision audit.
2.2b	**Please confirm if the Programme of Care is utilising a Caseload Weighting tool Yes/No** **If not, outline how the Programme of Care is managing current capacity, demand and workforce availability** Whilst the service area does not apply a caseload waiting tool, during this period they have implemented a risk stratification tool, to identify high, medium and low risk cases. The utilisation of this tool informs caseload allocation. Caseloads are kept under review through the supervision process, caseload analysis and allocation systems. The service area currently has sufficient staffing to meet referral demand.

	An informal review of caseloads during the reporting period highlighted the growing complexity of cases in Physical & Sensory Disability. However, it is noted, that where there are growing levels of risk, much of it concentrated within the Care Management team. As a result, a formal review of roles and responsibilities in social work and care management will be undertaken in the next reporting period, in consultation with staff, to achieve a greater balance of risk and ensure equity of caseload.
2.3	**Report at high level on any audits, research, outcome reports or evaluations undertaken during the reporting period, that relate to delegated statutory functions (bullet points only). Please ensure reference is made to the inclusion of service user involvement.**
	<u>Meeting accommodation needs for those with Complex Needs</u> Due to significant numbers of Alcohol Related Brain Injury (ARBI) service users within Physical & Sensory Disability, the service area continues to make progress in working with others, internally and externally to address this unmet need. The service area worked in collaboration with Leonard Cheshire and other stakeholders, to develop the first residential Care Home in Northern Ireland, offering rehabilitation for ARBI service users, opening in January 2020. This facility was initially to be for the Belfast Trust catchment area but has since become a regional unit. Physical & Sensory Disability currently have seven service users in the fourteen-bed facility. Leonard Cheshire hosted an international conference on ARBI on 25th March 2021 and commended the service area for their support in getting the facility established and helping to address this unmet need. The service area has also worked closely with Healthcare Ireland regarding their new facility in North Belfast, Jason Court, which is designed for those with complex physical and mental health needs. The unit opened in April 2021 following registration with RQIA. **<u>Self Directed Support</u>** With regard to structures in the Belfast Trust for the implementation of Self Directed Support (SDS), the Divisional Social Work Lead (Learning Disability) chairs the Trust SDS Steering Group who meet quarterly. The SDS Implementation Group continues to be chaired by the Service Manager for Physical & Sensory Disability and meets bi-monthly. There is representation from all service areas, service users, carers, contracts, training team, and information management. The Trust has adopted a co-production model with regard to the training on SDS, with engagement of service users and carers. Their lived experience and contribution has been positively evaluated, following feedback from staff at the training. In order to embed the ethos of SDS into social work practice, the SDS Project Manager and SDS Practice Development Lead from the

Learning and Development team attend team/staff meetings to address any practice or implementation issues. A SDS training calendar is in place until March 2022.

The on-going use of resource allocation panels across three service areas, including Physical & Sensory Disability, ensures that staff are engaging in the SDS approach, and there is consistency of allocation of resources to service users and carers.

All service areas are engaged in the SDS process, albeit at different stages, and are using the SDS approach when assessing or reviewing service users or carers.

Emergency Direct Payments (EDPs)

SDS Leads across all Trusts are working on the final suite of documentation for EDPs, to facilitate delayed discharges from hospital. The Department of Health secured £500k of funding for Covid pressures, which included Direct Payments. However, information from DoH would suggest that this funding ceases on 31st March 2021.

Activity SDS Support Plans

There are 2685 SDS Support Plans in place across all programmes of Care at 28th February 2021. The SDS Lead continues to report SDS monthly activity to HSCB. All programmes of care are engaged in the SDS approach to social care, albeit at different stages of embedding into practice.

Independent Living Fund

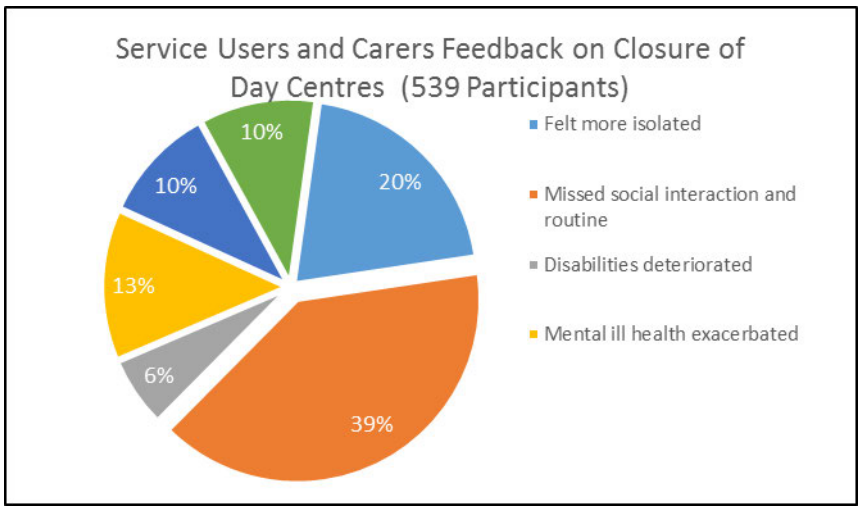
Independent Living Fund (ILF) Scotland has been working with NI government colleagues and other stakeholders, including all five Trusts over the last 24 months to explore a potential re-opening of the Independent Living Fund in NI. The rationale for re-opening the fund is to further enhance independent living opportunities for those with the most significant impairments. It is recognised that there are many young adults with complex needs who would benefit from ILF. Access to ILF would enhance a person centred approach with these service users, combined with the options already available under Self Directed Support. A survey of all stakeholders with regard to their choice of options was conducted in early December 2020, and results are being analysed by the Department of Health. The conclusion from the survey was that all stakeholders support the reopening of the Independent Living Fund. The service area welcomes and is supportive of this current review of Independent Living Fund arrangements.

ACOPS Day Care

Adult Community and Older People's Services have a number of Day Care Services that offer day opportunities to a variety of service

	users and responsibility for the management of these sits within the Physical and Sensory Disability service area.
	These include 4 Physical & Sensory Disability Day Care Services, 7 Older People's Day Care Services and 3 Dementia Day Care Services These services offer support to Older People and Adults with a range of needs including Dementia, Physical Disability and Sensory Disability The Covid19 pandemic resulted in the service having to adopt new ways of working, to balance the challenges of securing the health and wellbeing of the most vulnerable people in our community, with ensuring that we continue to deliver high quality and safe client services. To facilitate this, the service area, focused on essential work only, in order to maximize the number of staff available to deal with the emergency situation itself and to ensure compliance with social distancing requirements. All of the Day Care services had to close in March 2020 in order to protect the health and wellbeing of services users and staff. Outreach support and limited use of buildings for personal care was available to service users, once the services closed. To ensure the safety of our service users and reduce the impact of social isolation due to the closure of our centres and the wider lockdown, the service area worked to ensure regular contact with our service users and their families. They made regular phone calls to service users and completed domiciliary tasks, including home visiting to make lunch, completing shopping tasks or providing personal care if required in their homes. Activity packs were delivered on a weekly basis, and in addition to crafts, puzzles and activities, these provided information, food items and other useful items. Staff completed home visits for social interaction, and took service users for socially distanced walks, or for socially distanced outings on Trust transport. The Community Access Team led on a knitting project, which formed a unique partnership between service users and the paediatric hospital ward for whom they knitted hearts. Following closure, the service area set about planning for recovery of services focussing efforts on ensuring service user safety. . In August 2020 Day Centre facilities were recovered in line with the Day Care Recovery Plan. As lower numbers are able to attend, the successful outreach service has continued. Risk assessment of all environments were required and adaptations implemented to reduce any risks. Service Users and their carers/families have been kept updated during this challenging time. Through outreach calls and letter communication, they continue to be made aware of all progress, limitations and developments.

During this period, staff completed a scoping exercise/questionnaire with services users and their carers which has informed recovery planning. This survey has highlighted the negative impact that day centre closure has had on service users and their families and demonstrated the positive impact of day care. It concluded that 78% of people's health and well-being was negatively impacted by closure of day centres during COVID:



Sensory Support

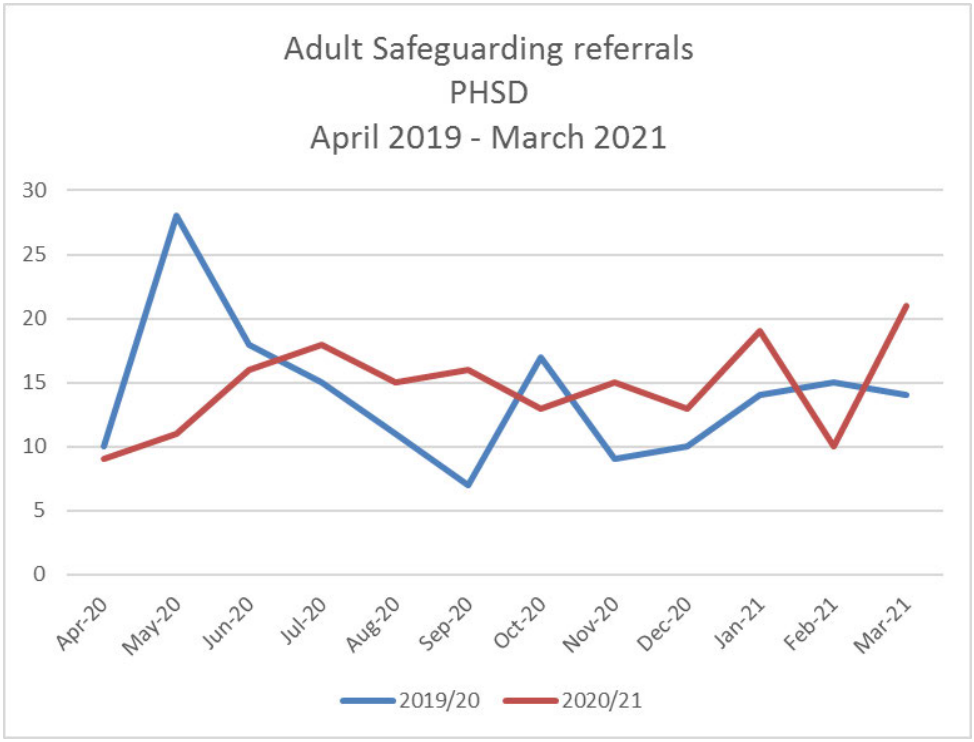
The public consultation of the provision of Communication Support Services for people who are profoundly deaf and hard of hearing was completed in November 2016. This showed overwhelming agreement of the recommendation for a Regional Communication Support Service (RCSS) supplied by BSO. The Health & Social Care Board approved the implementation of this in May 2017 and the service area is represented on the RCSS Steering Group. The focus of this work continues to be to develop and deliver a Regional Communication Support Service that includes robust governance and accountability arrangements. The service area continues to support the HSCB to progress this with fortnightly regional tele-conference calls. During Covid 19 the Sensory Support Team has worked with the HSCB and service users in relation to the introduction of remote interpreting services in the absence of face to face contact due to safe distancing procedures.

The Sensory Support Team continues to implement the actions and recommendations of the Deafblind Needs Analysis Review. The two staff members who obtained the Diploma in Deafblind Studies continue to hold a specialist role within the team in completing deafblind assessments. They also continue to provide support and education to colleagues in the assessment and delivery of effective programmes of care for deafblind service users.

The service area attends a regional sub group, which the purpose of, is to develop services for deafblind people regionally and they continue to meet on a bi-monthly basis.

	With regard to specialist training the Sensory Support Team continue to deliver deaf and sight awareness training to staff within Belfast Trust. Tinnitus courses were delivered virtually by two Rehabilitation Assistants. A service user led tinnitus support group has developed from the tinnitus course and is now an independent group. The team continues to avail of the much valued regional training, such as training on Language Deprivation Syndrome. The Sensory Support Team were involved in the development of the regional framework for the procurement of specialist equipment developed in 2019/2020. This has been fully embedded and ensures equitable and accessible provision of sensory equipment. The service area has continued to engage with service users to ensure a quality service is being provided. A survey was carried out relating to the changing manner of assessing and supporting service users during the pandemic. A second survey has been developed in conjunction with the Western Trust to explore the experiences of service users with a sight loss whilst out shopping, with a view to developing working partnerships with retail organisations to improve the shopping experience of our service users. Due to the challenges posed by the pandemic, the Sensory Team Leads participate in a monthly Covid-19 Recovery Planning and Service Delivery and the service area looks forward to services recovering. **Community Brain Injury Rehabilitation Team** The Covid 19 pandemic has created a greater need for remote working, for example, telephone and video consultations/meetings. As such, there has been a shift to remote assessment and intervention where appropriate. Face-to-face consultations and interventions have been maintained where remote working was not suitable. Building capacity to support service users to access software, to enable virtual assessments and rehabilitation therapy sessions, is continuing within the service and across other statutory and voluntary partners. In addition, information available to service users and carers through the team has been updated. Steps have also been taken to avoid exclusion from the service those persons who were less experienced in the use of information technology (i.e. provision of service user tablets and data). CBIRT increasingly is requested to assist with establishing and/or the maintenance of placements of service users within private nursing homes (PNH) often quite some time post-injury, and with significant complex needs. This represents a challenge in terms of the specialist support and involvement being sought from CBIRT. With these pressures in mind the Clinical Lead has been liaising with colleagues in adult mental health and learning disability, in relation to processes

	and standards being used, where service users present with behaviours that challenge, especially in Trust commissioned placements. This area of work has required close collaboration with staff within the Physical & Sensory Disability Care Management team.
2.4	**Programme of Care to advise of any significant judgements and/or decisions derived from Serious Adverse Incidents, Case Management Reviews, Mental Health Review Tribunals, Judicial Reviews or RQIA Inspection and/or Review activity during the reporting period, that directly relates to the Trusts discharge of their statutory functions.**
	Declaratory Order The service area has sought the jurisdiction of the court to support Best Interest Decision making, with one Declaratory Order granted for the purposes of safeguarding a service user from risk from others. The service area has been commended in both cases for the quality of interventions and reports. **Learning from Serious Adverse Incidents** The Community Brain Injury Rehabilitation Team (CBIRT) in conjunction with colleagues in Adult Mental Health Service (AMH) are making progress in relation to an earlier Serious Adverse Incident (SAI) which occurred prior to this reporting period. These were in relation to a clear pathway between Physical & Sensory Disability and Mental Health services for those presenting with both mental health and brain injury and/or physical health issues. CBIRT's senior clinicians are now able to access AMH electronic records. This facilitates improved and timely communication between service areas. Further work is ongoing in relation to better sharing of information and the potential for joint consultative clinics are being discussed with mental health services to ensure a more coherent and person-centred understanding of service-users' needs where there are concurrent mental and physical health care needs. Access to neuro-psychiatry opinion in a timely manner continues to be problematic as the post remains vacant within Belfast Trust; however, the current absence of a dedicated neuropsychiatry provision has led to a closer collaboration between CBIRT and various mental health and psychiatric services, in both the acute and community settings. **RQIA Inspections** Within ACOPS Day Centres, there have been three RQIA inspections within the reporting period; taking place in Enler Day Centre, Edgcumbe Day Centre and Shankill Day Centre. All inspections were exceptionally positive in terms of care provision and governance standards. No Quality Improvement Plans were returned for Enler or

	Edgcumbe, and the Trust was commended by RQIA for the quality and thoroughness of Covid 19 mitigation planning. One area for improvement was noted for Shankill Day Centre, regarding the current absence of corporate mandatory Adult Safeguarding training for day centre support staff, including cleaning staff and transport drivers. This had previously been raised by the service through the relevant leadership channels and plans are in place to ensure that these staff receive adequate training commensurate to their role.
2.5	**Advise on any challenges in the provision of Safeguarding services that have arisen in this Programme of Care during the reporting period and actions taken to mitigate any difficulties.**
	With regards to Adult Safeguarding, there continues to be an ongoing challenge in balancing the service user's right to a private life and promoting his/her individual choice to make their own decisions which may place them at risk of abuse. During this reporting period, the level of reporting, after an initial drop off during the first lockdown, has remained relatively stable in comparison to the previous year.  The 3 top types of abuse referred to the service area for investigation are physical, financial and psychological, with the predominant setting from which referrals arise. is the service users own home. The service area partook in a number of ACOPS initiatives that were developed to redress the impact of the first lockdown including a social media campaign and targeting of specific areas for increased awareness.

	The service area continues to have strong links with the Belfast Area Domestic & Sexual Violence and Abuse Partnership and there continues to be a focus on Adult Safeguarding awareness raising amongst our disabled population and the groups who work with them. The service area also acknowledges the fact that a pressurised caring role can at times result in Adult Safeguarding concerns, and therefore staff have continued to identify carer stress and offer carers support, during this difficult time for carers.

2.6 Progress Update on DSF Plan

This Section is for the Programme of Care to record their progress with the actions identified at the beginning of this reporting period (cross reference with section 1.3)

2.6	Issue/Action Agreed at DSF meeting in October 2020	Progress Update at 31st March	RAG Rating
	Physical & Sensory Disability		
	Issue: Domiciliary Service Provision	The number of people awaiting a package of care (29/03/2021) within PSD has significantly reduced to 27. The service area has structures in place for monitoring of SDS and PSD continues to meet DOH targets year on year.	
	Issue: Continuing Healthcare CHC	Physical & Sensory Disability services continues to be challenged in relation to historical cases for this matter. However, the clarification of the policy position is welcomed and significantly reduces this risk. The Ombudsman is currently investigating one case in relation to CHC.	
	Issue: Mental Capacity Act	The service area had a total of 65 legacy cases, which require Trust Panel Applications. This has been a significant area of learning for the social work staff and staff continue to develop experience in this area.	

Rag Rating:

Green - Complete
Amber - Partially Complete
Red - Not complete
Where the RAG status is Amber or Red, please include further detail in Section 2.7 of this template.

2.7 Discharge of Delegated Statutory Functions

This section enables the Trust to provide more details on the issues identified by the Executive Director at Section 1.4

2.7	Summary of areas where the Trust has not adequately discharged their Delegated Statutory Functions for this Programme of Care.	Please outline remedial action taken to address this situation and any proposed future action.
	Physical & Sensory Disability	
	Domiciliary Care Whilst the level of unmet need has significantly reduced to 27 cases (as of 29/03/21) and significant progress has been achieved in sustaining this reduction, there continues to be challenges in meeting needs as they are identified. This presents a risk to service users. Within the service area this risk manifests as, challenges in identifying time slots that support independent living needs for younger adults and there is an increased risk of carer stress..	Physical and Sensory Disability is part of a wider ACOPS strategy for the reduction of unmet domiciliary care provision across the Division. Key actions include: -implementation of a new brokerage system for more timely uptake of referrals by providers -weekly monitoring and reporting of unmet need to understand key influencers and to make timely intervention -development of transformation structure for Statutory Homecare Review -ongoing engagement with Homecare Sector to understand and address key barriers to provision -the service area has structures in place for monitoring of SDS and PSD continues to meet DOH targets year on year
	Mental Capacity Act As stated above the service area continues to work through outstanding legacy MCA cases, which have had a significant impact upon staff within PSD Care Management. Whilst the service area has made good	The service area has committed to recruiting an additional at risk post to support the additional duties being experienced by PSD Care Management staff, at this time. The service area continues to work to meet obligations in relation to legacy MCA by 31 May 2021.

	progress and continues to work towards completion by 31 May 2021, this increasingly complex work involves significant professional time without additional investment	
	Annual Reviews Due to the extended standing down of non-essential Statutory Reviews during this period, a number of annual reviews are outstanding at the end of this reporting period. This presents a risk to service users and carers, in relation to delay in reviewing care needs and potential for unrecognised change or deterioration. This also impacts upon the strength of the Trust's assurance in relation to its duty of quality for commissioned services	Actions taken by the service area to reduce risk include: - maintenance of telephone contact with service users throughout the pandemic - urgent visits and reviews maintained - normal face to face review activity has resumed within the final quarter of this reporting period. - an action plan for the rebuild of services is in place. - care Managers continue to monitor incidents, complaints and quality monitoring reports, to identify emerging risks in independent sector provision - service is closely linked to the ACOPS Commissioned Service Governance arrangements. -

PROGRAMME OF CARE DATA RETURNS 1 – 6 AND 9

DATA RETURN 1 – PoC / Directorate: Physical & Sensory Disability

1 GENERAL PROVISIONS				
			<65	65+
1.1	How many adults were referred for assessment of social work or social care need during the period?		1467	591
1.2	Of those reported at 1.1 how many adults commenced receipt of social work or social care services during the period?		1025	487
1.3	How many adults are in receipt of social work or social care services at 31st March?		1370	188
1.3a	How many adults are in receipt of social work support only at 31st March (not reported at 1.4)? *We are not able to accurately disaggregate this figure ,ongoing work by Business Support Team to develop further accurate reporting*		N/K	
1.4	How many care packages are in place on 31st March in the following categories:			
	vii.	Residential Home Care *(Actual total on 31st March 21)*	20	n/a
	viii.	Nursing Home Care *(Actual total on 31st March 21)*	93	n/a
	ix.	Domiciliary Care Managed	519	n/a
	x.	Domiciliary Non Care Managed	107	n/a
	xi.	Supported Living	61	n/a
	xii.	Permanent Adult Family Placement		
1.4a	For all those listed above in 1.4 provide assurance that the Care Management process is being applied in accordance with the DHSSPS Care Management HSC ECCU/1/2010 Circular. NO *If no, please explain* *Due to the suspension of non-essential visiting and reviews for an extended period of time during this reporting period, annual reviews are outstanding. This backlog is currently being addressed*			
1.5	Number of adults provided with respite during the period		*PMSI return*	*PMSI return*
1.6	Number of adults known to the Programme of Care in receipt of Centre based Day Care			

	- Statutory sector	239	n/a
	- Independent sector	3	n/a
1.6a	Number of adults known to the Programme of Care in receipt of Day Opportunities *(Manual Count)*	767	0
1.7	Of those at 1.6 how many are EMI / dementia		
	- Statutory sector	2	n/a
	- Independent sector	n/a	n/a
1.8	This is intentionally blank		
1.9	How many of this Programme of Care clients are in HSC Trust funded social care placements outside Northern Ireland?	2	n/a

DATA RETURN 1 – Hospital ___ Physical & Sensory Disability

1 GENERAL PROVISIONS - HOSPITAL				
		<18	18-65	65+
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the period?	n/a	n/a	n/a
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the period?	n/a	n/a	n/a
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?	n/a	n/a	n/a

Age is at date of referral for 1.1 and 1.2
Age at 31st March for 1.3

DATA RETURN 1 – Acute Hospital (general setting) _ Physical & Sensory Disability

1 GENERAL PROVISIONS – ACUTE HOSPITAL (GENERAL SETTING)				
		<18	18-65	65+
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the period?	n/a	n/a	n/a
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the period? (assessment is to include screening). **Please note it is expected that the response for sections 1.1 & 1.2 will be the same**	n/a	n/a	n/a
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?	n/a	n/a	n/a

Age is at date of referral for 1.1 and 1.2
Age at 31st March for 1.3

DATA RETURN 2 – PoC / Directorate PHYSICAL & SENSORY DISABILITY

2 CHRONICALLY SICK AND DISABLED PERSONS (NI) ACT 1978;			
		<65	65+
2.1	Details of patients less than 65 in hospital for long term (>3months) care who are being treated in hospital ward for over 65	0	X
2.2*	Number of adults known to the Programme of Care who are:		
	Blind	294	431
	Partially sighted	128	215
2.3	Number of adults known to the Programme of Care who are:		
	Deaf with speech	120	58
	Deaf without speech	81	33
	Hard of hearing	531	1883
2.4	Number of adults known to the Programme of Care who are:		
	Deaf Blind	20	114

*Please note that this return does not reflect service users who are registered visually impaired. There has been a decline in the number of people who are choosing to be registered blind and partially sighted. The service has noted an increase in service users who are registered visually impaired and feels it is important to reflect this in the returns as these individuals require assessment and service provision.

Adults who are visually impaired:

Under 65	192
Over 65	825

DATA RETURN 3 – PoC / Directorate PHYSICAL & SENSORY DISABILITY

3 DISABLED PERSONS (NI) ACT 1989 ***Note: 'disabled people' includes individuals with physical disability, sensory impairment, learning disability***		
3.1	Number of referrals to Physical/Learning/Sensory Disability during the reporting period.	**2058**
	Number of Disabled people known as at 31st March.	**1558**
3.2	Number of assessments of need carried out during period end 31st March.	**1512**
3.3	Number of assessments undertaken of disabled children ceasing full time education.	**N/A**

DATA RETURN 4 – PoC / Directorate PHYSICAL & SENSORY DISABILITY

4 HEALTH AND PERSONAL SOCIAL SERVICES (NI) ORDER 1972;
Article15, Article 36 [as amended by Registered Homes (NI) Order 1992]

4.1	Number of Article 15 (HPSS Order) Payments	33
	Total expenditure for the above payments	£ 1479.74
4.2	Number of TRUST FUNDED people in residential care	20
4.3	Number of TRUST FUNDED people in nursing care	90
4.4	How many of those at 4.3 received only the £100 nursing care allowance?	3

DATA RETURN 5 – PoC / Directorate PHYSICAL & SENSORY DISABILITY

5 CARERS AND DIRECT PAYMENTS ACT 2002

		16-17	18-64	65+	n/k
5.1	Number of adult carers offered individual carers assessments during the period.	**1**	**207**	**38**	**14**
5.2	Number of adult individual carers assessments completed during the period	**1**	**206**	**36**	**4**
5.2a	Number of adult individual carers assessments declined during the period and the reasons why	**0**	**1**	**2**	**10**
5.3	Of the total at 5.2 in how many of the assessments were the carers, caring for disabled children?	**0**	**0**	**0**	**0**
5.4	Number of adult carers receiving a service @ 31st March	**0**	**75**	**10**	**1**

5.5	Number of young carers offered individual carers assessments during the period.	**12**
5.6	Number of young carers assessments completed during the period .	**12**
5.7	Number of young carers receiving a service @ 31st March	**12**
5.8	(a) Number of requests for direct payments during the period 1st April – 31st March *(Interpreted as same figure as new approvals)*	**20**
	(b) Number of new approvals for direct payments during the period 1st April – 31st March	**20**
	(c) Number of adults receiving direct payments @ 31st March	**173**
5.9	Number of children receiving direct payments @ 31st March	**N/K**
5.9.a	Of those at 5.8 how many of these payments are in respect of another person? *(unable to aggregrate from Paris Data)*	**N/K**
5.10	Number of carers receiving direct payments @ 31st March *(unable to aggregrate from Paris Data)*	**N/K**
5.11	Number of one off Carers Grants made in-year.	**343**

Note: sections 5.8, 5.9 and 5.10 are to be reported as mutually exclusive.

Commentary

The Service Area has been challenged during this period in relation to outreaching to carers and in relation to accessing carers referrals. This has led to the implementation of telephone assessments, which has proved to be highly effective and well received by carers. During this time the service area has also found new ways of engaging with young carers and has developed new information for young carers which has been developed in partnership with them.

The service area also has provided additional support to carers of people who would normally attend the day centre, as well as continuing to utilise direct payments as an alternative to day care.

DATA RETURN 6 – PoC / Directorate ____ Physical & Sensory Disability

6 SAFEGUARDING ADULTS

6.1	Number of safeguarding adult referrals within the period	**169**
6.2	Number of safeguarding adult referrals within the period broken down by the following categories of abuse: (h) Financial (i) Institutional (j) Neglect (k) Physical (l) Psychological/ Emotional (m)Sexual (n) Exploitation	 **36** **0** **5** **52** **20** **12** **3**
6.3	Number of investigations commenced within the period	**36** Adult Protection **39** Adult Safeguarding **Total 75**
6.4	Number of investigations completed within the period No of cases closed to adult in need of protection?	 **30**
6.5	Number of care and protection plans commenced within the period	**39**
6.6	Number of care and protection plans in place on 31st March	**Not required**

No. of referrals in 6.1 is 169 but in 6.2 categories total 128. A difference of 41 This is the number of referrals received by the Adult Protection Gateway Team (APGT). Over this reporting period, BHSCT APGT received 41 APP1's (Adult Protection referrals) for PHSD which did not have a category of abuse, as these were screened as inappropriate referrals. However as the Gateway Team received the referrals on an APP1 form, this the data is reflected in section 6.1 Whilst the BHSCT added an additional line 'Inappropriate' to the HSCB return template section 4, to record the inappropriate APP1's, section 6.2 of this template did not provide this option and this is why there is a difference in figures

PLEASE ENSURE A SEPARATE RETURN IS COMPLETED FOR EACH PROGRAMME

DATA RETURN 9 – PoC / Directorate __ Physical & Sensory Disability __

Duties in relation the Discharge of the Mental Health Order in relation to Adults between 18 - 64 are usually discharged by Adult Mental Team and therefore reported in that Adult Mental Health Report

9 The Mental Health (NI) Order 1986
Article 4 (4) (b) Article 5 (1) Article 5 (6) Article 18(5) Article 18(6) Article 115

Admission for Assessment Process Article 4 and 5		**TRUST ASW**	**RESWS ASW**
9.1	Total Number of Assessments made by ASWs under the MHO	0	0
9.1.a	Of these how many resulted in an application being made by an ASW under (Article 5.1b)		
9.1.b	How many assessments required the input of a second ASW (Article 5.4a)		
9.1.c	Number of applications made by the nearest relative (Article 5.1.a)		
9.1.d	Can the Trust provide assurance that they are meeting their duties under Article 117.1 to take all practical steps to inform the nearest relative at least 7 days prior to discharge. **YES / NO** *If no, please explain*		

Use of Doctors Holding Powers (Article 7)		
9.2	How many times did a hospital doctor use holding powers?	
9.2a	Of these, how many resulted in an application being made?	

ASW Applicant reports		
9.3	Number of ASW applicant reports completed	
9.3.a	*Confirm if these reports were completed within 5 working days* ***YES / NO*** *If no, please explain*	

Social Circumstances Reports (Article 5.6)		
9.4	Total number of Social Circumstances reports completed. *This should equate to number given at 9.1c. If it does not please provide an explanation.*	
9.4.a	Confirm if these reports were completed within 14 days? **YES / NO** If no, please explain	

Mental Health Review Tribunal		
9.5	Number of applications to MHRT in relation to detained patients	

Guardianships (Article 18)		
9.6	Number of Guardianships in place in Trust at period end	
9.6.a	New applications for Guardianship during period (Article 19(1))	
9.6.b	How many of these were transfers from detention (Article 28 (5) (b))	
9.6.c	How many were Guardianship Orders made by Court (Article 44)	
9.6.d	Number of new Guardianships accepted during the period (Article 22 (1))	
9.6.e	Number of Guardianships renewed during the reporting period (Article 23)	
9.6.f	Number of Guardianships accepted by a nominated other person	
9.6.g	Number of MHR hearings in respect of people in Guardianship (provide total number)	
9.6.h	Total number of Discharges from Guardianship during the reporting period (Article 24)	

Discharges as a result of an agreed multi-disciplinary care plan	
Lapsed	
Discharged by MHRT	
Discharged by Nearest Relative	
Total	

Approved Social Worker (ASW) Register		
9.7	Number of newly appointed Approved Social Workers during period	
9.7.a	Number of Approved Social Workers removed during period	
9.7.b	Number of Approved Social Workers at period end (who have fulfilled requirements consistent with quality standards)	

9.8	Do any of the returns for detention and Guardianship in this section relate to an individual who was under 18 years old? If yes, please provide number and advise on any issues presenting

9.9	How many times during the reporting period has the Trust notified the Office of Care and Protection under Article 107? Please advise of any issues.	0

The Mental Health Order (NI) 1986 as amended by The Criminal Justice (NI) Order 1996.SArticle 50A(6). Schedule 2A Supervision and Treatment Orders.		
9.10	Number of supervision and treatment orders, (where a Trust social worker is the supervising officer) in force at the 31st March	
9.11	Of the Total shown at 9.10 how many have their treatment required as: (a) Treatment as an in-patient	
	(b) Treatment as an out patient	
	(c) Treatment by a specified medical practitioner	
9.12	Of the total shown at 9.10 how many include requirements as to the residence of the supervised person (excluding in-patients)	
9.13	Of the total shown at 9.10 how many of these supervision and treatment orders were **made** during the reporting period. Please advise of any issues presenting	

2. PROGRAMME OF CARE SUMMARY

Programme of Care / Directorate:- Mental Health

2.1	Named Officer responsible for professional Social Work
2.1a	**Accountability Arrangements - Please provide a copy of your Organisational Structure from Assistant Director to Band 7 Staff** During the reporting period, Ms Mary O'Brien discharged the role of Divisional Social Worker within the collective leadership model implemented within mental health services. The post incorporates professional responsibility for the Social Work and Social Care workforce. Ms O'Brien is accountable to the Director of Social Work for the assurance of arrangements underpinning the discharge of statutory functions related to the delivery of Social Work and Social Care services within the Division. The role of the Divisional Social Worker is outlined in section 1.1 An unbroken line of accountability for the discharge of statutory functions by the Social Work and Social Care workforce runs from the individual practitioner through the Divisions line management and professional structures to the Executive Director of Social Work and onto the Trust Board. The Divisional Social Worker has assured the Mental Health Division's Annual Statutory Functions Report, which meets the requirements of the prescribed audit process in respect of the discharge of statutory functions. **Highlight any vacancies and the action taken to recruit against these.** Currently within the Mental Health Division there are 5 band 6 WTE Social Work vacancies, however a recruitment process has taken place recently to address this. Future recruitment will be considered within the regional Social Work interview pilot to commence in May 2021 for future Social Work vacancies. In addition there are two band 8A MCA lead posts and one 8B MCA service manager post that are currently in a recruitment process. These have been developed to support MCA with a Trust support structure. In CAMHS there is one Senior Social work post currently vacant in Beechcroft. There are 7 permanent mental health practitioner vacancies, which are not designated Social Work posts although are open to Social Work. This is a feature of the CAMHS structure where there are only 7 designated Social Work posts across the service, despite 60 Social Workers being employed across BHSCT and SEHSCT (as BHSCT provide CAMHS service to SEHSCT).

2.1b	**Please highlight key Social Work Workforce planning issues, including recruitment, retention and professional roles (ie. ASW, DAPO, JP). Information provided should include level and type of vacancies and any vacancy control systems in place.**
	Across the Mental Health Division, there are 103 Social Work staff in post however only 72 are designated Social Work posts. This includes 18 managers at band 7-8C, (inc three new posts within the MCA team yet to be recruited). Within CAMHS, there are 60 Social Workers, with only 7 designated Social Work posts, and only 1 Social Work designated manager post. 163 posts in total. It is a concern that there is a large number of non designated S/W posts, if these posts were filled by other professions there would be a risk of not being able to fulfil the full range of Delegated Statutory Functions due to insufficient Social Workers in post. We would hope that this matter is considered by the Mental Health S/W Workforce task and finish group chaired by the Department. **Mental Capacity Act (NI) 2016** The Trust was required to develop an infrastructure to support delegated functions associated with the partial implementation of the Act in relation to deprivation of liberty, while continuing to ensure that statutory functions under the Mental Health Order were delivered. The Mental Capacity Act (MCA) Team provide short term detention authorisations, Trust panel authorisations and in addition have been offering support to complete legacy Trust panel applications and training sessions and support to wards and teams across all key programmes of care within the Trust. **Recruitment** Initially 6 temporary band 7 Social Work staff were appointed under the MCA as interim ASW's to undertake the role of STDA's and are on target to complete ASW training (by 2023) as per MCA. The Trust has invested in a permanent structure to support the delegated functions of the team with Senior Social Work management being recruited at present. This will be followed by ASW, medical, OT and admin recruitment to provide MDT support in regards hospital site based Trust panel application and authorisation panels and STDA's. **Approved Social Work Provision** The current service structure was developed to ensure delivery of ASW delegated statutory functions under MCA and the MHO. This was secured by continuing to provide an ASW daytime service (with ASW's based in substantive posts and participating on a Trust wide rota), and a separate MCA team to provide STDA and ASW Trust panel membership.

	Profiling of future ASW numbers in this context is a priority with the need for representation across all key programmes of care given the brevity and potential future scope of ASW statutory roles under MCA. Currently the majority of ASW's are based in the Mental Health programme with limited representation from older person's services, learning disability and CAMHS. ASW workforce planning estimates developed by QUB illustrate the need to increase and maintain ASW numbers across programmes. Current estimates recommend that the Trust will need approximately 47 ASW's to meet MHO and MCA requirements at present based on the ASW allocating 10% of their time to ASW practice. This suggests a current short fall of at 20 ASW's excluding those ASW's who are also in management positions. Currently, ASW staff allocate approximately 20% of their time on the rota based on providing 3 slots, (plus 1 day for report completion) per month out of 20 working days, (this excludes team leaders/8A who work one slot per month given their managerial responsibilities). **Impact of the Covid-19 pandemic on MHO assessment service provision** From 1st April to June 2020 the service lost over 50% of ASW slots over the month (33/60 slots) due to 3 staff shielding, 2 agency staff and 1 bank staff member removing themselves from rota and, 2 staff on maternity leave. However, early recruitment under the Coronavirus Act (2020) with modifications to the MHO, provided 8 ASW candidates who were fully appointed by August 2020, which significantly bolstered service provision along with continued need to use agency ASW staff to ensure rota coverage. During the period, the number of ASW assessments undertaken was 341, which was an increase on last year's figure of 20%. There have been two peak periods in regard to demand for ASW assessments during June – September 2020 and February to March 2021. This increase can be explained to some extent by assessments undertaken on behalf of other Trusts. To support ASW colleagues in other Trusts, Belfast Trust agreed to undertake assessment of service users who were being assessed under the MHO in Belfast based hospitals. During the period Belfast Trust undertook the following ASW assessments on behalf of other Trusts; WHSCT – 8 SEHSCT – 1 SHSCT - 1 NHSCT – 1 (April 2021) Total 11 During the pandemic, to reduce footfall into wards and potential exposure of ASW staff to the virus, the Trust developed a protocol whereby ASW staff were not entering the wards on arrival, but remained in situ and undertaking handover to staff by phone at the hospital. This protocol was later supported by the HSCB and adopted by all Trusts.

Current ASW cohort

Total : 33 ASW's on BHSCT register (includes 3 x 8A managers, 4 x team leaders who are not on the rota regularly).

The breakdown of programme representation amongst ASW's is 24 MH, 4 LD, 4 OPS, 1 CAMHS, 2 agency ASW.

This is an increase of 5 ASW's from last year however includes 3 staff not currently active ;
- 1 maternity leave
- 2 long term shielding due to immune compromised

In addition the service lost 9 ASW's during the reporting period:
- 5 moved post
- 1 career break
- 1 retired
- 2 stood down from duties

Recruitment and retention of ASW staff

There is a continued challenge in recruiting and maintaining ASW's on the daytime rota. While 8 staff successfully completed ASW training in the last period, continued demands on the role have impacted on staff moving post in the last period and in staff standing down from the role.

Retention of ASW staff has become a significant issue to elongated assessment timeframes, in the main due to reduced capacity of other services that are essential to the ASW role. The unpredictability of the role and personal safety during lengthy assessments is also a growing concern for ASW's. Main issues;

1. Lack of beds locally and regionally leading to prolonged waits for service users to be admitted to hospital, at times up to 12 hrs, (and at times overnight) which significantly impacts on ASW finish times and concern in regard to guarantee of a finish time, (where there are no beds regionally, the ASW is often left waiting with the patient for extensive periods). On at least 2 occasions, the ASW has needed to agree an emergency care plan overnight with conveyance only occurring the next day. While this is within the remit of the MHO, (i.e. conveyance within 48 hrs of form 3 completion), this is not in line with the MHO process of ensuring the person is conveyed to hospital as soon as possible and examined immediately after admission.

2. Bed confirmation delay – directly as a result of the regional bed management protocol that stipulates that a consultant to consultant agreement must take place before the bed can be confirmed. Waits by ASW's in this regard have been experienced during March 2021 on multiple occasions of up to 5 hrs while waiting with the patient in the community.

	3. Provision of ambulance – during July – September 2020 there was a significant impact of ambulance delays due to the pandemic on conveyance to hospital under the MHO, (16 times where the delay was significant). At that time, there were incidents of delays of up to 15 hrs necessitating delegation of the ASW role to colleagues in RESWS where this was possible to resource. To facilitate safe and urgent conveyance to hospital, the Trust invested in patient conveyance contracting which has significantly reduced waiting times for service users and also facilitates out of area admissions but is a cost pressure for the Mental Health Division. 4. Limited availability of GP's due to surgery duties often leading to requests later in the day and after 5pm to undertake assessments under MHO. This inevitably leads to longer working hours as ASW are forced to work outside of their working hours to facilitate the working patterns of GP's. This has been a long standing issue with longer working hours having an impact on the perception of and interest in the role by band 6 social workers in taking up ASW training. 5. Potential for verbal and physical aggression during assessments. 6. Interface issues with key agencies e.g. police and ambulance have been identified as problematic and impacting on stress and significant delays in progressing conveyance to hospital. 7. Lone working Key delays (i.e. of more than 1 hr to confirm service being provided) (GP, NIAS, BED) - GP referral after 3.30pm – 104 - Delay due to GP availability – 63 - Delay due to bed availability – 53 - Delay due to ambulance availability – 33 Total: 253 delays ASW supports to maintain adequate numbers and service delivery. This includes; -1 fulltime ASW to support the demands on the rota providing 12 slots per month, (this will be reduced to 8 slots per month to avoid work related stress associated with the cumulative impact of the role). - 2 agency ASW's who provide approximately 5 slots per month each. Without this additional resource the Trust would be unable to meet delegated statutory functions. This again is a cost pressure for the Mental Health Division.

- Exploration of developing an ASW hub to provide peer support, learning and to centralise the service in keeping with the recent draft Regional ASW Quality Standards.
- Use of private patient conveyance company to facilitate conveyancing of patients where NIAS delays are significant. This ensures safe and timely conveyance of patients, to avoid a further deterioration in the patient's presentation, to facilitate risk management and to progress admission. This also benefits carers and ASW staff and other key stakeholders by reducing the timescale of the interventions that are often lengthy due to delays.

- ASW 1-1 supervision 3 monthly.

- Access to on call manager after 5pm- pilot being currently developed which also supports current recommended ASW quality standards. Again cost pressure to the Mental health Division.

- RESWS joint working arrangement developed with BHSCT has now been extended to all Trusts.

- ASW Paris implementation as of the 1st June 2020 enabling the development of data collation, management and analysis enhancing information infrastructure and reporting capacity. This will aid current and future workforce planning regarding the ASW service based on capacity and demand.

Social Work Staffing requirements

As previously highlighted, the development of Social Work normative staffing levels equating to nursing would support more accurate workforce planning. As demonstrated in CAMHS only 7 of the 60 roles undertaken by Social Work within the service area are dedicated Social Work posts, with the remaining Social Workers being employed as generic mental health practitioners. In Mental Health, there are 6 Social Work staff working into 6 nursing posts with an additional 6 agency Social Workers filling non designated posts to meet service need (these are not funded).

There is a pressing need to complete the regional review of Social Work workforce planning to support additional Social Workers representation within services. QUB's evidence based estimate of the number of Approved Social Workers (ASWs) required for Trusts to fulfil their statutory duties under the MHO and MCA is also welcome in planning predicted ASW numbers to be trained in the next few years and also in regard to securing representation across programmes of care.

Team Leader recruitment

There continues to be a challenge in encouraging band 6 Social Work staff into band 7 team lead and Senior Social Work practitioner posts. Service Managers have indicated band 6 staff are not

attracted to the team leader posts due to perception of the level of responsibility and remit of the post in addition to other statutory roles such as professional supervision, DAPO and ASW roles which their nurse counterparts do not have. Mental Health has a total of 28 team leader posts of which 8 have been employed as Social Workers, but only 4 are dedicated to Social Work, CAMHS have 8 team leader posts, of which only 1 is a Social Work designated post.

4 band 7 Senior Social Work practitioner posts were created within Mental Health CMHT's in 2019 which have bolstered delivery of statutory functions within the teams particularly where the team leader is not of a Social Work background.

Adult safeguarding provision

All teams have a DAPO in situ or long arm support from the ASG team. Provision of Investigating Officers has significantly improved due to increased training amongst teams. See section 6 for further detail.

CAMHS Social Work recruitment

There are no issues in regard to recruitment with a good uptake of posts at the last recruitment drive in January 2021. The main focus of recruitment within CAMHS at present is in relation to developing central referral teams for BT and SEHSCT areas however these are generic posts. There can be delays experienced during the recruitment process working with BSO structure in relation to delays in processing interview outcomes letters/offers of appointment, scheduling/ processing of request to advertise. There can also be delays within the Trust HR process in not keeping Trust interview panels updated.

The forthcoming regional Social Work recruitment structure will have little impact on CAMHS as the majority of posts are generic.

There are no permanent vacancies at senior management level. One Social Work trained manager has secured the post of Network Manager, for the CAMHS Regional Managed Care Network.

Retention of staff CAMHS

There continued to be a low turnover of staff within CAMHS with staff remaining for longer periods in post. it has been noted that career development opportunities for staff within CAMHS is limited with staff having to go into management posts to progress to a higher banding e.g. Principal Social Worker and Principal CAMHS practitioner (both not currently available), Family therapist.

2.2	**Supervision arrangements for social workers**
2.2a	**Please confirm that the Trust is fully compliant with the Regional Supervision Framework Yes** **If not, outline the remedial action taken to address this** The Trust is fully compliant with the Regional Supervision Framework (July 2018). All Social Workers across Mental Health and CAMHS are in receipt of operational and professional supervision. The Trust has developed a monthly reporting system to provide assurance of supervision arrangements for all Social Work and Social Care staff. Many staff in CAMHS are working in generic posts but are still availing of professional Social Work supervision. Updated supervision templates for 1-1 ASW, professional and DAPO supervision have been developed to reflect the supervision policy and NI adult services regional Social Work supervision framework (2018). Supervision training is provided for those providing professional supervision along with coaching for professional supervisors. **Professional Supervision File Audit** A professional supervision audit carried out in April 2021 covering the period which indicated an improvement on the previous year. While all files met the standards expected, some issues highlighted were; - Signature of supervisee – not always evident due to remote supervisions taking place during Covid 19 emergency period. - Some instances of delay in supervision when supervisor or supervisee off on sick leave – impacted by the pandemic. - Recommendation that all supervisions are typed and not hand written.
2.2b	**Please confirm if the Programme of Care is utilising a Caseload Weighting tool Yes/No** **If not, outline how the Programme of Care is managing current capacity, demand and workforce availability** Yes, recently developed within Mental Health with participation from all disciplines to ensure the unique contribution that each discipline brings to the team is identified. Pilot being completed within North and West primary care team for three months. Timescales for completion of core Social Work tasks/activities were measured. This has been particularly beneficial for Social Workers as often the specific work identified can be extremely time consuming and involving imminent deadlines, e.g. a review tribunal circumstances

	report to be presented within the 14 day assessment period. While this would only constitute one Social Work referral, it requires significant resources to meet the timescale for completion and this can be more accurately represented in the Social Worker caseload allocation. CAMHS are using the CAPA model. All staff roles are job planned on quarterly basis according to banding and specialist job roles.
2.3	**Report at high level on any audits, research, outcome reports or evaluations undertaken during the reporting period, that relate to delegated statutory functions (bullet points only). Please ensure reference is made to the inclusion of service user involvement.**
	Mental Health Due to significant numbers of Service Users delayed in their discharge (27) as noted in March 2020, the Trust inpatient services undertook a system change to develop process and protocols to address the delayed discharge difficulty and to further work toward prevention of this reoccurring. This has been extremely successful with only 1 delayed discharge at the end of the reporting period. The work also included the development of a step down facility. The model created has been adopted regionally and has seen the development of Capacity bed managers being appointed in each Trust area. It is of note that this service improvement was led by the Divisional Social Worker and Social Work practice was core to its success. This is a significant service improvement which has Service Users and their carers at its heart. The Step Down facility has won a housing in partnership award and the service development in Acute Mental Health Inpatient Centre (AMHIC) has been shortlisted for a QI award. **Think Child, Think Parent, Think Family** Following the regional Think family Social Work Assessment (TFSWA) in 2017-2018, a request was made from the HSCB to write up the pilot as a research initiative for a special edition of the international journal 'Advances in Mental Health'. The focus of the edition was family-focused research from UK and Ireland. The Principal Social Worker, who was involved in the pilot, wrote the article for the edition which was published in September 2020, titled, 'The Think Family Social Work Assessment: outcomes of a family-focused initiative using The Family Model' (https://doi.org/10.1080/18387357.2020.1825969). The outcomes across all six domains of 'The Family Model' (Falkov 2012), which was the foundation of the pilot and the assessment framework, demonstrated positive support for family focused practice to be embedded within mental health.

	The study indicated recommendations for further research in the area, which is supported by the HSCB Think Family Consolidation Plan and Logic Model and by the three HSCB funded Think Family posts (one of which is a dedicated social work post) which is pending recruitment. **The Recovery College** The college won the AONTAS Award in the category "Learner Voice", there were 5 categories, this year the awards focused on how educators adapted their provision during the Covid pandemic. There was then an overall award for the winner across all the awards. The Recovery College also won this award. The awards recognise the very best in adult learning in Ireland. The college submitted to learning stories which were very powerful re the impact the college had had in the individual's recovery journey. The Divisional Social Worker and the Service User Consultant co-manage the Recovery College. **CAMHS** IMPACT CAMHS - Is a service user led initiative within CAMHS which have developed several projects during the pandemic; - Co-produced evaluation study with Queens University entitled: "A peer led examination of the development and sustainability of the IMPACT CAMHS service user group". The young people were involved in the collation and editing process. Parents/ carers and therapists also participated. The project was funded by the Economic and Social Research Council (ESRC). - Produced and disseminated a Quarterly Newsletter made up of contributions from staff and service users for service users in regard to self-care and promoting positive wellbeing during the Covid emergency period. - Developing a 'swap some support' project' whereby young people write letters/ poems/ artwork to service users anonymously to offer support to another service user within CAMHS with their mental health. Feedback from the letters was extremely well received. - Presentation at the Annual Social Work and Social Care Research Conference on 10th March 2021 co-presented by service users, CAMHS staff and Queens University. The recording can be viewed at - https://vimeo.com/517100804. **Safety Quality Belfast Quality Improvement Programme** A further project aimed at improving service delivery was led by a Social Work team leader within CAMHS for the Safety Quality Belfast (SQB) Quality Improvement Programme. This involved interpreting

	written communications with service users where English was not their language. This project is currently ongoing.
2.4	**Programme of Care to advise of any significant judgements and/or decisions derived from Serious Adverse Incidents, Case Management Reviews, Mental Health Review Tribunals, Judicial Reviews or RQIA Inspection and/or Review activity during the reporting period, that directly relates to the Trusts discharge of their statutory functions.**
	RQIA Inspection Beechcroft An unannounced inspection at Beechcroft Child and Adolescent Mental Health Inpatient Unit took place on 15th-16th March 2021. None of the issues raised related to delegated statutory functions or to social work practice. A detailed action plan was devised to address issues identified regarding; • Safe Nursing Staff Levels • Nursing Staff Induction and Preceptorship • Nurse Mandatory Training • Staff Support • Therapeutic Activity Programme • Management of Actual and Potential Aggression. **RQIA Inspection Shannon Clinic MSU December 2020** Following an RQIA inspection in Shannon Clinic MSU, concern was expressed regarding Adult Safeguarding processes. This was in respect of nursing staffs knowledge in recognising and reporting adult safeguarding, delays in adult safeguarding referrals being screened by a line manager, lack of clarity by the MDT of the IO/DAPO role, cross referencing of incidents and adult safeguarding referrals and follow up with referral, quality of protection plans and adult safeguarding data not being reviewed to analyse trends for learning and service improvement (see section 2.5)
2.5	**Advise on any challenges in the provision of Safeguarding services that have arisen in this Programme of Care during the reporting period and actions taken to mitigate any difficulties.** During the reporting period Mental Health has continued to provide an ongoing service within COVID restrictions. As lockdown and social distancing -measures decrease, staff have increased face to face contact with mental health service users in provision of adult safeguarding investigations. Mental Health initially noted a decrease in adult safeguarding referrals from care homes, however measures were put in place with increased contact with care homes by Mental Health staff and Care Management maintained weekly contact completing a questionnaire with care homes where adult safeguarding was monitored as part of this process.

	The Mental Health Adult Safeguarding Team are in the process of completion of an Adult Safeguarding audit across the service area for governance and quality improvement. This now will be a bi-annual audit. Currently within the Mental Health service area, one of the areas for improvement is in the use of the Adult Safeguarding thresholds for safeguarding investigation as defined within the Adult Safeguarding Policy of an Adult at Risk of harm or an Adult in need of protection. This is not currently being used consistently across the service area and impacts on data collection for stats where there is no differentiation in the type of adult safeguarding investigation undertaken on the data return. The Mental Health Adult Safeguarding Lead delivered an information session to all staff completing data collection returns including DAPO's and Line Managers in an effort to improve returns in this area. Also covered in this session was definitions of screening out a referral and alternative safeguarding response which also causes unreliable data reporting. For the purposes of DSF reporting, all of the monthly data returns were reviewed with community teams and have been amended to appropriately reflect thresholds and responses and are being forwarded to HSCB. While the Mental Health service is in the process of PARIS implementation, where reports can be sourced for relevant data, it is hoped that this will improve data collection returns for mental Health in the interim. Following an RQIA inspection in Shannon Clinic MSU December 2020, concern was expressed regarding Adult Safeguarding practice within Shannon Clinic. This was in respect of staff knowledge of recognising and reporting adult safeguarding, delays in adult safeguarding referrals being screened by Line Manager, IO/DAPO role, cross referencing of incidents and adult safeguarding referrals, quality of protection plans and adult safeguarding data not being reviewed to analyse trends for learning and service improvement. A quality improvement action plan was instigated to ensure staff training in Adult Safeguarding is completed as per mandatory requirements, incidents are reviewed to ensure safeguarding referrals are completed, all meetings have adult safeguarding as a standing agenda item, weekly audit of the PARIS duty desk to ensure that safeguarding referrals are dealt with in a timely manner by Line Manager and forwarded to DAPO as appropriate. An Adult Safeguarding notice board is in place on each ward with an adult safeguarding flowchart and aide memoire of an adult safeguarding referral to assist staff and ensure they are aware of the reporting procedure. An Adult Safeguarding tracking document has been developed to record all incidents for analysis, trends, learning and service improvements where learning is shared. Regular governance meetings are in place where adult safeguarding issues are discussed including Bed Management meetings, live governance meetings, safety briefs, DAPO/ASM meetings where Datix incidents and Adult Safeguarding are reviewed and that appropriate incidents are considered under the Adult Safeguarding Policy and Procedures.

	The DAPO in Shannon Clinic completes monthly reviews of Adult Safeguarding referrals to ensure quality and for improvement. In addition, Adult Safeguarding Lead Nurses have been identified for the three wards in Shannon Clinic who will undertake IO training, and Ward/Deputy Ward Managers have undertaken Level 3 Line Manager training. An audit was also undertaken of Adult Safeguarding referrals and protection plans by the Mental Health Adult Safeguarding Team with feedback provided for improvement and learning. Training of IO/DAPO's was initially stood down during COVID-19 lockdown, however all IO/DAPO training and support groups are being offered via Microsoft teams to increase numbers of IO and DAPO staff across Mental Health. Currently there are adequate numbers of IO and DAPO within core community teams with some teams such as Addictions service area increasing numbers of nursing IO trained staff. Deficits remain within Therapy teams for DAPO trained staff and some Band 7 Therapists who are Social Work trained have declined to undertake the training or the role. This issue has been escalated to the Service Managers for the service area to highlight the need for appropriate numbers of DAPO staff within their service area. The Mental Health Adult Safeguarding Team continue to provide DAPO cover to teams in the community that have no Band 7 DAPO. All service areas continue to be encouraged to consider internal workforce planning to ensure appropriate numbers of IO trained Band 6 and Band 7 DAPO trained Social Work staff to fulfil the adult safeguarding role. The Mental Health Adult Safeguarding team are currently completing an audit of all bandings of staff within teams to ensure compliance to relevant adult safeguarding training and refresher training as per mandatory requirements for their role. The Mental Health Adult Safeguarding Team is currently in the process of implementing PARIS for adult safeguarding referrals to the team, and for adult safeguarding investigations where a DAPO is within the Mental Health Adult Safeguarding team. The Social Work team in Shannon Clinic are also using PARIS for all adult safeguarding referrals and IO investigations. All other teams within Mental Health await PARIS implementation for Adult Safeguarding. This will also require additional virtual training, a process document for the service area and development of a training video for IO/DAPO and admin staff in the use of the adult safeguarding documentation, alerts, management of the duty desk and inputting of Adult Safeguarding referrals. The Mental Health Adult Safeguarding Team are meeting with the PARIS implementation team with other service areas in the development and implementation of the APP documentation on PARIS which is scheduled to be in use for Protection investigations

	by June 2021. The new APP investigation documentation will deal with Adult in need of Protection adult safeguarding investigations. Risk of harm investigations are not considered within the new APP documentation and will require consideration for how these investigations will be completed. This is important for the Mental Health service area as the majority of safeguarding investigations completed are within the Risk of harm threshold and a full adult safeguarding investigation is completed. Joint Protocol investigations and the numbers of PIA interviews and ABE interviews continue to decrease within Mental Health due to police thresholds for Adult Safeguarding investigations. As a result, only one member of staff was put forward for ABE training in January 2021. New DAPO staff have been trained in Joint Protocol for referring adult safeguarding cases and consultations with CRU. Band 7 Social Work staff have been prioritised currently for PIA training due to limited available places for face to face training due to COVID. Band 6 staff will be considered as per the needs of their community team and service area as we move forward from current social distancing measures.

2.6 Progress Update on DSF Plan

This Section is for the Programme of Care to record their progress with the actions identified at the beginning of this reporting period (cross reference with section 1.3)

2.6	Issue/Action Agreed at DSF meeting in October 2020	Progress Update at 31st March	RAG Rating
	Mental Health		
	Issue: The project to amalgamate primary care and recovery services is in process and has been delayed due to the current Covid19 arrangements. Update at DSF meeting – 5.10.20 Ongoing service improvement project has being progressed over the last 2/3 years. This has made significant improvements including: • Introduction of telephone triage, advice and guidance function for GPs • Amalgamation of teams – issue re flow through teams, they have introduced a RAG rating system for all teams • All Teams now have a duty system • GP alignment for integrated teams • All teams are co-located • Working on case load weighting • Established clear pathways • Dedicated e-mail line	This is not specific to delegated statutory functions. Project management is in process for the amalgamation of primary and recovery Community Mental Health Teams within BHSCT with one team amalgamating currently.	

	Workforce challenges remain with 18 vacancies in Social Work posts and therefore high levels of agency staff in place. **Action:** • HSCB and Trust to determine if there is regional learning coming from these improvements which can be shared across Trusts.	Addressed with only 5 vacancies currently and recruitment process completed.	
	Issue: Completion of ASW reports within 5 day timescale 9.3 – 91.5% (283/309) of ASW reports were completed within the required timescale of 5 working days Update at DSF meeting – 5.10.20 The Trust report a slight improvement in compliance, however there does remain concerns in relation to this. Delays can, in part be attributable to staff absence, annual leave etc. Duty Rotas are reviewed to minimise impact. If a report is not completed within 5 days the Trust follow up. The ASW role remains a challenging one, and coupled with multiple functions (DAPO, JP etc) it is increasingly difficult to retain staff as it is becoming an increasingly unattractive post.	During the current reporting period, there were only 2 reports that were not received within the regional standard of 5 working days. The reason for same was due to one ASW being on sick leave due to contracting coronavirus and the second ASW was covering urgent sick leave. Therefore the assessment and report completion was unplanned in their diary and needed to be fitted in within planned substantive post workload. This is a significant improvement in timescales aided by a reduction in the rota frequency of the full time ASW staff member (was on rota 4 out of 5 days per week and reduced to twice weekly), as report completion was being delayed by multiple assessments and only one day planned for admin. The current reporting system also identifies reports that may be outside the 5 day	

	Action: • Trust to review the multiple functions and determine how ASW role can be enhanced to ensure appropriate levels of staff are available.	timeframe. ASW staff have also been made aware of the necessity to complete on time.	
	Issue: CAMHS Update at DSF meeting – 5.10.20 **The Trust report that workforce is the most significant issue and there is currently recruitment ongoing. HSCB raised the Improvement plan in place re Beechcroft and asked the Trust to update on this. This was not provided at the meeting and needs to be forwarded as soon as possible.** **Action:** • Written update on improvement plan required • To be discussed further at Regional CAMHS meeting	The Workforce issue in CAMHS is in relation to the availability of nursing staff and therefore not subject to DSF notation. RQIA inspection, took place on the 15th and 16th March 2021. See summary in section 2.3.	

Rag Rating:
Green - Complete
Amber - Partially Complete
Red - Not complete

Where the RAG status is Amber or Red, please include further detail in Section 2.7 of this template.

2.7 Discharge of Delegated Statutory Functions

This section enables the Trust to provide more details on the issues identified by the Executive Director at Section 1.4

2.7	Summary of areas where the Trust has not adequately discharged their Delegated Statutory Functions for this Programme of Care.	Please outline remedial action taken to address this situation and any proposed future action.
	Mental Health Issues	
	While the Division has adequately fulfilled its Delegated Statutory Functions we would like to raise the following concerns; • The high level of non designated S/W posts across the Division approximately 50% of all S/W posts. • Continuing difficulties faced by the ASW service in fulfilling requirements under the Order as detailed in 2.1b ➢ Conveyance difficulties	• Review of current workforce across the Division to clarify and discern the required number of designated S/W posts to fulfil DSF on an ongoing basis. This work will be part of the task and finish group chaired by the Department of Social Services. • Exploration of developing an ASW hub to provide peer support, learning and to centralise the service in keeping with the recent draft Regional ASW Quality Standards • RESWS joint working arrangement developed with BHSCT has now been extended to all Trusts. • ASW Paris implementation as of the 1st June 2020 enabling the development of data collation, management and analysis enhancing information infrastructure and reporting capacity. This will aid current and future workforce planning regarding the ASW service based on capacity and demand. ➢ To facilitate safe and urgent conveyance to hospital, the Trust invested in patient conveyance contracting which has significantly reduced waiting times for service users and also facilitates out of area admissions but is a cost pressure for the Mental Health Division

	➢ Significant delays in Out of Trust admissions ➢ Access to on call manager after 5pm for ASW staff.	➢ We continue to raise concerns with the Board re the requirement for Consultant to Consultant discussion as detailed in the Regional Bed Protocol. ➢ A pilot is currently being developed to have an on call ASW support manager rota. This is in line with current recommended ASW quality standards. This is a cost pressure to the Mental Health Division.

PROGRAMME OF CARE DATA RETURNS 1 – 6 AND 9

DATA RETURN 1 – PoC / Directorate: Mental Health and CAMHS_____

1 GENERAL PROVISIONS (Please note figures for Mental Health include adults who are over 65 but remain open to Adult Mental Health services)				
		<65	65+	CAMHS
1.1	How many adults were referred for assessment of Social work or social care need during the period? *The figure represents referrals from the Central Assessment Centres had that been set up in Trust that account for 2058 referrals. For the current reporting period, only social workers who are working in designated social work posts have been included in the yearly figures. (ie those Social Workers who are working in non-designated social work posts will no longer be included).* *Please note figure for CAMHS also only includes the figures for social workers who are working in designated social work posts. As per DSF report 2.1a there are only 7 designated social work posts across CAMHS (service includes BHSCT and SEHSCT) however there are 53 social workers working across the service area in non-designated social work posts.*	5072	N/A	480
1.2	Of those reported at 1.1 how many adults commenced receipt of social work or social care services during the period? *923 Referrals were received by the Central Assessment Centres.*	*3068*	N/A	*480*
1.3	How many adults are in receipt of social work or social care services at 31st March?	*2314*	N/A	*284*
1.3a	How many adults are in receipt of social work support only at 31st March (not reported at 1.4)?	*1296*	N/A	*N/A*
1.4	How many care packages are in place on 31st March in the following categories:			
	xiii. Residential Home Care	*79*	N/A	N/A
	xiv. Nursing Home Care	*161*	N/A	N/A
	xv. Domiciliary Care Managed	*218*	N/A	N/A
	xvi. Domiciliary Non Care Managed	*n/a*	N/A	N/A
	xvii. Supported Living	*228*	N/A	N/A
	xviii. Permanent Adult Family Placement	*29*	N/A	N/A
1.4a	For all those listed above in 1.4 provide assurance that the Care Management process is being applied in			

	accordance with the DHSSPS Care Management HSC ECCU/1/2010 Circular. YES			
1.5	Number of adults provided with respite during the period	*PMSI return*	*PMSI return*	*PMSI return*
1.6	Number of adults known to the Programme of Care in receipt of Centre based Day Care			
	- Statutory sector	*196*	N/A	*N/A*
	- Independent sector	*12*	N/A	*N/A*
1.6a	Number of adults known to the Programme of Care in receipt of Day Opportunities	*56*	N/A	*N/A*
1.7	Of those at 1.6 how many are EMI / dementia			
	- Statutory sector	*0*	N/A	*N/A*
	- Independent sector	*0*	N/A	*N/A*
1.8	This is intentionally blank			
1.9	How many of this Programme of Care clients are in HSC Trust funded social care placements outside Northern Ireland?	*18*	N/A	*N/A*

DATA RETURN 1 – Hospital - Mental Health and CAMHS _____

1 GENERAL PROVISIONS - HOSPITAL				
		<18	18-65	65+
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the period?	N/A	N/A	N/A
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the period?	N/A	N/A	N/A
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?	N/A	N/A	N/A

Age is at date of referral for 1.1 and 1.2
Age at 31st March for 1.3

DATA RETURN 1 – Acute Hospital (general setting) Refers to inpatients at Acute Mental Health Inpatient Centre (AMHIC) & Shannon Clinic, Clare Ward, Neurological Rehabilitation Unit

1 GENERAL PROVISIONS – ACUTE HOSPITAL (GENERAL SETTING)				
		<18	18-65	65+
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the period?	0	217	N/A
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the period? (assessment is to include screening). **Please note it is expected that the response for sections 1.1 & 1.2 will be the same** *2 service users were discharged before assessment could take place.*	*0*	*215*	N/A
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?	*0*	*81*	N/A

Age is at date of referral for 1.1 and 1.2
Age at 31st March for 1.3

DATA RETURN 2 – PoC / Directorate Mental Health _____

2 CHRONICALLY SICK AND DISABLED PERSONS (NI) ACT 1978;			
		<65	65+
2.1	Details of patients less than 65 in hospital for long term (>3months) care who are being treated in hospital ward for over 65 *Children under 18 years of age who have sight or hearing problems are recorded within the stats for Children Disability Teams.*	8	X
2.2	Number of adults known to the Programme of Care who are:		
	Blind	7	
	Partially sighted	23	
2.3	Number of adults known to the Programme of Care who are:		
	Deaf with speech	5	
	Deaf without speech	0	
	Hard of hearing	31	
2.4	Number of adults known to the Programme of Care who are:		
	Deaf Blind	0	

DATA RETURN 3 – PoC / Directorate Mental Health and CAMHS _____

3 DISABLED PERSONS (NI) ACT 1989 ***Note: 'disabled people' includes individuals with physical disability, sensory impairment, learning disability***			
		18-65	CAMHS
3.1	Number of referrals to Physical/Learning/Sensory Disability during the reporting period.	**67**	**0**
	Number of Disabled people known as at 31st March.	**56**	**0**
3.2	Number of assessments of need carried out during period end 31st March.	**67**	**0**
3.3	Number of assessments undertaken of disabled children ceasing full time education.	**N/A**	**0**

DATA RETURN 4 – PoC / Mental Health and CAMHS _____

4 HEALTH AND PERSONAL SOCIAL SERVICES (NI) ORDER 1972;
Article15, Article 36 [as amended by Registered Homes (NI) Order 1992]

4.1	Number of Article 15 (HPSS Order) Payments	189
	Total expenditure for the above payments	£14, 381
4.2	Number of TRUST FUNDED people in residential care	1
4.3	Number of TRUST FUNDED people in nursing care	**3**
4.4	How many of those at 4.3 received only the £100 nursing care allowance?	**8**

DATA RETURN 5 – PoC / Directorate Adult Mental Health and CAMHS _____

5 CARERS AND DIRECT PAYMENTS ACT 2002

		16-17	18-64	65+
5.1	Number of adult carers offered individual carers assessments during the period. *Of note, the figure for Adult Carers includes those who have been referred via CAMHS*	**2**	**809**	**79**
5.2	Number of adult individual carers assessments completed during the period	**2**	**565**	**56**
5.2a	Number of adult individual carers assessments declined during the period and the reasons why *Key reasons reported by carers:* • *The carer sees their caring duties as a private matter which they prefer not to discuss* • *The carer does not see themselves as a carer and therefore does not see assessment as relative* • *The carer feels that they do not need any support / additional support (highest reported reason)* • *The carer would not give a reason / no reason recorded*	**0**	**244**	**23**
5.3	Of the total at 5.2 in how many of the assessments were the carers, caring for disabled children?	**5**	**221**	**0**
5.4	Number of adult carers receiving a service @ 31st March We recognise that there is a small number reported in comparison to completed carer assessments in regard to carers receiving a service during the period. It is of note that during the reporting period, 778 grants were awarded which would relate to a service being provided. There is a recognition that there has been a reduction in the number of face to face contacts with carers during the Covid emergency period. There is also work to be undertaken with teams to ensure that they recognise that the keyworker also provides a service to the carer and this should be included in stat returns. An audit of carers assessments and service provision was undertaken in October 2020 and action plan developed to improve carer services. As a result, the Trust is developing Paris collation of carer information with each carer being allocated a Paris ID to enable the service to run reports on carer service activity for those currently in receipt of a service. A checklist was also developed for CMHT's during the Covid emergency period to ensure that Team leaders	**Not collated**	**65**	**Not collated**

	are providing information to the team in regard to carer services.			

5.5	Number of young carers offered individual carers assessments during the period.	**24**
5.6	Number of young carers assessments completed during the period	**18**
5.7	Number of young carers receiving a service @ 31st March	**6**
5.8	***All figures relate to both direct payments and self-directed support.*** (a) Number of requests for direct payments during the period 1st April – 31st March	**25**
	(b) Number of new approvals for direct payments during the period 1st April – 31st March	**23**
	(c) Number of adults receiving direct payments @ 31st March	**10**
5.9	Number of children receiving direct payments @ 31st March	**0**
5.9.a	Of those at 5.8 how many of these payments are in respect of another person?	**0**
5.10	Number of carers receiving direct payments @ 31st March	**1**
5.11	Number of one off Carers Grants made in-year.	**778** ***(9 of which were young carers grants)***
Note: sections 5.8, 5.9 and 5.10 are to be reported as mutually exclusive.		
Commentary		

DATA RETURN 6 – PoC / Directorate Mental Health

7 SAFEGUARDING ADULTS

6.1	Number of safeguarding adult referrals within the period	**1558**
6.2	Number of safeguarding adult referrals within the period broken down by the following categories of abuse: (o) Financial (p) Institutional (q) Neglect (r) Physical (s) Psychological/ Emotional (t) Sexual (u) Exploitation	 **112** **9** **20** **605** **199** **587** **26**
6.3	Number of investigations commenced within the period	**510**
6.4	Number of investigations completed within the period	**510**
6.5	Number of care and protection plans commenced within the period	**473**
6.6	Number of care and protection plans in place on 31st March	**Not Required**

PLEASE ENSURE A SEPARATE RETURN IS COMPLETED FOR EACH PROGRAMME

DATA RETURN 9 – PoC / Directorate Adult Mental Health and CAMHS _

9 The Mental Health (NI) Order 1986
Article 4 (4) (b) Article 5 (1) Article 5 (6) Article 18(5) Article 18(6) Article 115

<table>
<tr><th colspan="2">Admission for Assessment Process Article 4 and 5

Figures presented reflect total numbers including all programmes of care</th><th>TRUST ASW</th><th>RESWS ASW</th></tr>
<tr><td>9.1</td><td>Total Number of Assessments made by ASWs under the MHO

Total figure include all programmes. See breakdown below;

<table>
<tr><th>POC</th><th>No. of Assessments</th><th>DET</th><th>VOL</th><th>ACP</th><th>NFA</th></tr>
<tr><td>LD</td><td>5</td><td>5</td><td>0</td><td>0</td><td>1</td></tr>
<tr><td>OPS</td><td>19</td><td>16</td><td>2</td><td>1</td><td>0</td></tr>
<tr><td>MH</td><td>260</td><td>185</td><td>23</td><td>51</td><td>8</td></tr>
<tr><td>CAMHS</td><td>17</td><td>17</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>OTHER / NOT SPEC</td><td>40</td><td>25</td><td>3</td><td>13</td><td>22</td></tr>
<tr><td>TOTAL</td><td>341</td><td>248</td><td>28</td><td>65</td><td>31</td></tr>
</table></td><td>341</td><td></td></tr>
<tr><td>9.1.a</td><td>Of these how many resulted in an application being made by an ASW under (Article 5.1b)</td><td>248</td><td></td></tr>
<tr><td>9.1.b</td><td>How many assessments required the input of a second ASW (Article 5.4a)</td><td>2</td><td></td></tr>
<tr><td>9.1.c</td><td>Number of applications made by the nearest relative (Article 5.1.a)</td><td colspan="2">0</td></tr>
<tr><td>9.1.d</td><td>Can the Trust provide assurance that they are meeting their duties under Article 117.1 to take all practical steps to inform the nearest relative at least 7 days prior to discharge.
YES</td><td colspan="2"></td></tr>
</table>

Use of Doctors Holding Powers (Article 7)		
9.2	How many times did a hospital doctor use holding powers?	129
9.2a	Of these, how many resulted in an application being made?	112

ASW Applicant reports		
9.3	Number of ASW applicant reports completed	341

9.3.a	*Confirm if these reports were completed within 5 working days* ***NO*** *If no, please explain:* *2 reports not completed in time scale due to 1 x Self Isolation and1 x Covid requirement to cover additional slot on Rota*	

Social Circumstances Reports (Article 5.6)		
9.4	Total number of Social Circumstances reports completed. *This should equate to number given at 9.1c. If it does not please provide an explanation.*	0
9.4.a	Confirm if these reports were completed within 14 days? **YES / NO** If no, please explain	N/A

Mental Health Review Tribunal		
9.5	Number of applications to MHRT in relation to detained patients (Mental Health ONLY)	81

Guardianships (Article 18)		
9.6	Number of Guardianships in place in Trust at period end	6
9.6.a	New applications for Guardianship during period (Article 19(1))	1
9.6.b	How many of these were transfers from detention (Article 28 (5) (b))	1
9.6.c	How many were Guardianship Orders made by Court (Article 44)	0
9.6.d	Number of new Guardianships accepted during the period (Article 22 (1))	2
9.6.e	Number of Guardianships renewed during the reporting period (Article 23)	4
9.6.f	Number of Guardianships accepted by a nominated other person	0
9.6.g	Number of MHR hearings in respect of people in Guardianship (provide total number)	3
9.6.h	Total number of Discharges from Guardianship during the reporting period (Article 24)	

Discharges as a result of an agreed multi-disciplinary care plan	1
Lapsed	0
Discharged by MHRT	0
Discharged by Nearest Relative	0
Total	1

Approved Social Worker (ASW) Register		
9.7	Number of newly appointed Approved Social Workers during period (5 MH, 3 OPS)	8
9.7.a	Number of Approved Social Workers removed during period 5 moved post 2 stood down from duties 1 Career Break 1 Retirement	9
9.7.b	Number of Approved Social Workers at period end (who have fulfilled requirements consistent with quality standards) Excluding 2 staff shielding due to Covid and 1 staff member on maternity leave	32

9.8	Do any of the returns for detention and Guardianship in this section relate to an individual who was under 18 years old? If yes, please provide number and advise on any issues presenting 17 (Beechcroft) all detained admissions	
9.9	How many times during the reporting period has the Trust notified the Office of Care and Protection under Article 107? Please advise of any issues.	2

The Mental Health Order (NI) 1986 as amended by The Criminal Justice (NI) Order 1996.SArticle 50A(6). **Schedule 2A Supervision and Treatment Orders.**		
9.10	Number of supervision and treatment orders, (where a Trust social worker is the supervising officer) in force at the 31st March	1
9.11	Of the Total shown at 9.10 how many have their treatment required as: (a) Treatment as an in-patient	0
	(b) Treatment as an out patient	1
	(c) Treatment by a specified medical practitioner	0
9.12	Of the total shown at 9.10 how many include requirements as to the residence of the supervised person (excluding in-patients)	0
9.13	Of the total shown at 9.10 how many of these supervision and treatment orders were **made** during the reporting period. Please advise of any issues presenting	0

2. PROGRAMME OF CARE SUMMARY

Programme of Care / Directorate:- Learning Disability

2.1	Named Officer responsible for professional Social Work
2.1a	**Accountability Arrangements - Please provide a copy of your Organisational Structure from Assistant Director to Band 7 Staff** Ms Rhoda McBride is the Divisional Social Worker for Learning Disability Services. The Divisional Social Worker has responsibility for professional issues pertaining to the social work and social care workforce within the Service Area. She is accountable to the Executive Director of Social Work for the assurance of organisational arrangements underpinning the discharge of statutory functions related to the delivery of Social Work and Social Care services within the Service Area. The role of the Divisional Social Worker is outlined in Section 1:1 An unbroken line of accountability for the discharge of statutory functions by the social care workforce runs from the individual practitioner through the Service Area professional structures to the Executive Director of Social Work and onto the Trust Board. **Highlight any vacancies and the action taken to recruit against these.** • 1x 8A Principal Social Work post has now been agreed and is currently being processed for recruitment. • 1x 8A Adult Safeguarding Lead- has been vacant since September 2020. This post has been successfully recruited and the post holder is due to take up post in June 2021. • 1x Band 7 Team Leader retired- this post is temporarily backfilled. This post is being progressed through scrutiny. • Another Band 7 Team Leader is due to take up a temporary Band 7 Care Management post. Several attempts to recruit to this post through an expression of interest have been unsuccessful. • 1x 0.5 B7 SW in Iveagh remains vacant – currently covered by agency. • 3x Senior Practitioners Band 7 recently appointed with DAPO responsibilities (Temporary). Two of these staff have only recently been trained as DAPOs. The third Senior Practitioner post (temporary) has only recently been appointed and is yet to be trained as a DAPO and take up post. These Senior Practitioner posts are currently being progressed through HPRTS to be recruited permanently. • Additional funding had been secured through IPTs to permanently recruit an additional Senior Practitioner Band 7 with DAPO responsibilities and 2 SW Band 6 with IO responsibilities. These posts are currently being progressed through HRPTS to be recruited permanently.

2.1b	**Please highlight key Social Work Workforce planning issues, including recruitment, retention and professional roles (ie. ASW, DAPO, JP). Information provided should include level and type of vacancies and any vacancy control systems in place.** **1. Mental Capacity Act (NI) 2016 Phase 1 (MCA)** • The MCA implementation has proved to be a challenge for the Learning Disability service. An early scoping exercise found that approximately 647 of the 1600 community service users possibly lacked capacity to agree to restrictions within their care plan, which would be considered to amount to a deprivation of their liberty. • MCA training was completed across the service area. A Learning Disability MCA Steering Group was established for the hospital and the community and a data base developed to monitor progress. • The service area was not provided with any additional resource to meet this demand. A MCA Action Plan was developed in order to try to plan to complete all DOLS before the end of May. This action plan was discussed and agreed with the Director. It included:- ➢ Temporary appointment of 8a LD MCA Lead with the intention to recruit a Band 7 and Admin; ➢ One practitioner per team would be identified to solely undertake MCA work (when backfill was in place); ➢ In addition, all Community practitioners would endeavour to complex 2 DOLs per month; ➢ Overtime was offered and retirees approached to assist with MCA and; ➢ The MCA central team provided input by way of a Short Term Detention Authoriser (STDA) and additional medical input to assist with the medical documentation. • There have been a number of challenges, which means that the service area is unlikely to meet this target by end of May 2021. ➢ Although the service area was able to successfully appoint an 8a MCA Lead, through an expression of interest, backfill could not be secured for this post. ➢ It has also been difficult to free up staff to work solely in MCA as the service area was unable to secure SW backfill staff from the agencies. They largely could only provide AYE staff, who do not meet the requirements to undertake MCA. ➢ Insufficient retirees agreed to return to complete DOLS and only a small number of staff agreed to do overtime. ➢ Additional pressures associated with absences and COVID also meant that it was difficult for each staff member to meet the requisite target of 2 DOLs per month. ➢ The lack of medical resources also proved to present a significant challenge.

- As this is a relatively new piece of legislation, it is a very fluid situation with advices and case law changing on a regular basis. This has had an impact on the workload and the service areas ability to meet the target. Some of these changes and additional challenges include:-

  - The Attorney General's office in February 2021 included family homes to the list of places where service users should be considered as being deprived of their liberty.
  - The onset of the Covid 19 pandemic had an immediate effect on the process for seeking Trust Panel authorisations for service users. As PHA guidelines suggested that face to face assessments should be kept to a minimum assessors committed to using virtual methods such as Zoom, Facetime etc. For many people with a severe learning disability the use of virtual methods was not always appropriate. Even when face to face assessments were carried out the use of PPE equipment made it difficult to communicate with many service users e.g. those service users with autism.
  - The Attorney General has referred 23 cases to the Review Tribunal. This has resulted in Rule 6 reports having to be completed, which was not initially considered during the original work plan.
  - Whilst the introduction of the MCA is welcomed by the service as being an essential protection for people lacking capacity, there have been huge workforce and resource implications, especially as service users with a Learning Disability could be subject to reviews under MCA from the age of 16 until their death. Due to the complexities associated communication needs and concentration levels of our service users very often assessors have to complete the capacity assessments over 2-3 visits and it takes considerably more time than anticipated.
  - After the first year of the authorisation, annual reviews are required and these are also required to be referred to the Attorney General. This may also possibly lead to an annual review by the Review Tribunal but at the very least a mandatory referral every 2 years. This will require a report to be produced by the applicant.
  - The issue of the Nominated Person (NP), where one cannot be identified is another issue for the service. Currently a senior manager is taking this role on but this does not provide the level of objectivity that the Nominated Person (NP) should provide. It is essential that independent advocacy take on this role and they are resourced to do so.
  - Issues relating to MCA regularly demand an input from DLS until the court cases can provide case law. This is also time consuming and a complex area requiring staff to have an excellent knowledge of legislation.

- To date the service has carried out 179 assessments- 103 Trust Panel applications; 40 service users were deemed to have capacity; and 36 are awaiting a panel hearing. This falls short of

	the target for learning disability despite a very robust action plan being put in place for the target to be achieved by the end of May. The service has 2 sessional staff (2 days per week) who are both social workers and one experienced social worker (4 days per week) have been funded to work on completing applications. It is hoped that in July another social worker who is retiring will join this workforce. • To assist the workforce the service area has developed a number of resources to help with understanding of MCA – these include social stories, easy read information and objects of reference. The introduction of MCA has resulted in excellent MDT working with social workers, CNLD, OT and SLT all working together to produce the required forms. • The service has also sought to run a number of workshops to augment the training provided by the Department of Health. Staff have reported that these have been useful and this should be embedded into the programme to share learning. • A proposal has been put forward to secure additional funding for MCA work within the service area to include admin support. • Given the challenges and workforce issues highlighted the service area is unlikely to meet the May or the November review deadline. This has been included on the Risk register **2. Approved Social Work (ASW)** • The service area now only has 3 qualified Band 7 ASW staff who participate on the ASW day time rota. • The service area also has an 8A ASW/Operations manager, who is on the ASW register. • The lack of qualified ASW staff within the service area continues to present challenges in respect of a lack of expertise relating to risk assessment and key legislation i.e. the Mental Health (N. Ireland Order) 1986, Mental Capacity legislation and Human Rights legislation. • The service area encourages staff to apply for places on the ASW programme to ensure there remains sufficient expertise in relation to the Mental Health (N. Ireland) Order 1986 and to reflect the new demands of the Mental Capacity Act (NI) 2016 Phase. • Unfortunately, attempts to encourage staff from the Learning Disability service to undertake the ASW training last year were unsuccessful. **3. Vacancies** • Generally, the permanent recruitment of Band 5/6 SW vacancies has not been an issue within the service area. • The Trust has agreed to participate in the regional recruitment of social workers during 2021-2022 but remains concerned in relation to the standards applied to job descriptions/ interviews particularly around specialist areas/posts will need to be addressed.

- At the end of March 2021, the service area has 1x Band 6 SW permanent vacancy in West Belfast which is still being processed through scrutiny and 1 Band 6 SW permanent vacancy in Muckamore Abbey Hospital due to be interviewed.
- Within South and West Belfast Community Teams – there are 5 temporary vacancies – 1 on maternity leave and 4 who took up Senior Practitioner/ Team Leader posts- now all unfilled.
- When staff have been temporarily promoted from Band 6 to Band 7 posts within the service area it has been difficult to secure backfill from the agencies. This has resulted in several of the SW Band 6 posts unfilled or the need for off contract agencies to be used which has proved costly for the service area.
- Any temporary posts have been mostly backfilled by band 5 AYE staff who lack expertise and require additional supervision and mentoring.
- There have been issues raised by staff side in relation to some of the job descriptions in relation to inclusion of ASW responsibilities in Band 7 job descriptions. Therefore, a number of these posts are currently being desk topped.
- The service area is seeking to recruit an additional 4x B7 Senior Practitioners in SW to provide support to team leaders with DAPO roles and to aid with development of B6 and unqualified staff in the teams.
- The service has now agreed that all team leaders will be social workers to reflect the requirement for DAPOs.
- 2x Band 7 Team leader posts which were vacant were successfully recruited. One permanently took up post in July 2020 and the other is covering the post temporarily.
- 1x Band 7 Team Leader retired- this post is temporarily backfilled. This post is being progressed through scrutiny. Another team leader is due to take up a temporary Band 7 Care management post. Several attempts to recruit to this post through an expression of interest have been unsuccessful.
- 1x 8A Principal Social Work post has now been agreed and is currently being processed for recruitment.
- 1x 8A Adult Safeguarding Lead- has been vacant since September 2020. This post has been successfully recruited and the post holder is due to take up post in June 2021.

4. Achieving Best Evidence (ABE)

- The service currently has 3 Band 7 staff trained as ABE interviewers.
- It is hoped to increase this in the coming year to meet the service area needs. The service would like to increase this number by 2 during the next reporting period.

5. DAPOs and IOs

- The service area has 5 DAPOs who are also Team Leaders/ Senior Social Workers and 1 permanent WTE B7 DAPO.

	• The service has 3 Band 7 Senior Practitioner/DAPOs recruited via an Expression of Interest. These posts are being recruited permanently. • A main workforce planning issue is the recruitment and retention of Senior Practitioner / DAPO. A proposal for additional ASG resource to include, an additional 8a ASG Lead, additional WTE DAPO'S, additional WTE lOs, admin and business support has been put forward. • Expression of interest for posts has not been successful to date and the input required into Muckamore Abbey hospital has impacted on the ability to retain DAPOs. • See safeguarding section for further details. This risk has now been included on the Corporate Risk register
2.2	**Supervision arrangements for social workers**
2.2a	**Please confirm that the Trust is fully compliant with the Regional Supervision Framework Yes/No** **If not, outline the remedial action taken to address this** • Within one of the Community Learning Disability Teams, the Team Leader has been on long term absence. The Senior Practitioner in the team has provided supervision for the Band 5 AYE staff and agency staff on a monthly basis. However, the remainder of the social work staff in this team have been receiving informal and group supervision. • There have been unsuccessful attempts to backfill this post through expression of interests but the service will continue to seek backfill.
2.2b	**Please confirm if the Programme of Care is utilising a Caseload Weighting tool Yes/No** **If not, outline how the Programme of Care is managing current capacity, demand and workforce availability** • At present within the service area, a caseload weighting tool is not used. • The service area has partially completed a review of current service users who were on the community caseload, who required minimal input from the service area. The West and East Belfast teams are completed and North and South are to be completed. This has been temporarily paused due to COVID. As a result of this review it has been agreed whether the service user; needs signposted on to other services; requires input; or can be discharged, on the understanding that if they require the service again they will be quickly reviewed. • There are ongoing audits of caseloads completed at monthly supervision. The Team Leader reviews information from the PARIS system. This includes the numbers of service users on

	each staff member's caseload, the frequency, type and duration of contact. This provides an overview of the capacity of each staff member and hence informs the allocation of work. • Supervision is also the forum whereby the Team leader can gain an understanding through discussion with the staff member in relation to the detail of each case including its complexity, the resources required and the workload capacity of the staff member. • Files are audited to ensure adherence to professional and agency standards. • Induction and training needs are identified and addressed at supervision to ensure staff are suitably trained and skilled to work with service users to meet their needs. This forms part of their SDR. • Team leaders regularly review caseloads across their teams and try to balance individual's caseloads with more complex and less complex cases and to match the skill set of each practitioner. • Backfill has been put in place through internal expression of interests or through use of agency. All agency staff have regular supervision and access to suitable training within the service area • Recruitment is underway to recruit any permanent vacancies.
2.3	**Report at high level on any audits, research, outcome reports or evaluations undertaken during the reporting period, that relate to delegated statutory functions (bullet points only). Please ensure reference is made to the inclusion of service user involvement.**
	1. Care Management Audit An updated audit took place by BSO in March 2020. The service area achieved a satisfactory report. Significant work has been ongoing which has included:- • Providing Care Plans for all Care Home placements, which explicitly detail Trust expectations. • A Care Management Analysis document has been developed: one for domiciliary packages and one for placements. This document analyses assessments from a variety of professionals and provides a record of BHSCT decision making in relation to assessed needs. This document records: the service user and family views; and capacity, consent and human rights implications. • Work has been undertaken with PARIS to create a separate team on the system so that reports can be easily run off to capture relevant information including activities. • A proposal has been developed to seek additional funding for business support to enable the full implementation of DATIX. This will enable care management to identify trends and patterns and thus enhance governance arrangements. • Care management are seeking funding for a finance officer to review placement costs to achieve value for money.

- An OT has now been appointed as part of the Care Management team to assist with the commencement and the review of placements.
- During the pandemic reviews were carried out virtually. However, now that the transmission levels have fallen, quality monitoring visits in all our facilities are now being completed.

2. Feedback from service users and carers

Carer Questionnaire 2021 in MAH.

- Given the Trusts commitment to meaningful involvement of service users and carers in the planning, design, review and evaluation of services (Personal and Public Involvement – PPI), Learning Disability Services wanted to ascertain the views of carers in Muckamore Abbey Hospital. The service area therefore in February 2021, sent out a questionnaire to all 48 carers of patients currently resident in Muckamore.
- There was a response rate of just under 40%.
- The completed questionnaires were returned anonymously to a member of the Trust's Community Development Team, who analysed the responses and compiled a report.
- The questionnaire contained a series of statements and carers were asked whether they agreed or disagreed with these. These were in relation to the following themes- being treated with care and compassion, attitude of the staff team, the quality and timeliness of sharing information, involvement in care planning, how to raise concerns, assessment of carer needs etc. There were also sections for comments, asking for ways the service could be improved.
- Generally, two thirds of the respondents were satisfied with several aspects of the service, with around one third of carers dissatisfied with aspects of the service.
- An action plan is now being developed to address these areas by the service area, in collaboration with carers, through a partnership and co-production approach.

Happy and safe project.

- Learning Disability commissioned work from Association for Real Change (ARC) to carry out a baseline assessment in Muckamore Abbey Hospital utilizing a number of different approaches and techniques, including group work and 1:1 support, to explore how safe and happy patients feel in Muckamore.
- This piece of work was initially paused because of COVID but it is now almost completed and we await the findings of this review, which will inform how we support future planning for our patients.

Real Time patient feedback.

- Work has commenced with the "Real Time Patient Feedback" team as to how best to capture the patient experience on the Muckamore (MAH) site.
- The MAH Patient Council and Telling It Like It Is (TILII) reference group have reviewed the questions to make them relevant to the service area.
- We are awaiting feedback to see if the amendments suggested by the service area fit within the domains of the Project.

Carer Feedback Report for ASG in Muckamore Abbey hospital 1.4.20 -31.3.21.

- There were pre and post questionnaire discussions with carers by the DAPO following an adult safeguarding incident.
- There were 55 carer feedback discussion sheets completed with carers by Adult Safeguarding DAPO relating to both staff on patient and patient on patient allegations. Not all carers wished to participate in a survey.
- The majority of carers reported feeling supported and well informed, and were happy to continue to receive follow-up calls as the investigation progressed.
- The findings of the pre investigation questionnaires had 33 responses with 24 either very satisfied or satisfied and with 6 Dissatisfied.
- The findings of the post Investigation had a total of 22 responses with 14 either very satisfied or satisfied; 5 neither satisfied nor dissatisfied; and 3 very dissatisfied
- A number of respondents expressed gratitude toward the investigative team and the PSNI for their involvement and expressed appreciation for the staff and the work that they were doing for their family members. Others shared that they were pleased that the CCTV picked up allegations.
- Carers who were dissatisfied: one outlined that this was because they remained concerned that their loved one was not sufficiently protected; others did not accept the outcome of the investigation or felt there was a 'cover up' despite the investigations finding no evidence to substantiate the allegations.
- A number of carers have been offered an opportunity to discuss their concerns with senior managers and pursue their concerns as formal complaints.
- Most of the families were accepting of the support and information shared by the DAPO.

Community Carer Engagement Sessions.

- Community Learning Disability services conducted a series of six engagement sessions through Zoom in February and March 2021. The sessions aimed to share what has been happening in the service and give carers a chance to hear about plans for the next 6-12 months. It was also an opportunity to ask questions and share their thoughts and ideas.

- Issues raised were in relation to impact of Covid, the vaccination programme that was rolling out across LD, resumption of services as well as agreement to participate in the soon to be established LD Community Forum.

Telling It Like It Is (TILII) (groups of adults with a learning disability that meet and get their voices heard).

- Within Muckamore Abbey Hospital, Muckamore Patient Council and Sixmile Patient Council share their voices on ideas to help improve the hospital but also make sure their voices are heard in the community, by working together with the other TILII groups in N. Ireland.
- Over the past year, they did: two roving reports about the hospital; made 28 TILII TV programmes and are currently making one about hospital life through Covid 19; developed easy read documents; shared their views on the NI Mental Health Strategy; NI Adult Protection Bill; Review of Restraint and Seclusion; and Terms of Reference for the Muckamore Abbey Inquiry.

3. ASCOT (Adult Social Care Outcomes Tool)

- The Department of Health advised in January 2015 that the Adult Social Care Outcomes Toolkit (ASCOT) would be the tool adopted by all Trusts to monitor qualitative data, as it could be readily integrated into service user review processes. The ASCOT data constitutes a key component of the Department's reporting against Programme for Government commitments and was referenced in the Departmental Business Plan for 2017/18.
- Belfast Trust implemented ASCOT in 2018, and continue to use this tool across adult services.
- The community teams continue to submit returns for any new referrals where the service user is able and willing to complete the assessment. These returns are submitted to PSD for collation.
- The service area is awaiting outcome of the analysis of this data and an update in relation to its future use.

4. Research

- A Senior SW Practitioner from the service area is on a secondment to complete a PhD at Queen's University. The title of Ms McIlroy's research is 'Decision-making processes in Learning Disability services: in whose best interests?' This research is still ongoing.

5. ASW audit

- There are quarterly audits in relation to compliance with the Mental Health (N. Ireland) Order 1986.

- The outcome of the last audit was that within Muckamore Abbey Hospital there were 2 administration errors one on a Form 5 and one on a Form 3.
- Good practice was highlighted which included:

  - documentation was completed to a good standard;
  - all detention forms had been scrutinised within two working days and had been processed to RQIA within the five working day timeframe by administrative staff;
  - each file reviewed showed that patients had had their Statement of Rights issued and a note had been made of their consent on the business file held in Medical Records.

6. Shared Lives

- The Shared lives model was regionally developed in financial year 2019/2020. This covered all elements from PPI, Community Engagement, Communication Tools, Administrative Frameworks, Performance Assurance Tools and Financial Framework.
- There was a consensus that Learning Disability was already providing this service through Families Matter and the use of host families for both long-term placements and respite. Significant work was completed on community engagement and the development of regional documentation and communication systems, which were very focused around service user involvement in the development process.
- Within the service area, we currently have 21 service users availing of shared lives.
- All the documentation and proposal to the Board was submitted by the project lead on 31st March and we have to date not received any update.

7. Community Learning Disability Adult Safeguarding (ASG) audit.

- In July 2020, Learning Disability Senior Management commissioned an Adult Safeguarding Audit of Community Learning Disability Adult safeguarding referrals and investigations across four community teams within the service in line with the Regional Adult Safeguarding Policy and Procedures.
- The Audit tool focused upon the Adult Safeguarding suite of forms on Paris.
- The sample used within the audit focused on a 6-month reporting period from January 2020-June 2020. A total of 52 referrals were identified from all four community learning disability teams and all 52 referrals were audited.
- The findings demonstrated that:- there was a timely response to case allocation by DAPO's; staff worked within the spirit of policy and procedures thresholds; there was good communication between professionals; alternative methods of service user

engagement were employed throughout COVID-19; and there was consideration to alternative safeguarding processes.

- There were areas for improvement identified to include: - better documentation and full completion of forms and to evidence service user involvement & perspective.
- As a result of the audit a number of actions have been completed across the service to include:- Audit outcome and feedback sessions completed during two Safeguarding forums with IO's and DAPO's; Bespoke training session provided by Learning and Development Lead and Adult Safeguarding Development Officer; Aide Memoirs and an Operational procedural manual developed and implemented.

8. Impact of COVID-19

Community Learning Disability Teams (CLDT)

- The greatest challenge to the workforce and to our service users and carers has been the impact of COVID.
- CLDT adapted to using virtual ways of keeping in contact with families and attending meetings but there were limitations with this in terms of assessing the service user and family situation and risks.
- It was difficult sharing information in a timely manner/ difficulty using video contact as approximately 60% of families did not have internet access and the workforce had to keep in touch by telephone in many instances.
- There was significant lack of IT equipment to facilitate staff working from home. There was and remains a lack of office space to allow for social distancing. There were issues in relation to the welfare of staff who were quite isolated from their peers. This was particularly relevant to new staff.
- Day care and short breaks was stopped during the first lockdown and this had an effect on the support that was required for our families.
- Two of the Community Learning Disability Teams (CLDT) were also seriously affected by COVID outbreaks and this put further pressure on the capacity of teams.
- There were various things introduced which worked very well for our service users, carers and for our staff including:-

  - Daily MDT huddles for information sharing / timely responses;
  - Regular communication with service users and families to monitor how they were doing and respond quickly to any concerns- regular updates and alerts to any concerns via telephone and Community Newspapers;
  - If Home visits were required, PPE readily available;
  - VIP Lanyards and Carer ID cards- carers felt valued and supported;
  - Creation of 4 Community Hubs;
  - Development of a SBAR which provided an aide memoire to guide staff to make comprehensive assessments on the

phone through focussing on the situation, background, assessment and recommendations;
- On line activities for carers/service users; and
- Updating Hospital passports

- The workforce were very flexible and showed resilience to changing circumstances. There was a range of supports offered to the staff by the Trust.

Learning Disability Day Services

- At the end of March 2020, all of our Day Centres, Community Day Services and Short Break beds were closed to protect service users and staff from COVID.
- 30% Day social care staff were redeployed from day care to the 4 LD Community Hubs, 24% were redeployed to Learning Disability supported living and residential care services and some were redeployed external to the Trust to support Independent providers.
- 4 Community Hubs were established along geographic patches and aligned to our Community Learning Disability Teams to keep in touch with service users and carers. This proved a very effective and positive initiative welcomed by all involved.
- The social care workforce were extremely flexible and innovative in responding to the challenges posed by COVID. This included:-

  - sharing easy read information to explain why centres closed, about handwashing, social distancing, PPE;
  - 650+ Safety Survival packs developed and delivered across the city;
  - Several thousand resource packs were delivered to family homes to provide alternative activities for service users;
  - Outreach took place in the form of walks/shopping/ prescription collection/ bus runs;
  - Ipads were loaned to carers and service users to maintain communication;
  - Zoom coffee mornings and closed facebook sessions;
  - Over 250 Hospital Passports were developed; and
  - Local day centre newspapers.

- A short questionnaire was sent to all families / carers to ascertain their views about the centres re-opening. Over 250 questionnaires were completed giving a very good response rate of over 40%.
- Prior to opening, an environmental risk assessment was completed. Pre-COVID day care attendance ranged from 22 up to 85 attendees per day. Currently of the 500+ service users who accessed our Day Centres pre-COVID, just over 300 are now attending our Day Centres and Community Day Services. The numbers of days that they are attending has been reduced and most are now attending twice a week, whereas previously they would have attended between 3 and 5 days, so the service provision is approximately 30% of what is was pre-COVID.

- Along with the 2 Day Centre attendances per week about 15% of service users are also accessing a third outreach activity such as a bus run or walk in their local community.
- In line with the regionally agreed Learning Disability Recovery Framework developed by the HSCB in conjunction with the Trusts the vast majority of service users living with family members have returned since the centres re-opened in July.
- Additionally, activity resources continue to be sent out and involvement with Zoom calls and some outreach activity such as walks is maintained.

Day Opportunities

- Alongside our Day Centres, we part fund a large number of Community and Voluntary sector Organisations to provide Day Opportunity services for adults with learning disabilities across the City, the majority of whom do not access statutory Day Services. In response to COVID, our partner Organisations developed a range of alternative activity options to enable them to continue to support and engage these service users.
- Utilising a range of IT systems, Social Media platforms, Smart Phone Apps etc. ensured that some form of service delivery was continued and contact maintained with service users and their families.
- Some Organisations also provided a range of additional activities, which could be shared and offered to all people with learning disabilities across the City, including programmes and information about “staying safe” online, crucial with the increased usage of different platforms.

Residential & Supported Living

- Our statutory Residential & Supported Living workforce have worked closely with Regional Nursing & Care Home Guidance to ensure that services are provided in the safest possible way for our service users. The staff also worked closely with families and carers, purchasing iPads to support regular contact, accommodating Care Partners and employing a number of Activity workers to ensure that service users are meaningfully engaged during the day.
- As part of the Community Learning Disability Surge Plan a need was identified to have available a number of beds for short term usage as a consequence of family and caring arrangements failing due to COVID related issues. It was agreed that a number of the stand-alone Short Break beds, which had been closed due to the outbreak, could be utilised for this purpose using existing staff resource. Twelve beds were identified across the city and a pathway put in place to define their usage. If allocated, a surge bed was provided for an initial 3 days after which it was reviewed with Community Team Leader.

Commissioned and Care Management (CM) services

- Our workforce was also challenged within care management and commissioned services. Care Manager reviews were replaced by virtual reviews. Staff visited facilities wearing PPE when service users were distressed or in relation to following up quality issues.
- Again the workforce was flexible and adaptive and a care manager was identified as the link for each care facility for advice/ support, PPE, testing, infection control etc. Care management also became the central point for PPE, stock checking and weekly delivery. Care Management staff arranged fit testing, carried out risk assessments for Aerosol Generating procedures, arranged donning and doffing training and infection prevention and control site visits
- They also maintained regular contact with families, offered support/ advice.
- However, there were difficult challenges for the staff associated with families unable to visit loved ones; staff unable to assess risks/ identify concerns as there was no access to care facilities; there was a psychological impact on staff when service users died; at times there was contradictory advices at time from other Trusts, PHA and RQIA and there were issues with remote working i.e. lack of IT equipment, lack of cohesion in team working, impact on mental health of staff, less cross learning also impacted on the workforce.

Muckamore Abbey Hospital

- During COVID to reduce footfall on the hospital site visiting was stood down and there was the cessation of off site and on site services. This contributed to a more challenging and less varied experience for our patients.
- Again the workforce responded to COVID through the Creation of COVID ward and Isolation pods within each ward; developing individualised isolation plans according to individual care needs; developing social stories e.g. hand washing, use of PPE, tests etc; creating Hospital newsletters; devising scripts for staff to address family queries regarding COVID; using iPads/ mobiles to assist services users and families to keep in touch; day services moved to individualised activity plans to ensure structured activities for patients; and COVID MDT planning meetings and Webinars took place.

COVID Vaccination Roll-out

All of our Residential & Supported Living, Day-care and Hospital workforce have facilitated service users getting the COVID vaccination and by the end of March 2021, all areas had received the first vaccination with plans for the second vaccination already in place.

2.4	**Programme of Care to advise of any significant judgements and/or decisions derived from Serious Adverse Incidents, Case Management Reviews, Mental Health Review Tribunals, Judicial Reviews or RQIA Inspection and/or Review activity during the reporting period, that directly relates to the Trusts discharge of their statutory functions.**
	1. Serious Adverse Incidents (SAIs) There were a number of SAIs within the service area during the reporting year of note to this report. The learning from some of the SAIs included:- • **SAI/19/078: Alleged assault by a staff member on an inpatient.** The learning identified was that Training should take place to support staff to complete witness statements and Adult Safeguarding documentation. This was also to be incorporated into induction training for new staff. • **SAI/20/077: Agency staff member locked a patient's bedroom door**. The Trust has an established process in place to ensure other Trusts are alerted to alleged safeguarding incidents involving agency staff as part of adult safeguarding processes. Staff were reminded of the Trust's Whistleblowing Policy and Procedure and the importance of escalating incidents of concern. • **SAI/20/093: Allegations of abuse by a staff member against a service user**. The BHSCT agreed to issue a Learning Letter throughout statutory and commissioned services highlighting the responsibility of staff to escalate concerns immediately. The service provider reviewed their Adult Safeguarding training to identify any areas for improvement. • **SAI/20/142: A service user was found with a lap belt around her neck**. Existing and new staff within care providers should receive training in Human Rights and Restricted Practices, covering the use of lap belts. Families and carers should be provided with information on the appropriate and safe use of lap belts as part of the equipment handover. **2. Financial Inspection in Muckamore** • In 2019/20 a Comprehensive Financial Audit was completed within Muckamore Abbey Hospital. A series of recommendations were made ranging from patient finance processes to a Financial Policy review. Muckamore Abbey Hospital was able to action all of the recommendations and received a satisfactory report from BSO. • An Internal Financial Audit in July 2020 was conducted by the Patient Finance Liaison Officer to ensure the new process and

policy was being followed by staff in terms of the management of patient finances.
- 2 patients per ward were randomly selected.
- Overall, the findings were that the ward staff had made excellent efforts to work within amended policy and new processes. There were a few areas for improvement noted across all wards listed
- Following the audit recommendations and an action plan was devised.
- These improvements were further endorsed by a further RQIA Inspection in January 2021 which reported, "in general, we were satisfied that the processes for managing patients' finances and property had significantly improved from previous inspections in 2019. The practices and documentation developed and implemented by the Trust could be used as a benchmark for good practice by other Trusts managing patients' finances and property."
- A new process regarding managing patient finances and property was introduced in February 2021.
- E-learning training regarding the management of patient property and finances is available every 3 years. Administrative strategies are now in place to ensure this is completed
- There are a range of audits completed including a monthly finance and property audit per ward and a quarterly property audit of high value items.

3. RQIA Inspections across Learning Disability

In the reporting year there have been:-

- Announced inspections in Statutory Day Care in Orchardville TRC and Everton resulting in QIP to ensure that staff have completed training and can demonstrate knowledge of adult safeguarding. As a result PCSS (Support Services including Transport) have developed a specific Safeguarding presentation (for Children and Adults). It is now mandatory and is being rolled out across the Trust. It will be part of the Trust's Induction Programme for all new staff.
- 3 announced inspections in Statutory Residential facilities resulting in 9 QIPs
- 3 announced inspections in Statutory Supported Living facilities resulting in 13 QIPs (further details of note below).
- 2 announced inspections in domiciliary care resulting in 6 QIPs
- Announced inspections in Muckamore Abbey and Iveagh Children's Centre as below.
- An action plan has been developed for all these areas of improvement. See below the ones of note for the purposes of this report.

RQIA Inspection in Annadale Supported Living Service on 18th August 2020- report received 2.9.20.

	The inspection recommended 6 QIPs. A number of actions were taken to address these. These included:- • The Trust will ensure all staff receive Adult Safeguarding Training. • The registered person will ensure all use of physical intervention is recorded appropriately within the DATIX system. • All incidents of physical intervention will be reviewed to ensure it was the least restrictive option to secure the safety of the service user and that of other service users. • The registered person will work with the Positive Behaviour Support (PBS) Team / Psychology to ensure the service user PBS plans and care plans are kept up to date and the staff team are aware of how best to support each service user so minimising the need to use physical intervention. • The registered manager will ensure that all relevant staff are MAPA trained and their training is kept up to date to ensure the safety of service users and staff. **RQIA Inspection of Trench Park Supported Living on 19th November 2020- report received 21.12.20- 4 QIP** The inspection recommended 6 QIP. A number of actions were taken to address these. These included:- • There is a system in place to review the service user's person centred plans with both families and social workers prior to each admission to the short break service. • A new contents list has been developed for the person centred plans to ensure they are accurate and reflective of a person's needs, including a section for DOLS/ restrictive practices. **RQIA Inspection Iveagh Children's Centre- 8th, 23th September and 7th October 2020- 12 QIP.** This inspection recommended 6 QIPs. A number of actions were taken to address these. These included:- • The Trust should agree a date for the transfer of responsibility and Management of Iveagh Centre to the children's directorate in BHSCT and review the model of care to inform the future commissioners model of acute assessment and treatment services for young people with a disability. ➢ In response to this area of improvement, the Trust previously held a stakeholder workshop on 13 January 2020 to discuss and agree the management and governance arrangements and the service model for the Iveagh Centre. ➢ Discussions in relation to this change in management were paused due to the retirement of the previous Director for Learning Disability Services and subsequently due to the Covid-19 pandemic. The management arrangements associated with the Iveagh Centre will be included in a wider

restructuring, which will be initiated by the Chief Executive on the Trust's return to normal business.

- The Trust was to ensure a plan was in place to recruit an additional psychologist.
  - To address this the current psychological provision has been re-profiled and advertised to provide a system of psychological support
- The Trust was to establish a single continuous record for all disciplines.
  - In response to this area of improvement there is now a single continuous record for all disciplines and one patient file per child along with PARIS records; the file includes Positive Behaviour Support plans and risk assessments. There are defined protocols for the recording of information.
- Provision of independent advocacy arrangements should be available.
  - In response to this area of improvement, advocacy arrangements within the Iveagh Centre are currently provided by Bryson House for children who are not considered Looked-After Children and by VOYPIC for children who are. Bryson House also provides a carers' advocacy service for families of children in Iveagh. The Iveagh Centre has a full-time social worker whose role includes liaison with advocacy services - monthly meetings take place facilitated by Iveagh's Social Worker to discuss issues at ward level and also delayed discharges. In addition, advocates attend a fortnightly MDT meeting and all Discharge Planning meetings. VOYPIC also provide 1 hour per month for direct contact time with the children.
- BSCT must communicate with placing Trusts to ensure the delayed discharges are urgently addressed.
  - In response to this area of improvement, there are Judicial Reviews listed for hearing at the end of February 2021 concerning 4 delayed discharges.
  - Each Trust has submitted business cases to HSCB for child centred support and accommodation packages.
  - The Iveagh team continue to hold 6 weekly discharge planning meetings for each child with the community teams within the respective Trusts. BHSCT have escalated concerns regarding delayed discharge with the relevant Trusts.
- Safeguarding documentation should be improved to ensure that the records are comprehensively completed to include dates, action taken and outcome.

- To address this the Iveagh Social Worker provides oversight for safeguarding documentation and works in close partnership with Iveagh and the Children's Services community teams to improve the quality of these records.
- A further review of current documentation and processes will take place to identify opportunities for improvement by the end of April 2021.

- Other recommendations included data analysis (this is being taken forward through MDT, live governance, clinical improvement groups) and to review induction to make it competency based.

RQIA Inspections in Muckamore Abbey Hospital

Announced RQIA Inspection took place 2-16 April 2020- report received 27/08/20.

- This resulted in 6 QIPs.
- Although there were no areas for improvement identified during this inspection the QIP however contained the areas for improvement carried forward from the last inspection on 10-12th Dec 2019. These included that the Belfast Health and Social Care Trust must:
- Implement effective arrangements for the management and monitoring of CCTV within MAH and ensure:
- Ensure that all staff understand the procedures to be followed with respect to CCTV;
- Ensure that there is an effective system and process in place for monitoring and managing CCTV images. Monitoring teams must be multi-disciplinary in nature and support staff to deliver care and learn collaboratively;
- Ensure that the MAH CCTV policy and procedural guidance is reviewed and updated to reflect the multiple uses of CCTV in MAH.
- Must strengthen arrangements for the management of medicines.
- Shall complete a review of the necessity for a functioning seclusion room taking into account the needs of the patients accommodated in the hospital, safety of patients and staff and the required standards and best practice guidance.
- Shall outline a statement of purpose for the use of the PICU as a "Low Stimulus Area" taking account of the required standards and best practice guidance and ensuring the safety of patients and staff.
- Shall develop and implement a systematic approach to the documentation used throughout the hospital for the recording of patients' physical health checks.
- Shall ensure if physical health checks are declined by the patient, this must be recorded in the patient's care records and evidence retained of ongoing attempts to engage the patient.
- There is an action plan in place to address these issues

Unannounced RQIA Inspection Report on 27 and 28 October 2020- report received 05/03/21.

The QIP contained 4 areas for improvement as follows. These included:-

- The Belfast Health and Social Care Trust shall develop and implement a communication strategy that will ensure that relatives/carers receive their requested level of communication about their relative's care and treatment in Muckamore Abbey Hospital. The agreed communication strategy should be documented and accessible to relevant staff.
- The actions to address this are as follows:-
  - The Trust has been developing a commitment to carers statement and a communication agreement template. This has been developed in conjunction with staff, a number of carers and advocacy services through the Carers Forum.
  - This includes details of the next of kin's preferred method of keeping in touch, frequency of contact etc. This information will be recorded in the agreed template which will be kept in each patient's file within the ward and on the electronic PARIS system.
  - A key contact information sheet containing the contact details of staff involved in each patient's care has also been developed. This will also be recorded in the agreed template, which will be kept in each patient's file within the ward and on the PARIS system.

- The Belfast Health and Social Care Trust shall ensure that a communication plan is developed which provides clarity to all staff about the information provided to the NOK following an incident, the date and by whom the information was provided, the NOK's response to the information, and the follow up arrangements planned. This information should be recorded in a standardised manner across the hospital site.
  - See safeguarding section for details.

- The Belfast Health and Social Care Trust shall ensure that all patients in Muckamore Abbey Hospital are subject to the Assistant Service Manager's monthly audit of monies and valuables at least annually.
  - As outlined in above section under financial audit

Unannounced RQIA Inspection took place in Erne on 21/1//21

The QIP contained eight areas for improvement:-

- All patients in Erne should have appropriate and timely access to the positive behaviour support service.

- That staff on the ward of Erne should have the skill and knowledge to effectively support patients who present with behaviours that challenge, including implementation of each patients positive behaviour support plans.
- The IPC team should record all visits to wards in Muckamore. Actions arising from the visit should be shared with the ward manger, disseminated to appropriate ward staff and actioned accordingly.
- Ensure a robust track and trace system is in place in Erne ward, which takes account of its multiple entrances and exits.
- All patients in erne should have access to a comfortable, clean, and warm living area. This should include robust audits of the ward environment and timely repair of broken items by the Trusts estate department.
- Staffing levels should allow for staff clinical supervision sessions, staff appraisals and the facilitation of regular ward/ staff meetings.
- All incidents should be graded appropriately to reflect the inherent risk rather than the outcome. The system should include audits of incidents and implementation of learning arising from the audits
- Implement a local incident debrief policy and procedure so that a learning arising from incidents is shared across MDT's and MAH in timely manner, trends identified and records maintained of all debrief sessions including actions required and persons responsible for ensuring the action is completed.
- An action plan is being developed to address these areas of improvement.

4. A Review of Leadership and Governance at Muckamore Abbey Hospital

- An Independent Review of the Leadership and Governance of Muckamore Abbey was commissioned by HSCB and DoH for period 2012-2017. This report was published in August 2020.
- The review focussed on governance, leadership, the Ennis investigation, CCTV and Mr B complaint. It made 7 conclusions and 6 recommendations for the BHSCT.
- The conclusions included:-

  - The complex governance arrangements hindered its agility and ability to be responsive.
  - Discharge of Statutory Functions (DSF) Reports were largely repetitive documents, which did not provide assurance neither in relation to the discharge of statutory functions, nor to the standard of practice in relation to same. There was insufficient challenge at Trust Board and HSC Board. The reports lacked outcome data.
  - Limited evidence of MDT working at MAH.
  - There was a failure to use data and learn from it- little evidence of data analysis or triangulating it to inform practice.
  - There were staffing difficulties especially nursing and medical posts. There was an inadequate 20:80 ratio of nursing to

health care support worker, limited training and lack of patient activities.
- There was focus on resettlement and less emphasis on safety and quality of the hospital as a whole.
- Muckamore had its own culture which was not informed by the leadership values of its parent organisation

- The 6 recommendations for the BHSCT included:-

  - The Trust should consider immediate action to implement disciplinary action where appropriate on suspended staff to protect the public purse.
  - The Trust has instigated a significant number of managerial arrangements at MAH following events of 2017. It is recommended that the Trust considers sustaining these arrangements pending the wider Departmental review of MAH services.
  - Advocacy services at Muckamore should be reviewed and developed to ensure they are capable of providing a robust challenge function for all patients and support for their relatives and /or carers.
  - The complaint of Mr B should be brought to a conclusion by the Trusts Complaints Department.
  - In addition to CCTVs safeguarding function, it should be used proactively to inform training and best practice developments.
  - The size and scale of the Trust means that Directors have a significant degree of autonomy; the Trust should hold Directors to account.

- The service area is currently implementing actions to meet the recommendations.

5. Significant legal proceedings during 2020-2021

Significant MHRT hearings

- Patient Z was a long stay patient in Muckamore Abbey Hospital under a Hospital Order with restrictions. Patient Z had been in a community placement since December 2018 and remained under Article 15 leave with ongoing approval by the DOJ for this and for any outings.
- A mandatory referral to the MHRT was made and the recommendation from the Trust would have been for his conditional discharge but this proved problematic due to a ruling by the Supreme Court in *Secretary of State for Justice V MM (*UKSC 60). In MM the Supreme Court ruled that conditions, which objectively amount to a DoLS cannot be imposed by the First Tier Tribunal or the Secretary of State.
- The MCA could not be used as Patient Z is assessed as having capacity. [redacted] the Trust requested the High Court to

	exercise its inherent jurisdiction to authorise a deprivation of liberty. • In December 2019 and February 2020 the MHRT found as follows:- a. That the patient's mental disorder does not warrant his detention in hospital for treatment; b. Discharge to suitable care would not create a substantial likelihood of serious physical harm to himself or others; c. For the purposes of Article 78(1)(a) of the Order the Tribunal was not satisfied as to either and both of the criteria at Article 77(1)(a&b); d. For the purposes of Article 78(1)(b) the Tribunal found that it was appropriate for the patient to remain liable to be recalled to hospital for further treatment. • The Trust applied to the High Court for a Declaratory Order permitting the detention of two patients due to be discharged from the low secure regional forensic unit in Muckamore Abbey Hospital (Patients Y and Z) who were deemed to have capacity but required community detainment. • Both patients were deemed to have capacity to understand aspects of their care plan relating to constant supervision and restrictions on their liberty and therefore authorisation via a Trust panel under the Mental Capacity (NI) Act 2016 was not possible. The case raised a new issue of law because historically the Declaratory jurisdiction of the High Court is for incapacitated persons. • The cases were heard by the High Court. The Court clarified that the law would potentially permit a Declaratory Order in such cases. • Patient Y is not subject to deprivation but rather restrictions as he is not constantly supervised. Patient Y's legal team issued a writ of habeas corpus which was dismissed by the High Court. Subsequently the Trust adopted a different approach to Patient Y's case and following a Review Tribunal decision in March he is currently subject to Article 15 leave under Part III of the MHO and has moved to his new home. • Patient Z remains subject to Article 15 leave under Part III of the Order and his case is due to be heard by the MHRT in April 2021. In the case of Patient Z it would appear that the restrictions imposed do amount to a deprivation of his liberty. Patient Z has been subject to Article 15 leave for a period of 2 years. The Trust is recommending to the MHRT that an absolute discharge is given. [redacted] • These cases have clarified that the Trust can approach the High Court in similar situations. There is one further imminent discharge from the unit where High Court authorisation may be required.

Judicial Review regarding a patient in Muckamore

- The service area is currently waiting for a judicial review to be heard in respect of a patient who has applied for a court order requiring the Trust to provide a suitable community placement. Patient A is a 26 year old man. He was admitted to Muckamore Abbey Hospital in 2012 and was fit for discharge in 2015. He has a diagnosis of severe learning disability, severe autism and extremely challenging behaviours. Following a failed community placement the BHSCT in January 2020 agreed to seek a bespoke assessment of his needs by an autism expert and commence a single action procurement regionally and nationally to seek a provider who could meet his needs. The single action procurement process was commenced in December 2021.
- To date no suitable community placement has been obtained for him and the service is undertaking a procurement exercise to look at his individual needs and a specialist assessment of his needs.

Judicial review regarding delayed discharges in Iveagh and the Trusts failure to provide appropriate community placements in a reasonable timescale.

- Judicial review proceedings are underway in a number of cases relating to delayed discharges from Iveagh. Discharge has been delayed due to lack of suitable community placements and services available to young people with complex needs.

Further Declaratory Orders

- **Patient A** is a 41 year old man with a severe learning disability, autism and who displays extremely challenging behaviours. Following a dental appointment, it was agreed that Patient A required a full dental excavation and that due to his behaviours this would need to be completed under a general anaesthetic. [redacted]. The High Court made the Order on 27 November 2020 and the dental work was carried out on the 18/12/20 with a very positive outcome for Patient A.
- **Patient B** is a 31 year old man with Down Syndrome and autism. The High Court authorised a Declaratory Order on 14/10/19. This came about following his parents issuing Judicial Review proceedings against the Belfast Trust for 'failure to admit him to Muckamore Abbey Hospital under the MHO (NI) 1986'. Alternative accommodation was sourced for him. As he required the use of physical intervention and had no capacity to understand aspects of his care plan amounting to a deprivation of liberty and he is subject to continuous supervision (2:1) the High Court agreed to a Declaratory Order. This was due for review in October 2020. The Trust has submitted reports to the Court in relation to this.

- **In the case of Patient C** the service was able to advise the Court that the Declaratory Order has now been replaced by the use of the MCA (NI) 2016. Patient C is a 27 year old man with a profound learning disability. He had been cared for in an adult placement until November 2019 when he moved to a residential placement in the Northern Trust Area. The Declaratory Order in place for Patient C was pursued following a recommendation from the Mental Health Review Tribunal. This was related to the Cheshire West case and Patient C did not have capacity to understand aspects of his care plan amounting to DOLs. Following the implementation of the MCA (NI) 2016 [redacted]. Trust panel authorisation was granted by the NHSCT on 22 December 2020 and the High Court were informed of this by DLS.

6. Risk Register

- Within the service area there are a number of risks which have been placed on the Learning Disability Directorate register. These include:-

  - Service Users, who are placed outside the Trust, face difficulties accessing services to meet their assessed needs. This matter continues to be unresolved regionally and continues to be looked at through the regional AD Learning Disability group.
  - Delayed discharges from Iveagh and Muckamore Abbey Hospital resulting in a deprivation of liberty and the right to family life, potential to become institutionalised. There are a number of judicial reviews taking place in relation to this issue. The hospital staff continue to work closely with our patients, and families and providers to identify suitable placements for our service users in the community (see 2.6 point 3 and 2.7 point 3).
  - Potential failure to meet assessed accommodation need due to lack of community infrastructure. There is an accommodation plan in place and a number of business cases are being progressed to address this need (see 2.6 point 4 and 2.7 point 4).
  - Inability to meet minimum staffing levels within Annadale Supported Living Service. There are recruitment plans in place to address this issue. There is a service user in Annadale, who the staff team withdrew support to, citing Health and Safety legislation. This will be subject to an SAI Level 3 investigation. There is a plan in place to recruit a bespoke team to address this service user's needs within Annadale in the future.
  - There are gaps in SW and ASG staff across Learning Disability Services (see 2.6 point 5 and 2.7 point 5). There are also workforce issues in relation to nursing staffing levels in

	the hospital, in Psychiatry and Psychology. There are recruitment plans in place to address this issue. ➢ Lack of assessment and treatment beds for patients with a Learning Disability- see 2.7 point 6. ➢ Potential failure to provide people deprived of their liberty with adequate safeguards and to meet legal requirements- see 2.6 point 2 and 2.7 point 2. **7. Complaints.** • Within the service area there were 15 Formal Complaints during the reporting period as below- Formal Complaints (Consented) as at 19.04.21 — Year/Month

	2020							2021		TOTAL
Specialty	Apr	May	Jun	Jul	Aug	Sep	Oct	Dec	Feb	Mar	
Residential and Supported Living	1	1	1	1	2	1	1	0	1	0	9
Muckamore Abbey Hospital	0	0	0	0	0	1	0	0	0	1	2
Community Treatment and Support	0	0	0	0	0	0	0	1	1	0	2
Day Services	0	0	0	0	0	0	0	1	0	1	2
TOTAL	1	1	1	1	2	2	1	2	2	2	15

• 100% of the complaints were categorised as 'low' grade but one has since been categorised as high grade.
• The key themes emerging from the complaints included:-

Learning Disability Formal Complaint 01Apr20-31Mar21 SUBJECTS @ 19.04.21	TOTAL
Communication/ Information	4
Staff Attitude/ Behaviour	4
Quantity of Treatment and Care	3
Quality of Treatment and Care	1
Discharge/ Transfer Arrangements	1
Environmental	1
Infection Control	1
TOTAL	15

2.5	**Advise on any challenges in the provision of Safeguarding services that have arisen in this Programme of Care during the reporting period and actions taken to mitigate any difficulties.**
	1. RQIA Safeguarding Improvement Notice in Muckamore Abbey Hospital • RQIA placed a safeguarding improvement notice on the Adult Hospital in 2019 with recommendations covering a range of areas including: improving staff awareness re adult safeguarding procedures; making adult safeguarding referrals; implementation of protection plans; improving information sharing with key stakeholders; effective management oversight arrangements and implementing good practice across the hospital site. • Following a significant amount of work this improvement notice was lifted in April 2020. This work included:-

	➢ Additional Training. ➢ Development and implementation of Aide memoires, new templates, flowcharts, escalation plans and noticeboards. ➢ Embedding ASG and Protection Planning across the hospital site e.g. through Daily handovers, safety briefings, PIPA, Weekly ASG MDT meeting, live governance, ward managers meeting, monthly ASG Forum, Clinical governance meeting and SMT meetings. ➢ Establishing a weekly ASG MDT meeting in each ward to discuss new and review existing referrals. ➢ Establishing a Monthly ASG Forum- to learn collaboratively in respect of ASG investigations through sharing outcomes, good practice, learning from CCTV viewing, sharing outcomes of audits etc. ➢ Developing an extensive ASG data base- to enable an analysis of ASG data to establish trends/ patterns to inform MDT team, live governance, ward managers meeting, Safety Report for SMT. ➢ Completion of regular audits to ensure compliance. ➢ Rolling out of preventative work i.e. keeping yourself safe programme. ➢ Completion of pre and post ASG questionnaires to receive real time feedback from carers to understand better if intervention is improving outcomes for service users. ➢ CCTV continues to be live across the hospital site. ➢ Contemporaneous viewing of CCTV also takes place- areas of good practice and areas for learning are fed back to the staff, and a new quality assurance process has been developed. ➢ Establishing interface meetings with PSNI and designated PSNI officers identified for the hospital site. ➢ Commissioning work from Association for Real Change (ARC) to : ❖ Carry out a baseline assessment in Muckamore Abbey Hospital utilizing a number of different approaches and techniques, including group work and 1:1 support, to explore how safe and happy patients feel in Muckamore. Progress with this has been slow due to COVID but this is now near completion. A report will then be developed to support future planning for patients. ❖ Carry out post incident ASG investigations with patients, to explore the impact of response, support offered and aftercare. This will include the completion of the questionnaire the service area has drafted which will be amended by ARC- due to COVID this has been temporarily placed on hold. ❖ Deliver the Keeping You Safe Programme to all the remaining patients within the hospital, who the social work team have been unable to deliver the programme to, including those with communication needs- due to COVID this has been temporarily placed on hold.

Unannounced RQIA Inspection Report in Muckamore on 27 and 28 October 2020 - report received 05/03/21.

- There were a number of QIPs as outlined in the previous section and one related to safeguarding which was as follows-
- The Belfast Health and Social Care Trust shall ensure that a communication plan is developed which provides clarity to all staff about the information provided to the NOK following an incident, the date and by whom the information was provided, the NOK's response to the information, and the follow up arrangements planned. This information should be recorded in a standardised manner across the hospital site.
- The actions to address this are as follows:-

  - An escalation plan is in place outlining whose responsibility it is to notify the next of kin of an incident during working hours and outside working hours following an Adult Safeguarding referral.
  - To ensure consistency of the information being shared with next of kin by ward staff, the Adult Safeguarding team has developed guidance which has been shared with the Service Manager, Assistant Service Managers and ward staff.
  - In addition, the Adult Safeguarding team along with the operational management are in the process of agreeing a template, which will be completed and placed in the patient's file and on the electronic PARIS record. This will include the details of what information has been shared with the next of kin following an adult safeguarding incident, by whom, the date of the incident, the date the contact with the next of kin was made, the response of the carer and what follow up arrangements have been in place - by whom and by when.

2. Adult Safeguarding workforce issues

- There are significant workforce issues in the service area in relation to the adult safeguarding workforce.
- Currently the Learning Disability Service has a limited resource of DAPOs and IO's.
- The 8a ASG Lead post has been vacant despite several attempts to recruit. Fortunately, we were recently successful in recruiting the 8a ASG Lead and he is due to start 1st June 2021.
- Most of the DAPO's in the service area are also Team leaders/ Senior Social worker. Adult safeguarding is only a small part of their substantive posts. This puts additional pressure on them as they are also undertaking other keys functions e.g. managing a MDT, chairing PQC meetings, undertaking ASW roles etc.
- Due to the current difficulties in relation to safeguarding the service area has agreed that the recruitment of future Team Leader posts will now be designated SW posts.
- Additional funding had been secured through IPTs to permanently recruit an additional Senior Practitioner with DAPO responsibilities

	and 2 SW with IO responsibilities. These posts are currently being progressed through HRPTS. • We currently have 1x WTE DAPO in post who solely provides in reach into Muckamore Abbey Hospital. • The Learning Disability service area has also recently appointed 3x Senior Practitioners with DAPO responsibilities (Temporary). Two of these staff have only recently been trained as DAPOs and they will continue to carry a complex caseload in the community and now provide in reach into the hospital in relation to ASG referrals. The third Senior Practitioner post (temporary) has only recently been appointed and is yet to be trained as a DAPO and take up post. These Senior Practitioner posts are currently being progressed through HPRTS to be recruited permanently. • Within the hospital, there are a range of staff on patient and patient on patient referrals. Recently there has also been a sizeable increase in the number of historic referrals. These have been generated as a result of the consultation undertaken by the Patient Client Council (PCC) in relation to the Public Inquiry. In addition, the ASG team have been asked to relook at a number of historic ASG investigations to provide assurances to families and service users. This involves resource intensive activities such as the viewing of CCTV, reviewing voluminous records, possibly interviewing staff and maintaining regular contact and support to services users and families. • The ASG staff providing in reach to Muckamore is subject to a higher level of scrutiny than other ASG teams and has additional workload such as the viewing of CCTV, chairing weekly ASG meetings per ward, reviewing voluminous documentation, interviewing staff, involved in the quality assurance process in relation to contemporaneous CCTV viewing etc. Further, given the CCTV historical abuse and the recent increase in historic referrals it is essential that the ASG maintain regular contact with our service users and families. • This has also had an impact on the ASG resource. Only one of the safeguarding posts is a WTE therefore the remaining staff who are adult safeguarding trained are diverted away from other responsibilities to deal with the larger scale adult safeguarding investigations in the community and hospital. • There is also a lack of business support to aid the safeguarding staff to represent data in a meaningful way to show trends and patterns. • The ASG staff also currently has no admin support and no dedicated IO staff. • Currently there are additional pressures on the existing resource to the extent that demand is greater than the capacity of the ASG staff. It has caused ASG staff to be under significant stress. It could place patients, families and staff in Muckamore Abbey at risk and potentially risk the Trusts reputation as it is compromising ASG ability to fully undertake the role and carry out robust investigations in a timely manner. It could also potentially mean that Protection Plans may be in place for delayed periods of time

for both patients and staff or insufficient protection plans are in place until CCTV viewed or investigation underway.

- The viewing of CCTV footage is a very time consuming process and therefore with insufficient resources this can cause delay and increase workload.
- Additional pressures have been placed on the ASG operational and professional management, as there is a requirement to offer necessary support and mentoring to new staff and other ASG staff. This vacant ASG lead post also impacts on the current Governance arrangements to provide assurances that care is safe and effective which leaves the service vulnerable.
- The lack of business support has impacted on the current workload of the ASG staff. Without having the appropriate business support the ASG staff have spent considerable time gathering data taking them away from undertaking their core roles and functions.
- The deficit of ASG resource and the potential risks has been escalated and is currently on the Corporate Risk Register.
- In order to address this increase in demand, which is only likely to increase, a proposal paper has been put forward for additional funding so that additional WTE DAPO staff are recruited.
- An action plan has been developed to address the ASG backlog. The Service Manager with ASG responsibilities is currently undertaking the line manager role to provide support and mentorship to inexperienced ASG staff who are under pressure in the absence of the ASG Lead.
- Weekly meeting ASG huddles are held with DAPOs by the Divisional SW and Service Manager to provide support to teams and assurance. This has impacted on the ability of the Service Manager and Divisional Social Worker to fully undertake other aspects of their roles.
- There is a system in place to ensure that all referrals are allocated to DAPO's by the Operations Manager.
- A Procedural manual has been developed by the Divisional Social Worker for LD to assist DAPOs in relation to completion of forms and documentation and adherence to the ASG process.
- The Divisional Social Worker and Service Manager are also supporting the ASG staff in relation to PCC referrals through regular meetings.
- Learning Disability continues to work very closely with the Training Department in the Trust who have been extremely flexible and responsive in terms of providing additional training for all staff in the hospital. This has included bespoke training for DAPO and IO staff, for medical staff, management and for contemporaneous CCTV viewers etc. This has ensured all staff are sufficiently trained and upskilled in relation to specific aspects of safeguarding.

3. Challenges in the provision of Safeguarding services that have arisen during the reporting period and actions taken to mitigate any difficulties.

COVID-19 Pandemic.

- Although there was business as usual adherence to Regional Policy there was a need to change some of the local processes in light of the pandemic.
- COVID ASG contingency plans were developed for the community and hospital.
- There was a move from face to face to virtual weekly meetings, patients were seen using of PPE, CCTV viewed as quickly as possible when required. The use of virtual meetings and PPE has had implications when communicating with families, service users and staff. This resulted in investigations being more time consuming and at times, many of the nuances that one picks up from face to face meetings were lost.
- A number of actions were taken because of COVID which included:
  - updating all external providers with contact details, thresholds for ASG referrals;
  - establishing an ASG Data base to identify priority cases; creating a central point for referrals through APGT;
  - liaising with PSNI re Domestic Violence cases;
  - sending alerts to RESWS;
  - ensuring daily contact with high risk service users; and
  - information was published on Trust Hub and Twitter regarding safe spaces, silent solution initiative etc.
- A number of these initiatives worked very well however, the service areas did struggle, like other areas, because of a lack of IT equipment, access to a socially distanced office space and remote working.
- The lack of structured activities due to the closure of day care, the lack of independent review of care homes/ community facilities and the concerns in relation to domestic violence were all challenges for the service area.

PARIS Information System.

- The service area continues to use the ASG forms from the previous policy and await PARIS implementation to ensure staff move to using the new documentation. Additional PARIS training will also be required to train up DAPO/IO staff and referral agents when this is being introduced. A significant amount of documentation, flowcharts and aide memoires will also have to be amended to reflect the new documentation.

Safeguarding within Muckamore Abbey Hospital.

- Over the reporting period there continued to be a significant number of Adult Safeguarding referrals in relation to both patient on patient incidents (136) and staff on patient incidents (85) within Muckamore Abbey hospital. The total number of referrals in the hospital was 221 and therefore lower than last year's referrals (241).

	• A low threshold is applied to all adult safeguarding referrals given the ongoing large-scale investigation following a high level of abuse identified from the viewing of CCTV in 2017. • Since 2017, there has been an increased level of scrutiny in the hospital and this resulted in an RQIA Improvement notice in relation to Adult Safeguarding, as outlined above. A significant number of improvements have taken place as outlined above. This has included the development of a large data set, which has been used to help understand and analyse trends and patterns to enhance patient safety. • During the reporting period, there has been 85 staff on patient incidents referred to the Adult Safeguarding Team. • A large number of staff on patient referrals relate to a small number of patients. A number of referrals are screened out very quickly after viewing CCTV, looking at witness statements etc. The majority of the screened out incidents relate to times when a service users mental state has been poor, or associated with a service user who has behaviours that challenge. • Within Muckamore Abbey Hospital CCTV is available in all the wards. The benefit of the CCTV is that ASG staff are able to screen cases on the basis of independent evidence of what did or did not happen. CCTV was not available for a significant number of incidents as they may have occurred in a private area or the referral did not specify the date/time/location of the incident to enable CCTV viewing. • The viewing of CCTV can also be very time consuming especially if the exact time/ date of the alleged incident is not known and so the term 'screened out' does not mean that no work was involved. • The service area is pleased to report that the vast majority of staff on patient referrals were first raised by staff. This is a very significant cultural change, when you consider that during the period of CCTV historical abuse at Muckamore Abbey Hospital there were very few whistleblowing concerns raised by staff. • There is ongoing Contemporaneous CCTV viewing across the hospital site. Although the Contemporaneous CCTV viewing generated a small number of referrals, it demonstrates the important contribution of contemporaneous viewing of CCTV. It is providing an extra level of assurance. Areas of good practice and areas for development are identified and taken forward. • A number of themes have been established in relation to some of the staff on patient referrals and as a result a number of workshops are being convened in the hospital. This is to include additional training, enhance awareness of the patients care plans, enhance understanding of safeguarding, restrictive practice etc. Some work is also underway to review the induction which the nursing and health care support staff receive and the ongoing supervision arrangements. This is particularly important given the high number of agency staff used across the hospital site. • A bespoke training session was also arranged in relation to adult safeguarding for the senior management team in Muckamore by the Training and Development team. A further training session is being arranged in May 2021.

- The ongoing historical and current investigations in relation to staff has had a significant impact on the stability of the hospital workforce and the welfare of staff given that a large number of both registrants and non-registrants have been placed on precautionary suspension and/or on supervised practice.
- A number of carers and families remain stressed and distressed by the investigations and this has resulted in the need for families to be offered additional support and assurances.
- In relation to Patient on Patient Referrals in Muckamore within the reporting period there were 136 patient on patient referrals. There has been a general reduction from previous years. This arose for a number of reasons- ward managers were trained to screen out low level referrals; 39 patients discharged from Jan 2019 (6 of which have been discharged in the last financial year); and there has been an increase in patients being nursed separately in individual pods across the site.
- The majority of patient on patient ASG incidents across the site related to a small number of patients who have allegedly been harmed by other patient. A number of patients would not have the skills to protect themselves or to understand the risks.
- Several measures have been taken to protect patients and to reduce the likelihood of other patients causing harm. This has included staggering meal times, changing the environment, increasing activities off the wards, increased observation levels, etc.
- Despite a number of steps taken to protect patients and to reduce the risk of patients harming others it is not possible to eradicate ASG incidents. There are many interconnecting factors, which still leads to incidents occurring in communal areas e.g. patient's mental health, communication difficulties, behaviours that challenge, the environment, the mix of patients and the staffing.
- The Adult Safeguarding (ASG) team have continued to develop a robust database so that trends and patterns can be analysed. This data is presented at the monthly ASG Forum, which is attended by the MDT team and has been used to improve patient safety through more informed decision-making.
- All ASG incidents are reviewed on a weekly basis at the Adult Safeguarding MDT meeting which the DAPO chairs. Risks are identified, analysed and protection plans reviewed in relation to new and existing ASG referrals.
- The high level of public scrutiny, the pressures on the existing staff across the site, the increase in historic referrals and a deficit of adult safeguarding resource continues to present challenges.

Safeguarding within the Community.

- There has been a decrease in the number of referrals received by the community ASG from 168 last year to 143 this year. It is highly likely this is related to the impact of COVID and the fact that the learning disability day centres and short break facilities were closed.

- The community teams service has continued to investigate concerns raised in community settlings, including nursing homes, residential homes, supported living units day care etc.
- The 143 community referrals cover a range of abuse including alleged physical abuse (72), sexual (9), neglect (16), psychological abuse (20), financial abuse (22), institutional practices (3) and exploitation (1).
- Within community facilities, a number of referrals are because of group living. This brings with it issues in relation to the environment, quality issues and the mix of patients. Care plans are reviewed regularly; staff are upskilled and additional support provided in an attempt to reduce the likelihood of further incidents.
- There have also been a number of large-scale complex investigations into alleged abuse in several community facilities, which has had an impact on the ASG workforce capacity.
- Again, given the resources issues in ASG across LD a number of the community Team Leaders with DAPO responsibilities have also had to take on work from the hospital site relating to staff on patient incidents to ensure objectivity.
- The community team recognise the importance of having more accurate data so that an analysis can be carried out to look at trends and patterns across the community. A robust data sheet has now been developed, similar to the one created in Muckamore, which will assist in the analysis of data, enhance preventative work and inform decision-making.
- ASG work streams were established to take forward learning from the Community ASG audit, internal reviews, SAI's and a pending SAI level 3 investigation. A significant amount of work has flowed from this including, creation of aide memoires, a procedural manual etc. Additional training for community ASG staff has been facilitated in relation to interviewing staff, clarifying the roles of DAPOs and IOs and completion of ASG documentation**.** ASG huddles are now in place to enhance oversight and governance arrangements. Supervision and review arrangements are also being reviewed and a new ASG supervision tool as well as ASG case audit tool has been developed and implemented. The staff continue to be encouraged to attend the DAPO, IO and ABE support groups facilitated by the ASG Learning and Development Trainer. The Trust ASG Lead is also facilitating a workshop with referral agents to enhance the quality of referrals and raise awareness.

Historical CCTV Adult Safeguarding investigation.

- The Muckamore Abbey Hospital large-scale historical CCTV adult safeguarding investigation remains ongoing. This continues to be an extremely complex and time-consuming investigation.
- From a safeguarding perspective, it is positive to note that at this stage all raw footage CCTV relating to the timeframe of the historical investigation has been viewed by either Trust or Police. MAH Historical ASG team have completed raw footage viewing of Cranfield 1 & 2 and Police have completed viewing of Six Mile

assessment and treatment. Therefore, collectively all raw footage CCTV has been viewed by either Police or Trust. The plan going forward is that each agency (Police and Trust) will ultimately view all CCTV footage for the time frame of the investigation.

- There are currently two core investigation processes ongoing – the Police led investigation and the Trust disciplinary investigation.

  - In this reporting period there have been a number of MAH staff arrested and questioned by Police in relation to MAH Historical Investigation. On Friday 16 April 2021, the Public Prosecution Service confirmed via media that they were progressing with criminal prosecutions in relation to seven MAH staff. This is a positive development in terms of the Police investigation and signals the next stage in the investigation process.
  - The Trust disciplinary investigations are ongoing and to date a small number of staff have been dismissed. The disciplinary investigation process is complex and it is anticipated that there will be a number of other staff who will be subject to disciplinary investigation.

- The focus of the MAH Historical ASG team's work over the last year is as follows:

  - View raw footage to identify incidents of concern.
  - Making referrals to senior management via HR for interim protection plans and where appropriate making referrals to PSNI for Police investigation.
  - The MAH Historical ASG team are also working on the second viewing of the PICU incidents forwarded to them by PSNI.
  - Quality-assure the current database alongside the merging of other relevant information held in a separate database.
  - The team are also engaged in ongoing family liaison work, with each affected family having a nominated family liaison social worker. Police also have family liaison officers appointed and there has been ongoing positive joint working in terms of liaison with families regarding the reporting of incidents of concern.
  - In addition, the MAH Historical ASG team hold cross-Trust meetings with Northern Trust and South Eastern Trust as some of the affected families have been from their localities.
  - Provide information when requested by the external disciplinary investigators.

- Further Updates in this reporting period include:-

  - The software solution referenced in the last DSF report has been developed and is being utilised to complete CCTV viewing. This has been a welcome development as it has improved the CCTV viewing process.
  - The 3-weekly Operational group meetings comprising of representatives from ASG team, HR, senior Nurse Advisor,

	RQIA and PSNI are ongoing and provide a forum for update and discussion on progress re the various work strands. ➢ A further development this year has been the establishment of a specific work-stream with a focus on interim protection plans. There are currently regular meetings taking place to facilitate a review of all current interim protection plans. These meetings involve MAH Adult Safeguarding, senior Nurse Advisor, RQIA and PSNI. ➢ The Health Minister, Robin Swann announced on 8 September 2020 his intention to call a Public Inquiry into allegations of abuse at Muckamore Abbey Hospital. He also said he would consult with families, patients and former patients on the terms and format of the Inquiry. He has now written to the families of patients to update them on the arrangements for hearing their views. He has asked the Patient and Client Council to facilitate this work on his behalf. The consultation with families commenced week of 7 December 2020. ➢ The announcement in relation to the Public Inquiry was welcomed by the Belfast Trust and the Trust have recently advertised a post in preparation for the Public Inquiry. To date we have received no confirmation of the terms of reference of the Public Inquiry.

2.6 Progress Update on DSF Plan

This Section is for the Programme of Care to record their progress with the actions identified at the beginning of this reporting period (cross reference with section 1.3)

2.6	Issue/Action Agreed at DSF meeting in October 2020	Progress Update at 31st March	RAG Rating
	Learning Disability		
1.	**Issue: Domiciliary Care waiting list** **Update at DSF meeting – 5.10.20** Trust confirmed there are issues around complex cases and geographical location. They have 20 on the waiting list as of DSF meeting date, mostly around small packages (shopping / showering etc). Continue to use SDS. Similar issues as in OPPC. **Action**: • To be reviewed alongside the Domiciliary Care issues outlined in OPPC	**Update:** There are currently 12 cases on the waiting list (08.04.21 update). The Learning Disability Service is represented on a project group to implement time bands for care packages in order to provide more flexibility in the system and to increase package availability. It is hoped that this will go live on 10.05.21**.**	
2.	**Issue: Potential failure to provide people deprived of their liberty with adequate legal safeguards.** **Update at DSF meeting – 5.10.20** Trust have carried out scoping exercise. They have 647 community DOLs to be completed. There are a number outstanding within Muckamore and these will be completed by the end of November. There remains a challenge in securing medical reports from GPs as	**Update:** MCA training has been completed across the service area. A service area steering group has been established and a data base to monitor progress.	

	recognised regionally. Trust LD service currently has 100 emergency orders in place which will all require a DOLS review. There is a significant resource implication associated with this. LD service is also experiencing a challenge in getting appropriate numbers of ASWs in the service. **Action**: • To be kept under review during 2020/2021	This is a complex area of work within Learning Disability and is more time consuming given the nature of our service users, many of whom have communication difficulties and behaviours, which challenge. This has been further exacerbated by COVID as there are difficulties communicating using PPE and virtual means. A MCA action plan was devised. There were no additional resources available although we were able to temporarily fund an 8a MCA lead (which we were unable to backfill), release one practitioner from each community team to solely undertake MCA work (again difficulty backfilling fro the agency) offer overtime and invite retirees to return to assist is in the process. It is anticipated that a further Social Worker will join this team in July 2021 for 2 days per week. In addition, as this is new legislation, there have been many challenges in implementing it and frequent legal advice has had to be sought on many occasions. [redacted] To date there have been no service users in receipt of a trust panel authorisation where the Trust has felt that a declaratory order is necessary. This will remain under review.	

		The MCA Central team have commissioned a number of medical staff to complete sessional work carrying out Form 6 assessments, which has assisted with the process. The service area has also been able to avail of a STDA from the central area to assist with MCA work. To date the service area has carried out 179 assessments- 103 Trust Panel applications; 40 service users were deemed to have capacity; and 36 are awaiting a panel hearing. All patients in Muckamore who are not detained under the MHO and who are deemed to lack capacity regarding those aspects of their care arrangements amounting to DOLS have a Trust Panel Authorisation in place. The first Trust Panel Authorisations are now at renewal point and this is putting further pressure on teams to meet this legal requirement. Of the authorisations in place the Attorney General has referred 23 to the Review Tribunal. The required Rule 6 report is also creating additional workload for the teams as there is usually a 10 day turn around required for these. Given the increased workload, lack of additional resource and ongoing challenges associated with the fluidity of this new legislation and emerging case law the service area is	

		unlikely to meet the target of completing all DOLS by end of May and reviewing them by end of November. A proposal has been put forward for additional funding and the action plan is continuously reviewed. This risk has also been placed on the risk register. The service area continues to only have a small number of ASW staff working within the area and this continues to present challenges in terms of having this expertise in the service area. Attempts to encourage staff to undertake the ASW training have been unsuccessful within the service area.	
3.	**Issue: Iveagh delayed discharges** **Update at DSF meeting – 5.10.20** Trust confirmed there are 4 patients in Iveagh, 2 from BHSCT (one of which is a voluntary patient). Legal opinion is being sought in relation to the judicial review. One of the BHSCT patients is 17 year old and transition process needs to be progressed urgently. Children's services have a business case with HSCB. **Action:** • Ongoing discussions with Adult Services • Trust to update HSCB on progress of discharges	**Update:** There are currently 2 patients whose discharge has been delayed in the Iveagh Centre. (1 WHSCT, 1 BHSCT). One of the main challenges faced by Iveagh continues to be the lack of community options for young people in the community. This has led to delayed discharges, which reduces the hospitals ability to function effectively for assessment and treatment. More comprehensive planning with community colleagues continues to be a focus for the clinical team; however, this is influenced by the regional nature of the service. There have been 5 Judicial Reviews in the past year in relation to children who are delayed discharge in hospital.	

		These issues have been escalated to the Executive Team within BHSCT and with all other Trusts. The HSCB and DOH are also aware of the issues of delayed discharge along with the RQIA and the Children's Commissioner. Judicial Reviews occurred in March 2021. It was agreed that the following action would be taken: • The Iveagh Operational Policy will be reviewed so that it better reflects the statutory duties on the Trust where the child ordinarily lives to ensure care planning is in place and where discharge cannot be effected that escalation arrangements are explicitly stated. • Iveagh would contribute to a standing forum chaired by the HSCB involving the five Trusts as required to monitor the issue of delayed discharge from Iveagh Centre and any action that may be required. Following the RQIA inspection on 8th, 23th September and 7th October 2020- 12 QIPs are also being actioned as outlined in section 2.5.	
4.	**Issue: Accommodation needs for those being discharged from Muckamore Abbey Hospital** **Update at DSF meeting – 5.10.20** Trust confirmed there are 4 PTL patients currently. A pivotal staff member has been on sick leave and is now leaving the service. This has had a significant impact and is a central factor in the delays. Recruitment for this	**Update:** There has been active planning for the discharge of patients from the hospital into appropriate and sustainable placements and a number of patients have already been placed successfully in the community from the hospital.	

	vacancy is now underway. They confirmed 13 delayed discharges - 5 planned, 8 unplanned. A number of service users have been moved to Bradley Court. Trust have had Initial discussions with RQIA to consider a residential living scheme around the Muckamore area, though this is in its very early discussion stage. **Action:** To be kept under review during 2020/2021 and update provided to HSCB	Since April 2020- March 2021 there have been 6 successful discharges and 3 patients are currently on trial leave. Three BHSCT patients have been discharged- two patients were discharged to specialist nursing and one to the community with family. In relation to the 16 current BHSCT patients- • 3 have a definite plan to be settled in the community • 1 is being considered for Mallusk. • 1 is being considered for an onsite proposal • A business case is currently being developed for 6 patients • 3 patients are being for forensic business case • 2 patients are on trial leave In relation to the remaining 20 NHSCT patients- • 7 have a definite plan • 9 have no plans • 1 is being considered for onsite proposal • 1 patient is being considered for Cherryhill • 1 patient is being considered for forensic business case • 1 patient is also on trial leave In relation to the 8 SEHSCT patients on site- • 1 has a definite plan	

		• 2 have no definite plan • 1 is currently on home leave with discharge imminent • 2 patients are being considered for forensic business case • 1 patient being considered for on site proposal • 1 being considered for Mallusk. There is one remaining WHSCT patient who is on Article 15 leave since March 2021. There is also one SHSCT patient who has a placement identified but does not wish to leave the hospital. It is hoped that Mallusk will be opening in the Summer of 2021 and it will provide a placement for 7 hospital patients. Within the Trust the Planning Officer post was vacant for some time and this delayed progress in relation to the development of business cases. This post has now been filled and the progression of business cases is being taken forward. There also continues to be a lack of community placements for patients with complex needs. A number of families have also requested that CCTV is in place within community facilities before their loved one is discharged.	

		An accommodation workshop was held and the Learning Disability Division are updating the Accommodation Plan for the period through until 2025. The plan will further identify accommodation requirements at a population level and has included inpatients in Muckamore Abbey Hospital. The Service area is engaged with potential providers across all sectors in exploring potential options. Supported Housing Schemes continue to be developed through Business Cases to Supporting People for capital expense only / revenue neutral. These will be for developments within the next 2-3 years. Any additional accommodation needs are being considered within a procurement framework as part of the Regional Learning Disability Operational Group with the HSCB and in partnership with BSO. The business case for five Lanthorne (Cedar) Supported Living Development for Community service users is being progressed. The business case for an extension of a forensic scheme is being progressed for four MAH patients and there are plans to have an additional two to eight placements (dependent on the site) for community service users. Following a failed community placement the BHSCT in January 2020 agreed to seek a bespoke assessment for an inpatient in Muckamore and commence a single action procurement regionally and nationally to seek a provider	

		who could meet his needs. The single action procurement process was commenced in December 2021. If successful, it is envisaged that this methodology will also be applied to other individuals with high levels of support needs.	
5.	**Issue: Recruitment of SW staff to strengthen the workforce** **Update at DSF meeting 05.10.20** As outlined in other programmes, workforce issues continue to be a significant challenge. This is further exacerbated with Covid and likely to impact on services for the remainder of the year. There is a regional issue with workforce and a local one. The Trust continues to progress their workforce planning and undertake recruitment exercises. **Action:** • To keep the workforce pressures under review • Await outcome of DoH Workforce Review	**Update:** An 8B SW service manager with responsibility for ASG, hospital SW and the MDT community teams has been appointed and commenced employment on1.9.20. 8A Principal Social Work post has now been agreed and is currently being processed for recruitment. Securing the 8A Adult Safeguarding lead post last year was extremely helpful to the service area especially given the ongoing complexities associated with adult safeguarding in the service area. Unfortunately, this person left post in September which has placed significant pressure on the service area, The newly appointed ASG Lead is due to take up post on the 1.6.21. The SSW Band 7 post in MAH which was vacant since July 2019 was also successfully recruited in June 2020	

		There has been some difficulties recruiting SW into B7 team leader posts. A number of the Team Leader posts were temporarily recruited by existing staff within the service area. Two Band 7 Team leader posts which were vacant were successfully recruited. One permanently took up post in July 2020 and the other is covering the post temporarily. One team leader retired and this post is also backfilled temporarily. It has now been agreed , give the pressures experienced in relation to Adult safeguarding that these new team leaders will be recruited from a SW background. Due to issues raised by Staff Side the Team leader job description is currently being desk topped. Three Senior Practitioners Band 7 have been recently appointed with DAPO responsibilities (Temporary). Two of these staff have only recently been trained as DAPOs. The third Senior Practitioner post (temporary) has only recently been appointed and is yet to be trained as a DAPO and take up post. These Senior Practitioner posts are currently being progressed through HPRTS to be recruited permanently. Additional funding had been secured through IPTs to permanently recruit an additional Senior Practitioner Band 7 with DAPO responsibilities and 2 SW Band 6 with IO responsibilities. These posts are currently being progressed through HRPTS to be recruited permanently.	

		Given the current risks associated with the delivery of Adult safeguarding across the service area a proposal to proceed at risk with expanding the ASG workforce is currently being considered. The DoH Regional Workforce Review in relation to social work across all programmes of care including Learning Disability is ongoing. Discussions have commenced within the Belfast Trust regarding a regional approach to recruitment of Social Workers. While the premise for regional recruitment has some benefits, there are concerns in relation to the standards applied to job descriptions/ interviews particularly around specialist areas/posts.	

Rag Rating:
Green - Complete
Amber - Partially Complete
Red - Not complete

Where the RAG status is Amber or Red, please include further detail in Section 2.7 of this template.

2.7 Discharge of Delegated Statutory Functions

This section enables the Trust to provide more details on the issues identified by the Executive Director at Section 1.4

2.7	Summary of areas where the Trust has not adequately discharged their Delegated Statutory Functions for this Programme of Care.	Please outline remedial action taken to address this situation and any proposed future action.
	Learning Disability Issues:	
1.	**Domiciliary Waiting List**	
	There are 12 service users on the waiting list for domiciliary care within Learning disability. This presents a potential risk to service users as the Trust is unable to meet their assessed needs in a timely way. This can also impact on carer stress levels	The Service continues to promote SDS uptake and access the Care Bureau. The Learning Disability Service is represented on a project group to implement time bands for care packages in order to provide more flexibility in the system and to increase package availability. This is planned to go Live on 10 May 2021.
2.	**Potential failure to provide people deprived of their liberty with adequate legal safeguards**	
	A significant number of service users in the community who lack capacity and who are restricted of their liberty is sizable within the service area. Whilst much work has been completed it is unlikely all these service users will have the appropriate legal safeguards in place before end of May 2021 There is a risk to the Trust and to individual employees under Section 269 of the MCA legislation regarding the potential individual criminal offence of unlawful	Most staff have been trained in MCA across the service area. All service users scoped across the service area. A steering group for hospital and community has been established. A comprehensive data base to monitor progress has been developed. An action plan was developed and temporary funding agreed for MCA 8a Lead, 1 staff member to be freed up in each community team to solely undertake MCA work, overtime offered, each community practitioner to

	detention. The threat of criminalisation on the incumbent workforce is likely to have a detrimental effect on the Trusts' ability to retain and recruit staff. Trade Unions have advised the Trust of their members' concerns and have raised the potential of industrial action to draw attention to their members' distress. The requirement to undertake a significant number of DOLs within the service area also places the staff at risk of increased workload and pressure in the absence of any additional resource. This could also negatively impact on the workforces ability to undertake other core functions of their jobs in a timely manner which could impact on service delivery.	undertake 2 DOLS per month, retirees invited back, STDA and medical input from the central team to assist with assessments. The service area has developed a number of resources to help with understanding of MCA – these include social stories, easy read information and objects of reference. The service has also run a number of workshops to augment the training provided by the Department of Health. Staff have reported that these have been useful and this should be embedded into the programme to share learning. A proposal for additional funding to undertake MCA work has been developed. It is unlikely the Trust will meet the May or November 2021 deadlines and this risk has been placed on Risk register. The action plan will continue to be reviewed. There is an inadequate number of ASW in the service area. The Job description of newly employed SW staff has been revised so that they are now required to undertake the ASW course within 2 years of being appointed. This should increase the number of ASW staff within the next 2 years and going forward.
3.	**Iveagh delayed discharges**	
	There a lack of community infrastructure for young people to facilitate their discharge from hospital, which leads to delayed discharges, an There a lack of	More comprehensive planning with community colleagues continues to be a focus for the clinical team; however, this is influenced by the regional nature of the service.

	community infrastructure for young people to facilitate their discharge from hospital, which leads to delayed discharges, an unnecessary infringement on their human rights leading to series of Judicial Reviews within the service area. This has the risk of damaging the reputation of the Trust and could result in media attention.	These issues have been escalated to the Executive Team within BHSCT and with all other Trusts. The HSCB and DOH are also aware of the issues of delayed discharge along with the RQIA and the Children's Commissioner. Judicial Reviews occurred in March 2021. It was agreed that the following action would be taken: • The Iveagh Operational Policy will be reviewed so that it better reflects the statutory duties on the Trust where the child ordinarily lives to ensure care planning is in place and where discharge cannot be effected that escalation arrangements are explicitly stated. • Iveagh would contribute to a standing forum chaired by the HSCB involving the five Trusts as required to monitor the issue of delayed discharge from Iveagh Centre and any action that may be required. The plan for future management of the service remains under review. Following the RQIA inspection on 8th, 23th September and 7th October 2020-12 QIPs are also being actioned as outlined in section 2.5.
4.	**Accommodation Needs**	
	Due to a lack of community infrastructure, the service area continues to have difficulty finding suitable accommodation for our service users with complex and challenging needs resulting in delayed discharges from Muckamore Hospital. This increases the risk of patients becoming institutionalised, and potentially infringing their human rights in respect of a deprivation of their liberty and their	The Learning Disability Division has developed an Accommodation Plan for the period through until 2023. The plan has identified accommodation requirements at a population level and has included inpatients in Muckamore Abbey Hospital. The Service area is engaged with potential providers across all sectors in exploring potential options. Regional procurement is underway for complex cases. A proposal is being progressed via procurement for one patient.

	right to family life. This again can give rise to adverse media attention and has the potential to damage the reputation of the Trust.	An Accommodation workshop has been arranged to update information and agree strategic plans. A new specialist LD nursing care provider opened in Autumn of 2020. Two MAH patients moved in to the Home and a further 2 placements are planned. The business case for five Lanthorne (Cedar) Supported Living Development for Community Service Users is being progressed. The business case for an extension of a Forensic scheme is being progressed for four MAH patients and there are plans to have an additional two to eight placements (dependent on the site) for community service users. There is active planning for the discharge of patients from the hospital into appropriate and sustainable placements and a number of patients have already been placed successfully in the community from the hospital. There continues to be insufficient community placements for complex service users.
5.	**Recruitment of SW staff to strengthen the workforce**	
	Additional SW staff are required to undertake ASW role, adult safeguarding and undertake DoLS/ DO. There is also a need to recruit PSW post to support the Division in relation to the discharge of statutory functions, ensuring SW adhere to good practice standards, to undertake audits, supervision, professionally develop the workforce and provide assurance.	8A Principal Social Work post has now been agreed and is currently being processed for recruitment. It has now been agreed, give the pressures experienced in relation to Adult safeguarding that the community team leaders will be recruited from a SW background.

	Deficits in the ASG workforce could pose a risk to the safety of service users and impact on the workload and wellbeing of the current ASG staff. Given expectations and the high level of scrutiny because of the current historical CCTV investigation, this could attract media attention and damage the reputation of the Trust. The lack of ASWs in the service area has a negative impact on the expertise and knowledge of the Mental Health Order and Human Rights legislation within the service area. This is important given the complex legal matters, which arise within the service area. It also impacts on the Trusts ability to discharge their statutory functions by having sufficient ASWs across all programmes to support the ASW day time rota.	Due to issues raised by Staff Side the Team leader job description is currently being desk topped. Three Senior Practitioners Band 7 have been recently temporarily appointed with DAPO responsibilities. These posts are currently being progressed through HPRTS to be recruited permanently. Additional funding had been secured through IPTs to permanently recruit an additional Senior Practitioner Band 7 with DAPO responsibilities and 2 SW Band 6 with IO responsibilities. These posts are currently being progressed through HRPTS. Given the current risks associated with the delivery of Adult Safeguarding across the service area a proposal has been put forward for additional resources. The DoH Regional Workforce Review in relation to social work across all programmes of care including Learning Disability is ongoing. Discussions have commenced within the Belfast Trust regarding a regional approach to recruitment of Social Workers.
6.	**MAH admissions**	
	The Service Area continues to struggle to make admission beds available as required even for detained admissions. There have been no admissions in the last financial year.	The Trust is currently developing a proposal, which, following successful resettlements, will provide a small number of admission beds for the BHSCT, SEHSCT and NHSCT areas. The overall strategy for the Hospital is a reduction in the number of inpatients through resettlement and admission avoidance – this is necessary

	If the service user has been assessed as requiring detention for assessment and is unable to be admitted to hospital, this could place the service user and or others at risk. This is also a potential infringement on the human rights of the service user, who if assessed as requiring detention for assessment, has a right to be assessed and treated for a mental disorder in a hospital. The Trusts inability to admit a detained patient can also impact on the Trusts obligations under the Order to discharge their responsibility and can be subject to legal challenge which may damage the reputation of the Trust. This will also impact on the ASW ability to discharge their statutory functions under the Mental Health (N. Ireland) Order 1986 in terms of conveying a patient to a hospital for assessment. The Trusts inability to admit a patient can affect the carers stress level.	for the overall safety and sustainability of the site to be able to achieve an appropriate skill mix of patients to registered learning disability nursing staff. Therefore, admissions to MAH are being managed on a case by case basis. In the first instance alternatives to hospital are being exhausted following a meeting/ consultation with the referrer including community staff, providers etc. The number of patients in the hospital is as below. **Trust of Residence** / **Number of Inpatients** / **Number of Patients on Trial Resettlement** Northern HSC Trust: 19 / 1 Belfast HSC Trust: 14 / 2 (Art 15) South Eastern HSC Trust: 8 / 0 Southern HSC Trust: 1 / 0 Western HSC Trust: 0 / 1 (Art 15) **Total: 42 / 4** If a service user is detained for assessment under the Mental Health (N. Ireland) Order 1986 and has a mild to moderate Learning Disability then a bed is still being sought within general psychiatric wards, initially in Belfast and then across the province. If the service user has a severe Learning Disability and has been detained for assessment under the Mental Health (N. Ireland) Order 1986 then a Learning Disability bed is sought either within Muckamore Abbey Hospital (MAH) or in another Learning Disability facility in N. Ireland.

		The HSCB have had workshops between mental health and LD at a regional level in relation to admission criteria as there is now some debate around the cut off point for moderate LD i.e. it is considered the range is too wide and there is perhaps a needs to review the criteria or devise a tool to assist in this process Progress has been made to develop a Community Intensive Treatment Team in a bid to provide an alternative to admissions through providing a wrap around community response.

PROGRAMME OF CARE DATA RETURNS 1 – 6 AND 9

DATA RETURN 1 – PoC / Directorate: Learning Disability

1 GENERAL PROVISIONS			
		<65	65+
1.1	How many adults were referred for assessment of social work or social care need during the period?	99	15
1.2	Of those reported at 1.1 how many adults commenced receipt of social work or social care services during the period?	84	13
1.3	How many adults are in receipt of social work or social care services at 31st March?	1197	400
1.3a	How many adults are in receipt of social work support only at 31st March (not reported at 1.4)?	1111	371
1.4	How many care packages are in place on 31st March in the following categories:		
	xix. Residential Home Care	97	28
	xx. Nursing Home Care	96	71
	xxi. Domiciliary Care Managed	27	3
	xxii. Domiciliary Non Care Managed	100	14
	xxiii. Supported Living	236	43
	xxiv. Permanent Adult Family Placement	18	0
1.4a	For all those listed above in 1.4 provide assurance that the Care Management process is being applied in accordance with the DHSSPS Care Management HSC ECCU/1/2010 Circular. YES / NO *If no, please explain*	Yes	
1.5	Number of adults provided with respite during the period	PMSI return	PMSI return
1.6	Number of adults known to the Programme of Care in receipt of Centre based Day Care		
	- Statutory sector	543	65
	- Independent sector	74	4

1.6a	Number of adults known to the Programme of Care in receipt of Day Opportunities	493	5
1.7	Of those at 1.6 how many are EMI / dementia		
	- Statutory sector	14	3
	- Independent sector	18	14
1.8	This is intentionally blank		
1.9	How many of this Programme of Care clients are in HSC Trust funded social care placements outside Northern Ireland?	1	0

DATA RETURN 1 – Hospital: Iveagh and Muckamore Abbey hospital

1 GENERAL PROVISIONS - HOSPITAL				
		<18	18-65	65+
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the period?	2	0	0
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the period?	2	0	0
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?	4	47	2

Age is at date of referral for 1.1 and 1.2
Age at 31st March for 1.3

Note: During this financial year Muckamore Abbey Hospital did not have any new admissions.

DATA RETURN 1 – Acute Hospital (general setting): N/A to Learning Disability

1 GENERAL PROVISIONS – ACUTE HOSPITAL (GENERAL SETTING)				
		<18	18-65	65+
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the period?	N/A	N/A	N/A
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the period? (assessment is to include screening). **Please note it is expected that the response for sections 1.1 & 1.2 will be the same**	N/A	N/A	N/A
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?	N/A	N/A	N/A

Age is at date of referral for 1.1 and 1.2
Age at 31st March for 1.3

DATA RETURN 2 – PoC / Directorate: Learning Disability

2 CHRONICALLY SICK AND DISABLED PERSONS (NI) ACT 1978;			
		<65	65+
2.1	Details of patients less than 65 in hospital for long term (>3months) care who are being treated in hospital ward for over 65	0	X
2.2	Number of adults known to the Programme of Care who are:		
	Blind	33	2
	Partially sighted	40	2
2.3	Number of adults known to the Programme of Care who are:		
	Deaf with speech	13	0
	Deaf without speech	21	0
	Hard of hearing	35	4
2.4	Number of adults known to the Programme of Care who are:		
	Deaf Blind	4	0

DATA RETURN 3 – PoC / Directorate: Learning Disability

3 DISABLED PERSONS (NI) ACT 1989 ***Note: 'disabled people' includes individuals with physical disability, sensory impairment, learning disability***		
3.1	Number of referrals to Physical/Learning/Sensory Disability during the reporting period.	99
	Number of Disabled people known as at 31st March.	1597
3.2	Number of assessments of need carried out during period end 31st March.	99
3.3	Number of assessments undertaken of disabled children ceasing full time education.	20

DATA RETURN 4 – PoC / Directorate: Learning Disability

4 HEALTH AND PERSONAL SOCIAL SERVICES (NI) ORDER 1972;
Article15, Article 36 [as amended by Registered Homes (NI) Order 1992]

4.1	Number of Article 15 (HPSS Order) Payments –	49
	Total expenditure for the above payments	£1,315.57
4.2	Number of TRUST FUNDED people in residential care	108
4.3	Number of TRUST FUNDED people in nursing care	167
4.4	How many of those at 4.3 received only the £100 nursing care allowance?	0 self Funders 2 awaiting Capacity assessment

DATA RETURN 5 – PoC / Directorate: Learning Disability

5 CARERS AND DIRECT PAYMENTS ACT 2002

		16-17	18-64	65+
5.1	Number of adult carers offered individual carers assessments during the period.	**n/a**	176	5
5.2	Number of adult individual carers assessments completed during the period		171	3
5.2a	Number of adult individual carers assessments declined during the period and the reasons why **Reasons cited were as follows-** They did not see themselves as a carer – 1 Stated it was a private issue and did not wish to discuss – 2 Stated they did not require support – 2 No reason provided – 2		5	2
5.3	Of the total at 5.2 in how many of the assessments were the carers, caring for disabled children?		0	0
5.4	Number of adult carers receiving a service @ 31st March		870	141
5.5	Number of young carers offered individual carers assessments during the period.		0	
5.6	Number of young carers assessments completed during the period		0	
5.7	Number of young carers receiving a service @ 31st March		5	
5.8	(a) Number of requests for direct payments during the period 1st April – 31st March		115	
	(b) Number of new approvals for direct payments during the period 1st April – 31st March		115	
	(c) Number of adults receiving direct payments @ 31st March		374	
5.9	Number of children receiving direct payments @ 31st March		0	
5.9.a	Of those at 5.8 how many of these payments are in respect of another person?		362	
5.10	Number of carers receiving direct payments @ 31st March		12	
5.11	Number of one off Carers Grants made in-year.		230	
Note: sections 5.8, 5.9 and 5.10 are to be reported as mutually exclusive.				
Commentary There has continued to be an increase in SDS. This increase has been related to the pandemic and the need for more flexible and tailored packages of care. This was				

particularly relevant when day centres were closed and short breaks unavailable as a result of COVID and so Learning Disability services were adaptive and flexible in how needs were met.
There has also been an increase in the number of carer assessments offered and completed this year as this has been a very difficult year for our carers who were under greater pressure during COVID due to the lack of access to conventional services like day care and short breaks.

DATA RETURN 6 – PoC / Directorate: Learning Disability – Hospital and Community

6 SAFEGUARDING ADULTS

6.1	Number of safeguarding adult referrals within the period ****NB** **143 relate to community** **221 relate to Muckamore hospital (85 staff on patient and 136 patient on patient referrals)**	364
6.2	Number of safeguarding adult referrals within the period broken down by the following categories of abuse: (a) Financial (b) Institutional (c) Neglect (d) Physical (e) Psychological/ Emotional (f) Sexual (g) Exploitation	(a)22 (b)10 (c)21 (d)241 (e)55 (f)14 (g)1
6.3	Number of investigations commenced within the period	257
6.4	Number of investigations completed within the period ****NB cases closed as per Board returns**	131
6.5	Number of care and protection plans commenced within the period **** NB this figure includes 88 alternative safeguarding responses**	300
6.6	Number of care and protection plans in place on 31st March	Not required

DATA RETURN 6 – PoC / Directorate: Learning Disability – Historical CCTV investigation at Muckamore Abbey Hospital

6 SAFEGUARDING ADULTS		
6.1	Number of safeguarding adult referrals within the period *****Please note, some of these incidents were logged historically, but this is a total of the number of incidents viewed by DAPOs during this time period**	398
6.2	Number of safeguarding adult referrals within the period broken down by the following categories of abuse: (h) Financial (i) Institutional (j) Neglect (k) Physical (l) Psychological/ Emotional (m)Sexual (n) Exploitation	******Please see Commentary below**
6.3	Number of investigations commenced within the period	Referrals made to PSNI/HR for investigation: 345
6.4	Number of investigations completed within the period	Not known as investigations are being undertaken by PSNI and external disciplinary investigation team.
6.5	Number of care and protection plans commenced within the period	On-going care and protection plans implemented from initiation of Institutional Investigation. Of the 345 Adult Safeguarding Referrals made during this time period, these were passed to Senior Nurse Advisor for review and decisions of any necessary staff

		action in relation to Interim Protection Plan.
6.6	Number of care and protection plans in place on 31st March **Commentary:** These statistics relate to the Historical Investigation of Institutional Abuse in Muckamore Abbey Hospital for the period 1st April 2020 – 31st March 2021 and cover what was viewed by the Band 7 DAPOs. All incidents recorded are 'staff on patient' incidents. Categories of Abuse as per institutional investigation are as follows: A- Ill treatment/Neglect/Physical B- Restricted/Inappropriate practices requiring MAPA assessment C- Inappropriate use of seclusion D- Sexual E- Conduct Please note there are a number of referrals which span across either 2 or 3 of the categories above. **PICU** Total of Adult Safeguarding DAPO viewing activity: 167 Screened out referrals: 14 Total Adult Safeguarding Referrals for Investigation: 153 Referrals for Investigation broken down into the following categories: A: 139 B: 2 C: 8 D: 1 E: 3 **Six Mile A** Total of Adult Safeguarding DAPO viewing activity: 62 Screened out referrals: 4 Total Adult Safeguarding Referrals for Investigation: 58 Referrals for Investigation broken down into the following categories: A: 50 B: 1 C: 5 D: 0 E: 2	As above

	Six Mile Treatment Total of Adult Safeguarding DAPO viewing activity: 3 Screened out referrals: 1 Total Adult Safeguarding Referrals for Investigation: 2 Referrals for Investigation broken down into the following categories: A: 1 B: 1 **Cranfield 1** Total of Adult Safeguarding DAPO viewing activity: 110 Screened out referrals: 13 Total Adult Safeguarding Referrals for Investigation: 97 Referrals for Investigation broken down into the following categories: A: 68 B: 20 C: 1 D: 0 E: 8 **Cranfield 2** Total of Adult Safeguarding DAPO viewing activity: 56 Screened out referrals: 21 Total Adult Safeguarding Referrals for Investigation: 35 Referrals for Investigation broken down into the following categories: A: 23 B: 1 C: 0 D: 0 E: 11	

PLEASE ENSURE A SEPARATE RETURN IS COMPLETED FOR EACH PROGRAMME

DATA RETURN 9 – PoC / Directorate: Learning Disability

9 The Mental Health (NI) Order 1986
Article 4 (4) (b) Article 5 (1) Article 5 (6) Article 18(5) Article 18(6) Article 115

Admission for Assessment Process Article 4 and 5		**TRUST ASW**	**RESWS ASW**
9.1	Total Number of Assessments made by ASWs under the MHO	5	RESWS will provide
9.1.a	Of these how many resulted in an application being made by an ASW under (Article 5.1b)	5	
9.1.b	How many assessments required the input of a second ASW (Article 5.4a)	0	
9.1.c	Number of applications made by the nearest relative (Article 5.1.a)	0	
9.1.d	Can the Trust provide assurance that they are meeting their duties under Article 117.1 to take all practical steps to inform the nearest relative at least 7 days prior to discharge. **YES / NO** *If no, please explain*	Yes	

Use of Doctors Holding Powers (Article 7)		
9.2	How many times did a hospital doctor use holding powers?	0
9.2a	Of these, how many resulted in an application being made?	N/A

ASW Applicant reports		
9.3	Number of ASW applicant reports completed	5
9.3.a	*Confirm if these reports were completed within 5 working days* ***YES / NO*** *If no, please explain*	Yes

Social Circumstances Reports (Article 5.6)		
9.4	Total number of Social Circumstances reports completed. *This should equate to number given at 9.1c. If it does not please provide an explanation.*	0
9.4.a	Confirm if these reports were completed within 14 days? **YES / NO** If no, please explain	N/A

Mental Health Review Tribunal		
9.5	Number of applications to MHRT in relation to detained patients ***1 BHSCT, 1 NHSCT, 2 SEHSCT**	4

Guardianships (Article 18)		
9.6	Number of Guardianships in place in Trust at period end	0
9.6.a	New applications for Guardianship during period (Article 19(1))	0
9.6.b	How many of these were transfers from detention (Article 28 (5) (b))	0
9.6.c	How many were Guardianship Orders made by Court (Article 44)	0
9.6.d	Number of new Guardianships accepted during the period (Article 22 (1))	0
9.6.e	Number of Guardianships renewed during the reporting period (Article 23)	0
9.6.f	Number of Guardianships accepted by a nominated other person	0
9.6.g	Number of MHR hearings in respect of people in Guardianship (provide total number)	0
9.6.h	Total number of Discharges from Guardianship during the reporting period (Article 24)	0

Discharges as a result of an agreed multi-disciplinary care plan	N/A
Lapsed	N/A
Discharged by MHRT	N/A
Discharged by Nearest Relative	N/A
Total	

Approved Social Worker (ASW) Register		
9.7	Number of newly appointed Approved Social Workers during period	0
9.7.a	Number of Approved Social Workers removed during period	0
9.7.b	Number of Approved Social Workers at period end (who have fulfilled requirements consistent with quality standards)	4

9.8	Do any of the returns for detention and Guardianship in this section relate to an individual who was under 18 years old? If No/yes, please provide number and advise on any issues presenting Belfast Trust patients under 18 years of age who were in Iveagh between 1st April 2020- 31st March 2021 who were subject to detention.

Patient A

Family Background:
Prior to admission Patient A lived at home with his parents. He is a 14 year old male with a severe intellectual disability, severe autism and ADHD. He has a history of aggression towards others.

Date of Admission/ Detention: 27/09/2018.

Reason for detention:
Patient A presented with high risk and challenging behaviours which had caused harm to others including a parent through kicking, biting, hair pulling, scratching and bruising. He was also highly destructive to property and recently pulled the lining of his car roof off. There had been a recent increase in severe violence and risk to others along with deterioration in sleep and sudden mood swings. He was assessed that his behaviour was only manageable with the specialised care and treatment available in the Iveagh Centre, as well as the specialised environment in the Iveagh Centre.

He required the support of a full multidisciplinary team including: 2:1 support by specialist LD nurses, social stories by SLT, detailed sensory programme from OT and ongoing assessment of his behaviours by clinical psychology, psychiatry and behaviour therapists.

Patient A was placed on a Form 10 on 09/10/18 as he has severe mental impairment and severe autism associated with very challenging behaviour. His behaviour manifests as severe aggression towards others requiring physical restraint and often self-injurious behaviour towards himself.

A period of further assessment in hospital was considered necessary to review his behaviour support plan so that his behaviour can be safely managed in the community.

Date of MHRT & Outcome:
On 04/11/2019 The Mental Health Review Tribunal directed that the patient remains detained in hospital for medical treatment.

Current status:
Patient A remains detained. He has been a delayed discharge since 1.9.20. The discharge plan for Patient A is to return home. However, in order for this to take place a business plan was developed to include purchase of new home and employment of a specialised team to meet his care needs when discharged.

This business plan was finally agreed approximately one month ago, with approval given by the Board. Currently the family, community SW, OT and Behavioural Specialist Nurse have identified a property in Belfast which is deemed will meet Patient A's needs. However, some adaptations are required. The next step is for the family to sell their house and to receive the funding from Belfast Trust before they are able to buy the house. Children's services

	community SW is also in process of trying to finalise a job description for a staff team to work with Patient A.	
9.9	How many times during the reporting period has the Trust notified the Office of Care and Protection under Article 107? Please advise of any issues.	0

The Mental Health Order (NI) 1986 as amended by The Criminal Justice (NI) Order 1996.SArticle 50A(6). Schedule 2A Supervision and Treatment Orders.		
9.10	Number of supervision and treatment orders, (where a Trust social worker is the supervising officer) in force at the 31st March	0
9.11	Of the Total shown at 9.10 how many have their treatment required as: (a) Treatment as an in-patient	N/A
	(b) Treatment as an out patient	N/A
	(c) Treatment by a specified medical practitioner	N/A
9.12	Of the total shown at 9.10 how many include requirements as to the residence of the supervised person (excluding in-patients)	N/A
9.13	Of the total shown at 9.10 how many of these supervision and treatment orders were **made** during the reporting period. Please advise of any issues presenting	N/A

2. PROGRAMME OF CARE SUMMARY

Programme of Care / Directorate:- Children's Community Services

2.1	Named Officer responsible for professional Social Work
2.1a	**Accountability Arrangements - Please provide a copy of your Organisational Structure from Assistant Director to Band 7 Staff** Ms Carol Diffin held the dual role of Director of Children's Community Services/Executive Director of Social Work during the reporting period and was the named officer responsible for professional social work within the Directorate. During the reporting period the Directorate had two Co-Director posts, both designated social work posts- Co-Director of Early Intervention and Safeguarding (Dr Michael Murray) and Co-Director of Corporate Parenting and RESWS (Ms Kerrylee Weatherall). The Director supported by the Co-Directors have the overarching responsibility and accountability for the operational delivery of statutory functions by the Children's Community Service Directorate within the BHSCT. The post of Deputy Executive Director of Social Work/Divisional Social Worker for Children's Community Services during the reporting period was held by Ms Dawn Shaw. An unbroken line of accountability for the discharge of statutory functions by the social work and social care workforce runs from the individual practitioner through the Service's line management and professional structures to the Executive Director of Social Work. The Executive Director of Social work reports to the Chief Executive and to the Trust Board. As the Deputy Director of Social Work/Divisional Social worker left the Trust on 31.3.2021 the Director of Children's Community Services/Executive Director of Social Work has assured the Service Area report. **Highlight any vacancies and the action taken to recruit against these.** The Co-Director of Early Intervention and Safeguarding has been granted permission to take an employment break from 1.4.21-31.3.22 and the post will be covered by Ms Edel McKenna throughout this period of time. The Deputy Director of Social Work/Divisional Social Worker left the Trust on 31.3.2021 and interviews for a replacement Deputy Director will take place on 27th April 2021.

	The Directorate has continued to experience a high level of vacancies within Social Work, band 6, during this reporting period with a total of 60 permanent and temporary vacancies across the main fieldwork teams at the time of submission of this report. During the reporting period the Directorate had a rolling recruitment campaign in December 2021 and March 2021 and has recently engaged with the regional recruitment campaign. The Belfast Trust is experiencing the same pressures as other Trusts within NI as the demand continues to outstrip supply due to a strategic lack of qualified Social Workers coming into the workforce to meet the demand. This is being addressed in the Regional Workforce Planning Group led by the DOH, who are developing a five – ten year plan to help resolve the issue. Belfast Trust is actively participating in this work. The constant turnover of staff puts pressure on the system with the additional support required to support AYE staff.
2.1b	**Please highlight key Social Work Workforce planning issues, including recruitment, retention and professional roles (ie. ASW, DAPO, JP). Information provided should include level and type of vacancies and any vacancy control systems in place.** A weekly workforce meeting has continued throughout the reporting period to ensure timely recruitment campaigns and a proactive management of vacancies. The Directorate invested in a band 5 HR staff member dedicated to supporting the Directorate manage its recruitment processes more effectively. The Trust successfully recruited to 9 Senior Practitioner positions in response the additional monies from DoH aligned to unallocated cases across Gateway / Family Support and Children with Disabilities. The recruitment for the 10 Band 4 Social Work Assistants is underway with interviews scheduled for May 2021. There has been a decline in the use of Agency staff within the Directorate over the reporting period. The main contributory factor was the emergency Covid Regulations, which enabled the service to fast-track graduates quickly into the workforce. Recruitment, retention and workforce availability within Family Support has continued to be challenging throughout this reporting phase. Whilst the Trust has just recently completed another recruitment campaign, it is difficult to attract social workers into busy, statutory fieldwork teams given the plethora of choice available for social workers, where demand for social workers outstrips supply. The retention of social worker's within Family Support and the turnover of staff have contributed to having a largely inexperienced group of staff within this service area. This impacts on demand and

	capacity given the high volume of AYE staff within the Family Support service area. Challenges presented by recruitment, retention and workforce availability within CWD have also impacted on this service. A recent Trust recruitment campaign has resulted in filling only 1/3 of vacancies. However, the service will continue to prioritise regular recruitment of sufficient Social Work staff. Challenges with recruitment and retention of staff has also been experienced within the Looked After Children's teams. With the growing number of looked after children within the system, caseload sizes have also continued to grow within this service. This service has experienced a turnover of staff that outstrips the number of new staff being recruited. Despite the Trust agreeing to fund an additional LAC team at risk the service has been unable to recruit enough social workers to establish this additional team and alleviate some of the pressure being experienced by staff. As outlined in the previous report the recruitment of staff for the residential homes was impacted upon through the closure of Donard and the need to go through a change management process with staff. All affected staff were settled into their new roles by the end of July 2020 and this allowed a recruitment campaign to be taken forward specifically for residential staff. In addition, during the pandemic, our residential services experienced challenges linked to staffing levels due to sickness levels, staff shielding and staff having to isolate at times. Consequently, a number of fieldwork staff and other staff were redeployed to support safe staffing levels. Currently the Directorate has 42 AYE staff employed across the Directorate of which 16 are located across our Family Support Teams. The Learning and Development Team have provided additional support to this group of staff through monthly mentoring sessions in their AYE. This has been critical in supporting the retention of this workforce particularly given the pressures experienced with coming into the workforce early. Ensuring sufficiently trained staff to deliver on our statutory responsibilities with the Joint Protocol arrangements continues to be a challenge. The role is complex, and requires continuous professional development and feedback in addition to ensuring the psychological well-being of staff. The Trust is aware of a pilot project in SHSCT involving a cadre of trained PSNI and Social Workers co-located in the PPU and look forward to the outcome of this evaluation.
2.2	**Supervision arrangements for social workers**
2.2a	**Please confirm that the Trust is fully compliant with the Regional Supervision Framework Yes** **If not, outline the remedial action taken to address this**

	The Directorate has overall achieved satisfactory compliance in respect of the supervision of staff. During the pandemic almost all supervision was conducted virtually through the use of virtual platforms. The Trust continues to implement a professional social work supervision exception reporting system. Monthly returns from the service area evidence satisfactory compliance with the requirements in respect of the frequency of supervision and facilitate monitoring of non-compliance. With the additional demands on first line supervisor's during the pandemic, the Social Work Training Team provided direct support to the new qualified AYE's by providing monthly professional supervision and mentoring. On the very few occasions when the Residential Homes have been particularly unsettled and combined with leave and / shift rotational patterns, a supervision may not have taken place, this is achieved at the earliest opportunity. A mechanism via the Monthly Monitoring Report system is in place to track this. Issues of any non-compliance are generally associated with short-term vacancy at manager level; pressure on services due to a combination of vacancies and responding to crises situations; staff off on sick leave, extended annual leave.
2.2b	**Please confirm if the Programme of Care is utilising a Caseload Weighting tool Yes/No** **If not, outline how the Programme of Care is managing current capacity, demand and workforce availability** The Directorate does not universally use a caseload weighting tool and would be of the view that it requires to be updated following the introduction of Signs of Safety. **Early Years** The Early Years Service utilise a caseload weighting tool. This however had to be amended as a result of Cov19 given the direction of only being able to physically visit one provider per day. The enhanced supportive element also limited the application of the tool **Gateway** The Gateway Service does not utilise a Caseload Weighting tool due to the nature of the work, that is, the high throughput of cases within tight timescales. Other measures are used as an alternative, such as using the waiting list to prioritise need alongside the allocation of cases based on the social workers capacity and experience. Of note,

over the course of this reporting period the Gateway Service has consistently reported a downward trajectory of families waiting for assessment and waiting times for assessment.

Family Support

Usage of the Caseload Weighting Tool is not consistent across the Family Support Service due to staff shortages, vacancy levels and more latterly the Covid pandemic. Supervision with staff is utilised in relation to ascertaining demand and capacity for individual social workers. Team meetings are utilised at all levels to ascertain demand and capacity for teams and within a service area to identify particular difficulties/ issues as they arise and ensure appropriate actions are implemented to manage demand and capacity issues as required.

Children with Disability

Usage of the Caseload Weighting Tool has not been implemented within this service as it has not added to existing workload prioritising processes. The service is reviewing the effectiveness of the regional caseload weighting tool within CWD given the complexity of work and size of caseloads and will report on any action taken following the completion of the review. Team meetings have also provided a helpful forum in which staff can raise capacity concerns, provide managers with local information and contribute to resolution of issues.

Looked After Children/Leaving and After Care

Across these teams a range of processes are applied to ascertain and monitor demand and capacity for individual social workers. Monthly supervision is the primary method of monitoring social work capacity. The Looked After Children and Leaving and After Care teams utilise the case load weighting tool.

Fostering and Adoption

Fostering teams and the Adoption teams in addition to supervision utilise the following processes to monitor capacity and demand.

- Monthly assurance meetings to monitor enquiries for both fostering and adoption assessments.
- Fortnightly allocation meetings within the fostering service which reviews the demand and capacity of social work caseloads.

Waiting lists determine how the service meets the demand on the service and any pressures within it.

The Residential Service does not utilise a caseload weighting tool.

2.3	**Report at high level on any audits, research, outcome reports or evaluations undertaken during the reporting period, that relate to delegated statutory functions (bullet points only). Please ensure reference is made to the inclusion of service user involvement.**
	Gateway Audits Within the Gateway Service the CSM and PSW continue to regularly sample completed initial assessments by the Service to ensure compliance with UNOCINI standards. During this reporting period the Service also completed an audit in relation to the thresholding of cases referred and allocated for assessment. The findings of this audit evidenced compliance with the SBNI Child Protection Policy and Procedures in respect of referrals. **Signs of Safety Practice Framework** The pandemic significantly impacted on our implementation trajectory due to the multiple competing demands on our front line services as well as wider workforce pressures linked to recruitment, retention and redeployment. Notwithstanding these challenges there has been progress across a range of areas, eg, during the reporting period 80% of all ICPCC within Gateway have had a family network meeting, the practice lead clinic continued to be progressed with good attendance from mangers and the monthly dashboard analysis is showing that the framework is being used across the fieldwork teams. Collaborative and Gain audit training was delivered in April 2020 with a group of manager and practitioner pairs who trialled the collaborative approach. Since then the managers and staff who participated have continued to apply this in practice and it is hoped further Trust and regional wide application will be rolled out over the course of the next reporting year. **Research – Feb 2021 – May 2021** Gateway Pilot Project (part of SQB Innovation) The aim of this project is to increase the number of Family Network meetings (FNM) **(Target 75%)** held prior to ICPC for families referred to Gateway Service, This project seeks to explore and strengthen systems and practice in Gateway so that staff can effectively identify and engage with the natural network around the child to provide for and ensure their immediate and interim safety. The evaluation includes gathering feedback from Family and Gateway staff. To date feedback has highlighted positive benefits of the use of FNM as well as important learning which will inform

service delivery and design both within Gateway and across all our services.

Family feedback example
"*SW talked to me about the worries and she was so clear about why they were involved…. The network got my family together and we all agreed how they could support me and the kid*s"

"*I was very frightened (re ICPC) at first but the network meeting helped us all feel listened to and we needed to do more for the children*"

"*We looked at good and bad and they have all supported us to make things better. My family have been there but this was different they knew everything now and have been very supportive"*

Gateway staff feedback examples:
Family were on board already but it gave them a chance to define their roles and formalise an action plan. They already came up with a plan before the FNM and talked it through at the Family Network which was good"

Where Network meeting could not be held did the process help in any way?
It was very beneficial as it highlighted that we couldn't see any assurances of safety. It really helped in assessing risks.

Children Protection Case Conference

Chairs are currently engaged in a learning review and development of the CP practice pathway building on the survey of Family members who attended a CP conference between Dec – March 2020.

Focus:
- Strengthen Signs of Safety practice in the ICPC pathway
- Support adaptation to delivering conference within the restrictions of COVID19
- Improve family participation and partnership in the process.

Survey

The SOS staff Survey and Parenting Survey were not completed in 2020 – 21 as had been planned. There is a regional plan for both of these surveys to be carried out in the autumn of 2021.

Family Support

Following on from the Thematic Review in relation to Child Sexual Exploitation (CSE) in November/December 2016, SBNI commissioned a further audit into how the SBNI member agencies are effectively responding to and managing CSE within Northern Ireland.

	This was carried out by Leonard Consultancy and Associates (report February 2020). This evaluation took the form of file audits, focus groups with social work staff and service users, and the audit team was assisted by the CSE lead for BHSCT. The Belfast Trust, along with the other Trusts and the HSCB are currently working together to consider and progress the implementation of the recommendations of the Leonard Review. The Trust's Senior Practitioner (SP) for CSE has continued to work with her regional peers and PSNI to capture data with regard to the numbers of young people at significant risk of CSE and the number of young people who go missing from home/care. The Trust reports on this data to the HSCB. Joint working between the PSNI and Trusts is crucial and has enhanced service delivery in the area of missing children. The sharing of information has facilitated analysis of trends, patterns and networks in assessing and managing risks by predatory individuals and groups to vulnerable young people. Action planning in respect of the Harmful Sexual Behaviour (HSB) audit, which was commissioned by the HSCB and carried out by the NSPCC with a view to developing an evidence informed operational national framework for children and young people who display harmful sexual behaviour, continues in conjunction with the other Trusts and HSCB. The Belfast Trust are working with our service provider Aim To Change and NSPCC in the development of a local action plan to progress the recommendations from the audit. The Belfast Trust are also working collaboratively with the other Trusts, NSPCC and HSCB to progress a regional action plan. **Thematic Audit** During January 2021 a thematic audit 'Pathways into care' was undertaken which focused on the admission of children into care during 2019 and the decision making at the point of entry to care, as Belfast Trust have more 'Looked After Children' than other Trusts. A total of 35 cases across the Directorate were subject to audit from Gateway, Family Support, Looked After Children and Children with Disabilities services. The audit was undertaken remotely using the PARIS computerised Information System. Standardised guidance was compiled using UNOCINI Guidance and Looked After Children Policy and Procedures. The key findings from the audit include that in the majority of cases: • there was evidence of attempts made to avoid an admission to care • there was evidence of discussions with parents/ care givers prior to admission as to why admission to care was being considered. • there was evidence of assessment, analysis and wishes and feelings of the child and parent/care givers having informed the plan.

Administrative Findings

- While there is strong evidence that the 'Essential Information' (LAC 0) document is completed and circulated on the first day of placement, social Workers need to ensure it is updated and shared at every Looked After Child Review meeting.

- Again there is strong evidence that the Parent/Carer 'Agreements' Document (LAC 1) is completed on the first day of a new placement. Social Works need to explicitly state if the LAC 1 was signed by parents, child and carer. The introduction of a document management system, planned for the next reporting period in 2021, will enable signed copies to be 'attached' to an electronic version within PARIS.

- Social Workers need to ensure that the 'Notification of an Admission to Care/ Discharge from Care/ Change of Placement' document (CLA 1) are completed.

Quality Findings

- Evidence of assessment prior to admission to care, with a clear focus of the child/ young person remaining within the extended family were possible.
- Good communication with families before, during and immediately after the admission to care.
- There is a need for Social Workers to explicitly document both discussions with Principal Social Worker regarding decision-making for admission and pre-placement checks with kinship carers.

An Action Plan is currently being developed and will be taken forward in the next reporting period.

The impact of the covid 19 pandemic on frontline practice has increased the demand on a depleted workforce during this reporting period. Consequently the capacity to engage win research, audits and evaluations has been limited.

Care Orders

A quality improvement project into “Care Orders at Home” undertaken by the LAC service has led to an improved performance as to how these cases are managed under the Placement with Parent’s regulations. This work continues to be ongoing and a priority for the Trust. The participation of parents and young people in this project was of key importance.

There are clear plans in place to review each case within the looked after review process to determine if the Care Order is still required. The lead Principal Social Worker for the project undertakes a twice annual audit of all looked after children subject to a care order at

	home to monitor progress of the above plans. The Trust has reduced significantly the number of children at home on Care Order as a result of this work. **Post Adoption Support** The adoption services has completed an evaluation of the development of the provision of post adoptions support services. This transformation funded development enabled the Trust to increase staffing within the post adoption teams which has enabled the service to achieve the following: • 79 children availed of enhanced support with direct contact arrangements • 102 children and their respective birth and adoptive families have been supported with indirect contact arrangements. • A total of 230 families currently accessing the service for post adoption support issues. • Increase capacity of the team to engage child and families in direct work including narrative/ life story work and Dyadic Developmental Psychotherapy approach to family work, with the 4 social work practitioners having been trained in this model of practice. • The team have been enabled to be more proactive in the promotion of post adoption support provision with a post adoption support plans being actively reviewed on a yearly basis.
2.4	**Programme of Care to advise of any significant judgements and/or decisions derived from Serious Adverse Incidents, Case Management Reviews, Mental Health Review Tribunals, Judicial Reviews or RQIA Inspection and/or Review activity during the reporting period, that directly relates to the Trusts discharge of their statutory functions.**
	<u>RQIA Inspections</u> **Children with Disabilities** RQIA carried out three remote/virtual inspections during the reporting period as outlined below: **Somerton Rd CH Medication inspection 4/12/20:** Outcome of Inspection: • Care Plans to be amended to take full cognisance of the detailed medication requirements for each young person • Better assessment of pain recognition and use of FLACC pain management protocol to be evidenced in daily recordings and Trust documentation

Somerton Rd CH Announced Care Inspection 25/2/21:

Outcome of Inspection/Areas for improvement:

The Trust is pleased to report no identified areas for improvement. The Authority did express concern at the lack of a permanent registered manager, however accepted that the Trust had made appropriate efforts to recruit the post and that areas of good practice were noted as follows:

- Implementation of COVID restrictions and protocols
- Review and management of Restrictive Practice and DOLS
- Developing a learning culture within the team

Forest Lodge announced inspection 9/2/21:

Outcome of inspection and areas for improvement:

This was a challenging inspection, as the Authority did not accept Trust assurances that satisfactory arrangements were in place for the safety and wellbeing of young people admitted to the Isolation Unit (established during the pandemic). Two Intention meetings took place via Zoom on 23/2/21 and 1/3/21 and the two intended Failure to Comply notices were withdrawn following engagement with Trust managers and the revision of existing Isolation Unit Guidance for managers and staff. The Trust was grateful for the opportunity to correct some misperceptions and misinformation and to have the opportunity to clarify arrangements and update guidance.

The Trust notes that Areas for Improvement from Previous Action Plans were not reviewed/inspected during the Pandemic and managers are continuing to ensure that these improvements are implemented where possible and deficiencies mitigated if issues cannot at this point be fully resolved.

The period of the Pandemic and various periods of Lockdown created significant challenges to young people, staff and managers throughout, however, the Trust was able to continue to provide safe long-term placements and to prioritise the best possible level of Short Break placements and outreach to our most vulnerable children and families. This has been acknowledge by RQIA.

Mental Health Review Tribunal

Children with Disabilities

During the reporting period one tribunal took place, on 16th November 2020, for a detained patient within Iveagh. The Tribunal confirmed this young person's continued detention in hospital.

Judicial Reviews

Children with Disabilities

During the reporting period, Children with Disabilities Service was engaged in three Judicial Reviews: two relating to the lack of local and accessible placement options for children who have been assessed for residential care and one relating to the retraction of Short Break services due to the pandemic. Two of these cases relate to young people who have remained in the Iveagh Centre when their period of assessment and treatment had ended. The Trust actively sought placements for both young people, but were unable to identify suitable options which could allow for their safe discharge from hospital. The Trust submitted two bespoke business cases in June 2020 and are in discussion with DoH/HSCB regarding the capita land revenue requirements needed to support these children transition back into the community. A third Judicial Review relates to Willow Lodge where a child who is currently placed there on a full time basis has resulted in the temporary withdrawal of the residential Short Breaks provision provided to families of children with disabilities by that Unit. The Trust is cognisant of Service Users dissatisfaction, which has resulted from this placement and is actively seeking to provide alternative provision for these families and the child who is currently resident in the facility.

The Trust had completed an outline business case a number of years ago for the extension of its Short Break and Shared Care provision. Unfortunately, the HSCB at the time advised that there was no additional revenue to support this proposal. The Trust has identified the building of this new facility as a priority and it has been identified for capital expenditure in 2024-2025. The issue of any additional revenue funding to support this facility will still need to be agreed with the HSCB. The Trust is concerned that the service pressures and lack of provision are long standing and require urgent investment and collaboration with the HSCB and other Trusts.

Family Support Service

Over the course of the reporting period there has been a significant volume of pre-action notifications predominantly in respect of our Family Support Services. Cases subject to PAPL's have been varied in nature and have included:- Trust's authority to suspend contact, not providing a placement for a mother and baby together, not agreeing to fund Dialectical Behaviour Therapy (DBT) as per recommendation of an expert report, delay in filing an Article 4 report, not providing contact to a mother incarcerated in prison and failing to provide accommodation. Some of the PAPL's ended following the response back from the Trust, some were dealt with within the public law proceedings as cases were already in Court and some Judicial Reviews were lodged and progressed to leave Hearings but leave was not granted. Failure to provide accommodation was the most significant and common theme, and of these, most related to the accommodation needs of our young people particularly our 16+ which continues to be a challenge in

terms of service provision. The Trust is currently in advanced discussions with one of our providers in relation to increasing our provision of joint commissioned beds.

Case Management Reviews (CMRs)

- Four CMR notifications were made by the Trust to the SBNI during the reporting period:

- The first CMR notification, September 2020, related to a young person known to our Intensive Adolescent Support Service, who was subject to an alleged sexual assault by a stranger.

- The second CMR Notification, September 2020, related to a Looked After Child in one of our Residential Homes, who was also subject to the same alleged sexual assault referred to in the first notification. With regards to both these cases, the CMR Panel in February 2021 recommended 'No CMR', however, when both cases were presented to the Safeguarding Board Northern Ireland (SBNI) Board Meeting, the decision was made to progress a joint CMR with a focus on a 16 hour timeline when the incident is alleged to have occurred. The Trust is currently completing an IAR in relation to this matter.

- The third CMR Notification, November 2020, related to a Looked After Child who was subject to an alleged sexual assault. This was considered at the CMR Panel in February 2021, and 'No CMR' was recommended. The case is currently with SBNI Board for final decision.

- The fourth CMR Notification, March 2021, related to a Looked After Child who was subject to an alleged sexual assault. This case will be listed before the CMR Panel in June 2021 for consideration.

- A fifth notification was made by an SBNI member agency in November 2020 but which related to a regional CAMHS service delivered by the Belfast Trust. The March 2021 CMR Panel recommended 'NO CMR', however, this is currently before SBNI Board for final decision.

- Three CMRs have been completed during this report period, two of which involved RESWS where BHSCT was not the lead Trust. One CMR is currently subject to a factual accuracy check while the other two are awaiting final release.

- CMR R and CMR J that were reported on the previous DSF report – all actions have now been achieved.

- The Trust are currently involved in eight CMRs, for which the BHSCT are not the lead Trust but are contributing to the learning, and these CMRs are at various points of completion.

	IARs submitted: • During this reporting period, the Trust submitted 2 IAR reports – one where the Trust was the lead Trust and the second related to a case where the family had involvement with Trust services across both community and acute. **Residential** Two safeguarding incidents within the Residential Service were referred for CMR within this reporting period with one progressing to CMR and one reverting to an SAI. The date of the SAI is to be confirmed. A further CMR (pertaining to an incident date July 2019) was undertaken and will be shared in the next reporting period. Two SAIs will take place, with dates to be confirmed. These relate to Covid outbreaks in two of the Children's Homes. A further SAI will take place in April 2021, relating to a (non Covid related) incident in a Children's home. **RQIA Inspections/ Activity** Throughout last year, 7 RQIA inspections were completed virtually in Children's Mainstream Residential Homes. On a number of occasions over the reporting period, the Trust has had to inform RQIA of the need to make amendments to a number Homes' Statements of Purpose in order to accommodate young people outside the age range for the home, increased capacity and/ or to extend timeframes of placements to allow for future placements to be identified (This relates specifically to the short term assessment home). **Themes from Inspections** A number of themes were identified including • The requirement to have a comprehensive standardised induction package across the Homes, incorporating a competency checklist and training matrix. • The requirement to evidence proactive planning captured at handovers referencing how shift is to address risk • Requirements regarding internal management audits for some systems, e.g. medication and fire • Requirements for Individualised Care plans that identifies how each assessed need will be met, corresponding desired objectives/ outcomes that can be measured and reviewed.
2.5	**Advise on any challenges in the provision of Safeguarding services that have arisen in this Programme of Care during the reporting period and actions taken to mitigate any difficulties.**

	The Trust has tracked the following child protection information on a weekly basis throughout the reporting period: the total number of child protection referrals into the service, the number of children on the child protection register and the response to a child protection referral within 24 hours. The Trust can report that the number of child protection referrals initially decreased but in the months following the pandemic, there began an upward trajectory and this been sustained. The Gateway Service throughout this period did not move its visits to virtual and continued to undertake face to face initial assessments. At the point of the initial lockdown period, visits to children on the child protection register moved to virtual visits unless risk assessed as a priority for face to face visits. By June 2020 it had been agreed regionally that a minimum of one fact to face visit should take place every four weeks to those children on the child protection register as Trusts were concerned that there were risks inherent in continuing only with virtual visits. This was in keeping with the regional Action Card. Due to the stressors on families as a result Covid, including school closures, decrease and closure of other statutory and voluntary agencies, there was an increase in families experiencing crisis and seeking intervention from family support teams with increased levels of families in need and at risk. There was also an increase in the number of initial case conferences convened and children added to the register and in the number of unplanned admissions to care, placement breakdowns and issues with availability of fosters and the use of short-term bridging placements. Collectively this led to an increase in the volume of applications for Public Law proceedings. There were challenges linked to engaging with service users via virtual platforms particularly in relation to engagement with children and while some of the young people provided positive feedback in using these platforms to engage in the LAC Reviews, staff welcome the increasing return to face to face visits. The Trust manages the regional residential facility for unaccompanied and asylum seeking children and young people and following an initial downturn in numbers of unaccompanied young people presenting into the region, this number again increased. This presented challenges in providing accommodation and the Belfast Trust led on implementing a rota based response shared amongst the Trusts. This meant that when Aran House reached capacity, the Trusts would take turns in accommodating any further presenting young people. In this year, the Belfast Trust worked collaboratively with the HSCB in developing a step down facility provided by a voluntary sector agency. This has now successfully provided accommodation for a number of the UASC and young people requiring a step down facility

	that meets their needs as assessed by the residential staff in Aran House. The Residential Service has also developed a service in partnership with another voluntary sector provider. This provides accommodation and a wraparound support package for 3 unaccompanied and separated young people, which has further developed the menu of services that can meet their assessed needs. Within the mainstream Children's Homes, there has been a significant rise in the numbers of Children who have been missing from care within this reporting period. In tracking this information it is clear that particular spikes in missing from care episodes are linked to periods of lockdown and the cessation of groups and other structured diversionary activity that would have been available to the young people pre lockdown. It is anticipated that the reopening of services will contribute to the reduction of missing episodes. The deployment of the Doors Residential Peripatetic Support Service back into the Homes (following a year that necessitated their redeployment to assist with Covid related absence) will further assist this. It is anticipated that being able to reprise their role of meaningful and needs assessed engagement with the young people will help provide further structure and diversionary activity and help reduce episodes of missing form care.

2.6 Progress Update on DSF Plan

This Section is for the Programme of Care to record their progress with the actions identified at the beginning of this reporting period (cross reference with section 1.3)

	CHILDRENS SERVICES		
2.6	**Issue/Action Agreed at DSF meeting in October 2020**	**Progress Update**	**RAG Rating**
	Issue: Detention under MHO **Update at DSF meeting – 5.10.20** Legal advice has been sought with regards to all these children. There are 2 delayed discharges and there is due to be a JR Hearing in November. The Children's Law Centre have raised issue with the level of consultation with the families. This is refuted by the Trust. These circumstances outline the lack of community resources, both locally and regionally and as such it urgently requires a clear action plan, involving HSCB, Trust and DoH. **Action:** • HSCB, Trusts and DoH to continue to work on development of community resources	**Updated on 5th May 2021** The Trust submitted two Business Cases to HSCB which addressed the specific assessed needs of 2 YP who were Delayed Discharge within Iveagh Ctr during the reporting period. One YP has since been discharged and has now transitioned to Adult Services however there are on-going court proceedings regarding suitability of placement. The second YP remains a delayed discharge and there are on-going discussions with DOH regarding the release of capital funding. The Trust is fully engaged with the Children Disability Reform Group and work is being led on by HSCB to develop a Regional Operational Framework for Disability Services. Whilst resourcing remains a significant challenge the recommendations in the framework outline a wide ranging and ambitious reform and modernisation agenda for CwD services. One of the strategic	Amber

		themes will focus on the approach to residential provision and how to support CwD effectively in out of home placements.	
	Issue: Children with a disability **Action:** The Trust is working with the HSCB to address these shortfalls and to carry out a further assessment of need to inform commissioning priorities. Individual business cases have been developed in relation to young people who are delayed discharges from Iveagh. The Trust also continues to fund a private placement for one young person who was not accepted by the ECR panel but whose needs could not be met within the existing residential or fostering provision. **Update at DSF meeting – 5.10.20** Trust have been looking at this over the last 4 years and there still remains a significant service gap across the region for children with a disability. **Action:** • HSCB, Trusts and DoH to continue to work on development of community resources • To discuss where CwD are positioned within the DoH	**Updated on 5th May 2021** The Trust is currently updating its CWD Edge of Care/ placement requirement data base and will share this information with HSCB when complete. The Trust is keen to see progress in the development of a fully funded reform and modernisation programme as referenced above. The Trust is fully engaged in discussions with DOH to release Capital funding for one YP who remains a delayed discharge from Iveagh. There remains the potential this case will be returned to Court if funding is not made available soon. One CWD LAC is placed in an Out of Jurisdiction placement due to the lack of suitable placements within NI. The Trust is also seeking a therapeutic ECR in respect of another child whose needs cannot be met within NI. The Trust has made 3 other emergency placements during the Pandemic, 2 fully accommodated within Willow Lodge, thus initially reducing and now pausing Short Breaks provision to families of Children in Need. This has resulted in high levels of unmet need despite the deployment	Amber

		of SDS and Article 18 Payments to offset pressures. The Trust continues to advise DOH of the need to place CWD services within Children's and not Learning Disability service division and is committed to a child centred integrated approach to the delivery of Children's services. CWD Service has reviewed the needs of all young people over 16 and identified within that group those requiring Deprivation of Liberty Safeguards. The service subsequently referred 39 young people to the Trust's MCA Team and Social Workers have assisted this team in the completion of the required processes and documentation. The service has itself completed the process for 9 young people and a further 15 DOLS will be complete for a further 15. By 31/5/21 all those who require DOLS will have had the process completed and ready for DOLS Panel consideration. All eligible staff have completed the required training and a tracking system is in place to ensure that those who become eligible have the process completed in a timely way. Attendance at Special Schools to which YP cannot consent and which have locked doors have been included in any DOLS process	

	Issue: Personal Advisors **Update at DSF meeting – 5.10.20** Current number of young people without a personal advisor is 72. Two new staff members have been recruited and the Trust have an action plan which aims to reduce this number to 9 without an advisor in 3 months. **Action**: • Trust to provide HSCB with an update at midyear point	**Updated on 5th May 2021** Broader workforce issues have impacted progress in relation to this area of work in addition to the challenges arising from the management of the Covid-19 pandemic. Factors influencing the allocation of a personal advisor include, the increased trajectory in the number of looked after children and late entrants into care. Within the next review period the Trust will undertake a review of the systems in place to track and monitor the allocation of Personal Advisors, and produce an action plan to address this failure to comply. The HSCB have also outlined a review of Leaving Care Services as one of the priority areas of work to be progressed in 2021/22.	Amber

	Issue: Unaccompanied minors **Update at DSF meeting – 5.10.20** Trust confirmed that Home Office funding is utilised directly on young people. Over the last 7 months £20k spent to date – areas of expenditure inc. accommodation, travel, clothing, heating, activities etc. There was a downturn in numbers arriving in NI during the first period of lockdown, however this has begun to increase and current numbers are around one per week. It is anticipated that these numbers will increase due to Brexit and the new protocol of a 'duty system' across all 4 nations. The Trust awaits outcome of the DoH Workshop on how this will be implemented and arrangements around this. **Action:** • To be kept under review during 2020/2021	**Updated on 5th May 2021** The HSCB have agreed a protocol with the five HSCTs to accommodate children arriving in the region should the Trusts residential home (Aran House) be full at the time of their arrival. Funding has been secured from the DoH to develop the regional model for UASC; this currently is being consulted upon and will be implemented as agreed. Home Office funding continues to be applied for and utilised appropriately in line with the requirements of the provision. A regional workshop will be scheduled once arrangements in relation to the National Transfer Scheme are endorsed at Executive / Ministerial level in NI – no further action is required at this stage.	Green
	Issue: Early Years, Outstanding Inspections **Action:** There is a plan in place to reinstate the Inspections in line with the regional resetting of services and the Early Years plan to have these completed by the end of September. **Update at DSF meeting – 5.10.20**	**Updated on 5th May 2021** The initial pause on all inspections in the first 6 months of the pandemic (when many settings were closed), coupled with the requirement for an inspector to only complete one inspection per day, has created an unavoidable impact on the ability of all Trusts to complete annual inspections of each registered setting.	Amber

	COVID planning started significantly earlier than lock down on 23rd March. Trust confirmed they were on target before COVID and have had an action plan in place. The Trust advise that these inspections and registration should now be completed and up to date. **Action:** • Trust to confirm current numbers. • Trust to forward Action Plan referenced	Trusts have worked extremely well together to agree a regionally consistent approach to meeting their statutory duties and ensure that settings were operating safely during the pandemic, through regular communication and advice. The Trust has adhered to the regional direction from DoH / HSCB regarding the relevant Covid guidelines and moved (as per the regional agreement) to a staggered inspection process from December 2020 with observation visits being deferred until after the lockdown period. Inspections resumed in March 2021. 187 Inspections have been carried out during the reporting year with 355 outstanding inspections as of 31/03/21. The Trust will assess the capacity to complete all other outstanding inspections in line with the DoH guidance. Where they cannot be completed the settings will be risk assessed taking account of the information obtained from remote inspections. Where the risk assessments identify concerns, follow up visits will be completed. The Trust action plan referenced in October 20 had been developed prior to the second lockdown in December 2020 and is therefore no-longer applicable/ relevant.	

	LAC & Leaving Care **Issue: 29 LAC Statutory Visits not completed** **14 CwD Statutory Visits not completed** **Issue: 76 Statutory Reviews not completed** **Update at DSF meeting – 5.10.20** Delays are due to staff vacancies. The Trust also advise that the numbers of children in care has risen, putting increased pressure on the service. **Action:** • Trust to ensure compliance during 2020/2021 • To be monitored during 2020/2021 and reviewed by the Trust and the Social Care lead. • To be addressed through AD Group	**Updated on 5th May 2021** Compliance in respect of statutory visiting has been impacted during the reporting period due to a combination of staff vacancies, sick leave, caseload pressures and redeployment during the third surge of the Covid-19 pandemic. Technology enabled a blended approach to be used incorporating both virtual and face to face visits (risk assessed in line with PHA guidelines). Social work mangers ensured the service was able to respond to crisis and implement actions arising from risk assessments. At the end of March 21, there were 35 unallocated cases within the LAC teams and 92 unallocated cases within CwD due to the issues noted above and from the increase in numbers of looked after children within the Belfast Trust over a number of years. The Trust are managing these cases via the duty social work system and there are escalation procedures in place and oversight by the Head of Service. 3 x Social Workers have been recruited and will take up post in relation to existing vacancies within the next 2 months. Within CwD 4 x Senior Practitioners have been appointed and will take up post within the next two months. The unallocated cases will be assigned to these staff members. It is envisaged the 3 x further	Red

		vacancies in LAC will be filled through the regional recruitment campaign being completed in May 21. Whilst there is no additional funding available the directorate has secured agreement to go at risk and create an additional LAC Team to address the capacity issues on a longer term basis with recruitment for a SSW and 5 x SWs posts being progressed.	
•	**Issue: Care Pathway Project Review - clarify when report is to be available** **Update at DSF meeting – 5.10.20** The Review Report has been forwarded to the HSCB just prior to the meeting. This needs to be reviewed by the Social Care Lead and outcomes discussed with the Trust. **Action:** • HSCB to review report and outcomes • Trust to provide update on progress of recommendations contained within the report.	**Updated on 5th May 2021** The Care Pathway Project Review Report and accompanying presentation was received by the HSCB on 4th October 2020. Recommendations relating to Personal Advisors is noted separately in this action plan as detailed above. The aims of the Care Pathways Review have been achieved. Importantly, Looked After Children have less transition points in their care journey with access to key professionals at an earlier stage to support them through these fewer transitions. Similarly, professionals have more robust processes in place to promote more streamlined case transfer of young people coming into their service area, which prevents delay at key transition times. The review recommendations from this review which will be taken forward in	Green

		• Partnership with the service user groups in respect of informing and co-producing improvements for practice with staff, Reviewing methodologies to improve the retention of personal advisors.	
•	**Issue: Numerous placement moves for children** **Update at DSF meeting – 5.10.20** Recruitment difficulties, more break down of placements. Have put some Band 4s in to support children. Kinship placements breaking down. Inescapable pressures used to fund this area. Placing children with very complex needs that are not ready for fostering. Foster carers are overstretched. Considering bringing back the Leads Model and considering all options. Trust is looking at a regional group to look at the development of this. **Issue: What plans have the Trust in place to recruit locally so statutory duty to LAC can be met and some placement choice afforded to minimise disruptions.** **Update at DSF meeting – 5.10.20** The Trust has very close links with TSS. This situation reflects the pressures across fostering currently. An inescapable pressure paper has been submitted to the DoH by the Trust for a wraparound support service for foster	**Updated on 5th May 2021** The Trust is working in collaboration with the Early Intervention and Support Service to progress a quality improvement project which aims to provide increased support to placements under pressure, improve stability and prevent breakdown. In addition, a new agreement has been reached with Extern to provide 2 placements per week for short breaks which enhances existing provision. The Trust works collaboratively across the region to progress the recruitment planner for foster carers and track the outcomes of this work. Across corporate parenting LAC and Fostering Teams B4 support staff are being utilised to support children in care (these posts are currently unfunded). The annual recruitment planner has been collaboratively worked up on and outlines a	Amber

	carers. The Trust has also a significant challenge in meeting the needs of 8-12yr old children. A bespoke residential unit has been established, as some of these children are not able to manage foster placements and require a therapeutic residential placement before being considered for fostering. **Action**: • To be reviewed during 2020/21 and update provided to HSCB	number of complimentary local and regional recruitment events. The rebuild planning will promote the resuming of face to face recruitment events in addition to those which are occurring virtually. The Regional Assistant Directors for Corporate Parenting and HSCB have agreed to review commencing a regional piece of work to develop a proposal for a skill/fee based fostering framework. The framework will be aligned to the DoH Strategic Direction and priorities for improving outcomes for LAC, placement choices and regional equity. The proposed framework will be presented to CSIB for approval upon completion and may require additional investment and a bridging approach between current practice and full implementation of a new model. The operation of the home for younger children remains in place for those whose needs have been assessed as best met within the home whilst they are being considered for fostering.	

•	**Issue: Impact of vacancies on the delivery of services** **Update at DSF meeting – 5.10.20** HSCB considering setting up further meetings in relation to the impact of COVID. Significant pressures within Early Years and it was suggested by the HSCB that Una Lernihan to link in with this meeting also. There are 42 AYEs in post but they need extensive support and are on reduced caseloads. The Trust Learning and Development teams are providing additional support to AYE's. Trust have also put their learning and development modules on line to improve training opportunities and supports for staff. There are currently 35 vacancies across children's services, and 65 vacancies across adults and children's. The Trust held a Workforce workshop in February with HR. Whist there are local workforce issues, this is also a regional matter and the Trust await the DoH Workforce Review. **Action:** • Workforce planning to be kept under review during 2020/2021, to include vacancy numbers • Await outcome and Recommendations of DoH Workforce Review.	**Updated on 5th May 2021** The number of vacancies has had a significant impact on the delivery of services, the full extent of this is likely to be more fully realised in the coming months as we rebuild our services. Many duties which were previous paused during the pandemic, for example contact, or significant reduced, for example face to face visiting will now resume therefore placing additional demand on teams who have depleted staff and have been carrying vacancies for a sustained period. The impact of the growing proportion of AYE staff located across our front line services should not be under-estimated. These staff require high levels of supervision, mentoring and support as they remain in the consolidation stage of their professional development. The number and complexity of cases that they hold has to be protected however the consequent impact is reduced levels of throughput of cases. The DoH Workforce Strategy remains in draft form and will be circulated to Trusts upon completion. The Trust review vacancies and workforce pressures via weekly meetings with Co-directors, HOS, HR colleagues, & Learning & Development team. A regional recruitment campaign is	Amber

		underway for social workers and subsequent Belfast Trust local recruitment is being planned across all services areas. The HSCB are currently working to scope the existing number of vacancies across children's services with a position report being compiled for presentation to CSIB in May 21.	

Rag Rating:
Green - Complete
Amber - Partially Complete
Red - Not complete

Where the RAG status is Amber or Red, please include further detail in Section 2.7 of this template.

2.7 Discharge of Delegated Statutory Functions

This section enables the Trust to provide more details on the issues identified by the Executive Director at Section 1.4

2.7	Summary of areas where the Trust has not adequately discharged their Delegated Statutory Functions for this Programme of Care.	Please outline remedial action taken to address this situation and any proposed future action.
	Early Years In order to undertake the 355 outstanding inspection as well as the additional inspections the Trust will follow Departmental and HSCB guidance as it evolves.	As Directed by HSCB inspections will continue to follow the regional process where inspections are sampled and focussed on quality of care and compliance with DoH COVID19 Guidance for Registered Childcare Settings. Guidance was developed by the COVID19 HSCB/HSCT Regional Group for Inspections and approved by the PHA will be undertaken as per a process of identifying those with significant action plans as well as those that need additional input. Consequently, minimising risk. As restrictions are lifted the nature of the inspection process will undoubtedly evolve. BHSCT will strive to complete as many inspections as possible; however, the limitation of only being able to visit one provider per day is a significant challenge. BHSCT are of the view that all inspections require a visit. Registrations as per legislation will continue to be undertaken within time frames.
	Children's Disability Service - Delayed Discharge – Iveagh and availability of appropriate community placements	The Trust continues to engage in weekly discussions with colleagues from the Disability Unit, DoH regarding the release of capital funds for a family of a child who is a delayed discharge from Iveagh, purpose a new property, which will enable the child's discharge. The Trusts is also finalising arrangements to a bespoke Care Package, which will be required when the child returns home. This will likely involve the need to recruit additional staff at various Bands to ensure safe levels of care and support.

		The Trust is currently updating its CWD Edge of Care/ placement requirement database and will share this information with HSCB when complete. The Trust is keen to see progress in the development of a fully funded reform and modernisation programme and the completion by the HSCB of the Framework for Children with Disabilities services. The Trust will continue to prioritise the identification of long-term placements for the two children currently placed in its short breaks home Willow Lodge. This has resulted in high levels of unmet need amongst the users of this short breaks home, which the Trust will continue to address in the interim through the deployment of SDS and Article 18 Payments to offset pressures.
	Workforce – Impact of vacancies on delivery of services	Currently across Gateway, Family Support, Children with Disabilities and LAC Services the high volume of vacancies have had a significant impact on the ability to fully discharge our statutory functions. With the onset of Covid and the downturn in services, the extent and impact of our vacancies were not fully realised. However as the process of rebuilding commences, including an increase in face to face visiting, increase in direct parent child contact and the notable increase in referrals, including Child Protection, the gaps in our workforce compliment and the services ability to deliver timely, safe and effective services will be more challenging in the months ahead. We await the outcome of the Regional Recruitment in anticipation that this might create increased capacity however contingency arrangements may need to be considered if the extent and pace of vacancies continues, in particular, the downturn of non-frontline services to enable staff to be redeployed into our critical service delivery teams.

	Personal Advisors 109 young people did not have a personal advisor appointed at 31st March 2021. This is a key role for this group of very vulnerable young people	A tracking system is to be established to monitor the demand for PAs across the service. A number of vacant posts are to be recruited to over the next 2 -3 months to manage the number of unallocated PA.
	Unallocated LAC cases 35 young people did not have a named social worker at 31st March and team members via a duty system were undertaking their statutory visits. This impacts significantly on the development of a meaningful relationship between social worker and young person which is a key support for every looked after child.	Within the LAC service a number of vacant post will be filled within 2 months which will enable the allocation of all cases. The Trust is currently processing recruitment for an additional LAC team to manage the caseload pressures within Looked after children's services. The additional team will be a cost pressure for the Trust.
	Statutory Visits 72 statutory visits did not take place within the regulatory timescales.	Within the LAC service a number of vacant post will be filled within the next 2 months which will ensure the Trust is compliant with statutory functions regarding visiting. The Trust is also currently processing recruitment for an additional LAC team to manage the caseload pressures within Looked after children's services. The additional team will be a cost pressure for the Trust.
	Statutory reviews 94 statutory looked after children reviews did not take place within the required timescales.	The impact of the first lock down period and subsequent postponement of some looked after children reviews resulted in a number of the reviews taking place outside of timescale. In addition, staff sickness and vacancies contributed to this issue as the pandemic progressed. The LAC service has experienced transition and sickness within the PSW staff group. This has currently been resolved and will enable the Trust to ensure compliance with statutory LAC reviews. It is hoped that the regional recruitment campaign will also allow the additional LAC social work team to be filled.

	Placement Moves 117 children experienced a move in placement during the reporting period.	The Trust continues to look at a range of initiatives to support placements and minimize the need for a young person to move. • The development of an Early Intervention and Support Service to support to placements under pressure, • Commissioning through Extern 2 placements per week for short breaks which enhances existing provision. • Use of band 4 staff to support children in care • The development of a recruitment planner for foster carers • The development regionally of a skill/fee based fostering framework • Continuation of the Home for younger children aged 8-12 yrs. • Continued work with TSS to support vulnerable placements at risk of breakdown

Progress Update on DSF Regional Issues

REGIONAL DSF ISSUES			
Older People, Physical Disability & Sensory Impairment and Adult Protection	**Progress Update as of 31.03.21**	**HSCB Lead Responsible**	**RAG Rating**
• **Issue: Workforce** **Action**: To explore alternative recruitment processes in statutory domiciliary care services.	• Additional non-recurrent funding secured for approx 10 staff per Trust area; • Working with DoH and Health Sector Talent to develop interest in care work and recruit people who would not normally respond to conventional recruitment exercises. • Trusts continue active recruitment activities on a regular (monthly) basis.	**HSCT**	
• **Issue: Data issues in relation to Hospital Social Work and Adult Safeguarding;** **Action** To clarify interim data requirements for adult protection.	• Interim regional data return agreed and issued to Trusts • Review of current data and development of new regional data set will form part of work of the Interim Adult Protection Board.	**HSCT/ Adult Protection Board**	

• **Issue: Adult Safeguarding** **Action** To examine recent regional reduction in the numbers of Joint Protocol cases	• Review of Joint Protocol will address issue of thresholds and co-working. • Revised Joint Protocol to be agreed by regional Adult Protection Board for Northern Ireland	**Adult Protection Board for Northern Ireland**	
• **Issue: Domiciliary Care** **Action** • Continue to monitor levels of demand against available supply; • Move away from "time for task" model of delivery to outcomes based approach	• Regular Trust monitoring processes in place; • Note increasing complexity of need of individuals; • New model of care and support scaling up in SET, and planned roll out across other Trusts • Ongoing Engagement between HSC and providers on pressures	**Trusts**	
• **Issue:** Care Homes **Action** Monitor impact of COVID 19 pandemic on care home residents and work with HSC Trusts and providers to alleviate this impact wherever possible	• Close monitoring of care homes in place and service capacity; • Joint working with HSC, providers, PHA and RQIA • Regional Covid-19 Action Plan in place with associated performance monitoring	**HSC**	

• **Issue: Mental Capacity Act** **Action** Ensure all legacy DoLS assessments in care homes are completed	• Performance managed by DoH via regular regional meetings • Risk noted in BHSCT regarding capacity to meet statutory function.	**DoH and HSC Trusts**	
• **Issue: Continuing Healthcare** **Action** New regional policy requirement in this area.	This is a Policy matter to be addressed by DOH	**DoH**	
MENTAL HEALTH AND LEARNING DISABILITY SERVICES	**Progress Update**	**HSCB Lead Responsible**	**RAG Rating**
• **Issue: Mental Health social work vacancies** **Action** • Continue to monitor and assess impact	• DoH Mental Health Action Plan, Action 13.1, *Initiate a review of mental health workforce subject to funding* is outstanding and the Board awaits direction	**DoH & HSCTs M McCafferty**	
• **Issue: Approved Social Work training places** **Action** • Continue to explore potential of increase in training places	• All Trusts to continue to monitor rota, vacancies and emerging need	**DoH & HSCTs via Approved ASW Forum J Haslett**	

• **Issue: Acute inpatient bed pressures/estates delays** **Action** • Continue to monitor levels of demand	• Reported daily via Regional Daily Bed Management return • Delays to estate works communicated via Trust capital works schemes	**DoH, MHLDIB, Regional Bed Capacity Network** **M McCafferty**	
• **Mental health surge which is expected due to COVID-19 pandemic** Continue to monitor levels of demand	• Discussed at fortnightly COVID-19 Asst. Director meetings and monthly Adult Mental Health Group - chaired by M McCafferty • Discussed at Mental Health Emotional Wellbeing P - Marie Roulston and Ciaran Mulholland	**All** **M McCafferty**	
• **Issue: Mental Capacity Act** **Action** • Ensure all legacy DoLS assessments are completed	• This is performance managed by DoH	**DoH & HSCTs** **J Haslett**	
• **Issue: Mental Health Carers assessments** **Action** • Continue to monitor numbers offered and uptake and await IT system to offer quality data	• Continue to work with Encompass project to address need for more quality data reporting to inform emerging carers' needs and offers supports where needed	**HSCTs** **S McErlean**	

• **Issue: Mental Health funding constraints** **Action** • Monitor impact of any funding delays and/or inescapable pressures to meet anticipated mental health surge	• Discussed at MHLDIB meetings on a fortnightly basis and monthly at Adult Mental Health Group • Awaiting funding decision from DoH	**DoH** **L Conn**	
LEARNING DISABILITY SERVICES	**Progress Update**	**HSCB Lead Responsible**	**RAG Rating**
• **Issue: Availability of LD Inpatient beds** **Action** • Continue to monitor levels of demand against available supply; progress the discharge of those in hospital but not in active treatment and continue to explore potential for regional support	• Discussed at MHLDIB meetings on a fortnightly basis and the specific MAH focused Resettlement meeting which also meets fortnightly; • Monitored through regional returns submitted monthly from each of the 3 LD hospitals: • New model and care pathway for community assessment & treatment which is almost complete needs to be consulted on and rolled out across the region	**Lorna Conn**	
Issue: Lack of Bespoke Community placements and accommodation **Action** • To support the development of community infrastructure and provider capability	• Discussed at MHLDIB meetings on a fortnightly basis and monthly at AD LD Group. • Monitored through the Regional LD Operational Delivery Group monthly meetings	**Lorna Conn**	

	• Under consideration through development of a regional procurement of service provides for those with LD and complex needs		
• **Issue: Implementation Of DOLs MCA Phase 1** **Action** • Continue to monitor; assess the impact and support service improvements in regional consistency and compliance • Support trusts to ensure all legacy DoLS assessments are completed	• Discussed at MHLDIB meetings on a fortnightly basis and monthly at AD LD Group. • Monitored through the Regional MCA Strategic Advisory Group monthly meetings and monthly returns	**Julie Haslett** **Ruth Donaldson**	
• **Issue: Recruitment of workforce in general and specifically to ASW; STD Approvers and IO/DAPO roles.** **Action** • Continue to monitor and assess impact on service delivery	• Workforce is managed by DoH • Impact of roll out of MDTs to be monitored by HSCB as well as through DSF governance processes	**Lorna Conn**	

• **Issue: Implementation of the LD service model**	• Completed • To be submitted for final sign off by DOH • Development of an regional implementation group and associate work streams to progress	**M.McCafferty/ U.Cushnahan**	
CHILDREN'S SERVICES	**Progress Update**	**HSCB Lead Responsible**	**RAG Rating**
• **Issue: Workforce** **Actions:** • Await completion of DoH Regional Workforce Review and associated recommendations • Monitor distribution of funding for additional workforce resource to manage unallocated cases • Residential Review paper agreed by CSIB and currently awaiting agreement from DoH to progress recommendations	• DoH Regional Workforce Review to be completed and issue 2021 • Funding for unallocated cases to increase workforce • Residential Review paper regarding skill mix which has been progressed and sent to the DoH for sign off	Martin Quinn/ Judith Brunt/Maurice Leeson	
• **Issue: Children with complex needs, inc. placement needs, short breaks and community supports** **Action:** • Disability Framework to be completed following targeted engagement sessions with key stakeholders	• Finalise the disability framework which will focus on children with complex health needs • Implement plans to facilitate move of young people from Iveagh to community home based services	Maurice Leeson/Kieran McShane	

• To ensure young people currently placed in Iveagh are moved to community based placements			
• **Issue: Unaccompanied Minors** **Action:** • Position Paper has been completed and it will be presented to CSIB and DoH. • Secure funding as outlined in the paper	• DoH Task and Finish Group position paper (Feb 21), options appraisal to be progressed • 8a Social Work commenced in August 20 to work on a coordinated approach to unaccompanied minors • Regional support process in place to assist in appropriate placements	Judith Brunt/Deirdre Coyle	
• **Issue: Placement availability for Looked After Children** **Action:** • Ensure ongoing implementation of Regional Recruitment Strategy for Foster Carers • Ensure progression of development of peripatetic teams • To monitor implementation of Edge of Care Services in each Trust • HSCB to develop placement option paper • HSCB to complete ECR review	• Progress regional recruitment strategy for foster carers • Finalise rollout of peripatetic teams in each Trust, to include recurrent funding allocation • Edge of care teams to be developed, recruited to across all Trusts • HSCB to develop a paper focusing on placements options • Implement the recommendations from the review of ECR placements has commenced by HSCB	Judith Brunt/Deidre Coyle/Fiona Gunn/Pamela Mooney	

• **Issue: Investment in CAMHS** **Action:** • **HSCB will oversee the development of the Managed Care Network through the Regional Programme Board** • **Commencement of Interim Manager for Managed Care Network**	• Currently a proposal with the draft DoH Mental Health Strategy to increase the funding to 10% of the Mental Health budget • Development of the Managed Care Network	Maurice Leeson/Paul Millar	
• **Issue: Transition of children to Adult Mental Health/Learning Disability services** **Action:** • Await outcome of DoH review and engage with recommendations	• DoH currently undertaking a review of transition arrangements with a view to development of a new model	DoH	

PROGRAMME OF CARE DATA RETURNS 1 – 5 AND 9

DATA RETURN 1 – PoC / Directorate: Children's Disability Service – RBHSC/RJMH

DATA RETURN 1 – Hospital

1 GENERAL PROVISIONS - HOSPITAL				
		<18	18-65	65+
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the period?	RBHSC 1133 RJMH 64	RJMH 623	n/a
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the period?	*1197*	*623*	
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?	*RBHSC 386* *RJMH 20*	*RJMH 226*	

Age is at date of referral for 1.1 and 1.2
Age at 31st March for 1.3

DATA RETURN 3 – PoC / Directorate - Children's Disability Service ___

3 DISABLED PERSONS (NI) ACT 1989 ***Note: 'disabled people' includes individuals with physical disability, sensory impairment, learning disability***		
3.1	Number of referrals to Physical/Learning/Sensory Disability during the reporting period.	**217**
	Number of Disabled people known as at 31st March.	**602 without waiting list** **693 with WL**
3.2	Number of assessments of need carried out during period end 31st March.	**741**
3.3	Number of assessments undertaken of disabled children ceasing full time education.	**0**

DATA RETURN 4 – PoC / Directorate _Children's Disability Services _

4 HEALTH AND PERSONAL SOCIAL SERVICES (NI) ORDER 1972;
Article15, Article 36 [as amended by Registered Homes (NI) Order 1992]

4.1	Number of Article 15 (HPSS Order) Payments	11
	Total expenditure for the above payments	£335
4.2	Number of TRUST FUNDED people in residential care	
4.3	Number of TRUST FUNDED people in nursing care	
4.4	How many of those at 4.3 received only the £100 nursing care allowance?	

DATA RETURN 5 – PoC / Directorate - Children's Disability Services __

5 CARERS AND DIRECT PAYMENTS ACT 2002

		16-17	18-64	65 +
5.1	Number of adult carers offered individual carers assessments during the period.		**457**	
5.2	Number of adult individual carers assessments completed during the period		**457**	
5.2a	Number of adult individual carers assessments declined during the period and the reasons why None of the 8 carers considered there was added value with a carers assessment additional to their current support pathway		**8**	
5.3	Of the total at 5.2 in how many of the assessments were the carers, caring for disabled children?		**457**	
5.4	Number of adult carers receiving a service @ 31st March		**457**	
5.5	Number of young carers offered individual carers assessments during the period.		**72**	
5.6	Number of young carers assessments completed during the period		**72**	
5.7	Number of young carers receiving a service @ 31st March		**70**	
5.8	(a) Number of requests for direct payments during the period 1st April – 31st March		**168**	
	(b) Number of new approvals for direct payments during the period 1st April – 31st March		**168**	
	(c) Number of adults receiving direct payments @ 31st March		**187**	
5.9	Number of children receiving direct payments @ 31st March		**206**	
5.9.a	Of those at 5.8 how many of these payments are in respect of another person?		**187**	
5.10	Number of carers receiving direct payments @ 31st March		**5**	
5.11	Number of one off Carers Grants made in-year.		**449**	

Note: sections 5.8, 5.9 and 5.10 are to be reported as mutually exclusive.

Commentary

Trust staff carried out 57 carer assessments for 16/17 year olds.

Action for Children continue to be funded by the HSCB to deliver Young Carer Support in the BHSCT area.

- In 2020/2021 Action for Children worked with **73** young carers in Belfast.

- At the 31st March they were working with **58** young carers with **9** on the waiting list.
- They also completed **15** young carer assessments.

In 2020/2021 **147** Young Carers received a grant from the BHSCT for short breaks to support their health and well-being.

DATA RETURN 9 – PoC / Directorate: Children's Community Services

Nil Return for CCS to avoid duplicate reporting – figures in respect of any Children are reported in either the Mental Health/CAMHS report or Learning Disability report.

9 The Mental Health (NI) Order 1986
Article 4 (4) (b) Article 5 (1) Article 5 (6) Article 18(5) Article 18(6) Article 115

Admission for Assessment Process Article 4 and 5		**TRUST ASW**	**RESWS ASW**
9.1	Total Number of Assessments made by ASWs under the MHO	NIL	See RESWS Report
9.1.a	Of these how many resulted in an application being made by an ASW under (Article 5.1b)	NIL	See RESWS Report
9.1.b	How many assessments required the input of a second ASW (Article 5.4a)	NIL	See RESWS Report
9.1.c	Number of applications made by the nearest relative (Article 5.1.a)		
9.1.d	Can the Trust provide assurance that they are meeting their duties under Article 117.1 to take all practical steps to inform the nearest relative at least 7 days prior to discharge		

Use of Doctors Holding Powers (Article 7)		
9.2	How many times did a hospital doctor use holding powers?	
9.2a	Of these, how many resulted in an application being made?	

ASW Applicant reports		
9.3	Number of ASW applicant reports completed	
9.3.a	*Confirm if these reports were completed within 5 working days* ***YES / NO*** *If no, please explain*	

Social Circumstances Reports (Article 5.6)		
9.4	Total number of Social Circumstances reports completed. *This should equate to number given at 9.1c. If it does not please provide an explanation.*	
9.4.a	Confirm if these reports were completed within 14 days? If no, please explain	

Mental Health Review Tribunal		
9.5	Number of applications to MHRT in relation to detained patients	

Guardianships (Article 18)		
9.6	Number of Guardianships in place in Trust at period end	
9.6.a	New applications for Guardianship during period (Article 19(1))	
9.6.b	How many of these were transfers from detention (Article 28 (5) (b))	
9.6.c	How many were Guardianship Orders made by Court (Article 44)	
9.6.d	Number of new Guardianships accepted during the period (Article 22 (1))	
9.6.e	Number of Guardianships renewed during the reporting period (Article 23)	
9.6.f	Number of Guardianships accepted by a nominated other person	
9.6.g	Number of MHR hearings in respect of people in Guardianship (provide total number)	
9.6.h	Total number of Discharges from Guardianship during the reporting period (Article 24)	

Discharges as a result of an agreed multi-disciplinary care plan	
Lapsed	
Discharged by MHRT	
Discharged by Nearest Relative	
Total	

Approved Social Worker (ASW) Register		
9.7	Number of newly appointed Approved Social Workers during period	
9.7.a	Number of Approved Social Workers removed during period	
9.7.b	Number of Approved Social Workers at period end (who have fulfilled requirements consistent with quality standards)	

9.8	Do any of the returns for detention and Guardianship in this section relate to an individual who was under 18 years old? If yes, please provide number and advise on any issues presenting.	
9.9	How many times during the reporting period has the Trust notified the Office of Care and Protection under Article 107? Please advise of any issues.	

The Mental Health Order (NI) 1986 as amended by The Criminal Justice (NI) Order 1996.SArticle 50A(6). Schedule 2A Supervision and Treatment Orders.		
9.10	Number of supervision and treatment orders, (where a Trust social worker is the supervising officer) in force at the 31st March	
9.11	Of the Total shown at 9.10 how many have their treatment required as: (a) Treatment as an in-patient	
	(b) Treatment as an out patient	
	(c) Treatment by a specified medical practitioner	
9.12	Of the total shown at 9.10 how many include requirements as to the residence of the supervised person (excluding in-patients)	
9.13	Of the total shown at 9.10 how many of these supervision and treatment orders were **made** during the reporting period. Please advise of any issues presenting	

Delegated Statutory Functions

Data Return 10

In order to ensure that there is no duplication in submitting data to HSCB the key below indicates which data should be completed in this return. Data which is sourced from the DSF spreadsheets or HSCB/DoH is indicated by colour coding.

Key to Data Items:-

	This data item is completed in the DSF spreadsheet
	This data item should be completed in this Data return 10
	Other - there is no need to complete this data item and it is sourced from HSCB/DoH

DATA RETURN 10 – PoC / Directorate _Children's Community Services

Please Note: ***Information for this section will inform the Corporate Parenting Report (CC3/02)***

10 Children (NI) Order 1995
Article 18 (2)Schedule 2 Para 1, Article 18 (2)Schedule 2 Para 5(2) ,Article 18 (2)Schedule 2 Para 9, Article 27 (1)(2),Article 27 (1)(2), Article 27 (8), Article 35,Article 36 (1) Article 44,Article 45 (1)(2) ,Article 45 (3)(5)(6)(7)(8), Article 108 (1), Article 118, Article 130,Article 174 ,Article 175, Article 177

10.1 CHILDREN IN NEED

10.1.1 How many Children in Need are there in your area as at 31st March? (exclude children on the caseloads of statutory mental health services)

DSF -Children In Need Spreadsheet

Trend analysis and commentary (Trusts must clarify how they arrive at this total figure, and reference any likelihood of double or under representation)

Data Return 10

Children in Need	2015	2016	2017	2018	2019	2020	2021
As at: 31 March	5739	5153	4262	4331	4088	3546	**3681**
As at: 30 Sept	4939	4778	4272	4179	3844	3528	

10.1.2 Ethnic Origin of Children in Need

DSF -Children In Need Spreadsheet

Ethnicity	Total
White	2508
Chinese	22
Irish Traveller	22
Roma Traveller	9
Indian	8
Pakistani	6
Bangladeshi	3
Black Caribbean	1
Black African	66
Black Other	10
Mixed Ethnic Group	82
Any Other Ethnic Group	65
Not Stated	879
TOTAL	**3681**

10.1.3 Religion of Children in Need

DSF -Children In Need Spreadsheet

Religion	Total
Roman Catholic	1092
Presbyterian	454
Church of Ireland	98
Church of England	11
Methodist	16
Other Christian	320
Jewish	0
Muslim	65
Other	96
Not Known	655
Not Completed	794
None	80
Refused	0
TOTAL	**3681**

10.1.4 (a) How many children have been referred for an Assessment of Need during the reporting period i.e. 1st October – 31st March

DSF -Children In Need Spreadsheet

3422

(b) What was the source of referral for children referred for assessment of need during the reporting period i.e. 1st October – 31st March

See CIN spreadsheet 10.1.4 for referral details

10.1.5 How many children are currently awaiting an Assessment of Need at period end by length of wait (unallocated cases including disability as at 31st March).
Source PMSI data on Unallocated cases – comes with child protection data.

HSCB (PMSI)

10.1.6 How many of these Children in Need are Disabled and known to Trust Social Workers (by major category) at 31st March?
Ensure any specific issues are raised in the Service level summary

DSF -Children In Need Spreadsheet

Major Disability	Total
Physical (Ex. Sensory)	90
Sensory	16
Learning	413
Chronic illness	4
Autism(ASD)/ADHD/Asperger	222
Other	5
TOTAL (With Disability)	**750**

10.1.7 Disabled children known to the Trust who left school during the reporting period and the transition plans that are in place.

DSF -Children In Need Spreadsheet

	Age at leaving school / **Disability Type**	**>16 <17** M: 7, F: 3 / **>17 <18** M: 0, F: 4 / **18+** M: 3, F: 2 / **Number with Transitions in place** M: 10, F: 9
	Physical disability	2 0 / 0 0 / 0 0 / 2 0
	Sensory Impairment	18 8 / 22 6 / 11 8 / 51 22
	Learning disability	0 0 / 1 0 / 0 0 / 1 0
	Chronic illness	4 0 / 6 2 / 1 1 / 11 3
	Autism (ASD)/ADHD / Asperger	0 0 / 0 0 / 1 0 / 1 0
	Other	**31 11 / 29 12 / 16 11 / 76 34**
	TOTAL	
	CWD service users do not leave school at 18. The 18+ represent the children that left CWD service. The children known to CWD service from 16+ will have a transition plan, but will not leave school until 19+, due to special educational needs provision. **27** Young People, of the figures above, represent CWD service users transferred to Adult Services. All users have a Transitions plan.	
10.1.8	How many Children in Need are currently awaiting assessment or treatment with child and adolescent mental health services as at 31st March?	HSCB (PMSI)
	Trend analysis and commentary (Refers to ALL i.e. tiers 2-4 children awaiting CAMHS regardless of the pathway to the waiting list)	
10.1.9	This is intentionally blank	
10.1.10	How many of the Children in Need are Young Carers **147**	Data Return 10
10.1.11	How many young people aged 16 and 17 years presented to the Trust as homeless / or were referred by NIHE to Trust as homeless during the period and their outcome *This is sourced from Client level Data returns sent into HSCB. The data is summarised into a Homelessness spreadsheet which is held in Meridio – Children's information – Homelessness.*	HSCB (Homelessness Data)

<table>
<tr><td>10.1.12</td><td>(a) How many Trust sponsored Day Care Places provided through any means including Article 18, Fostering or others are there for Children in Need at period end

276

(b) How many of these children have a disability

<table>
<tr><td>Day care</td><td colspan="2">Number of Purchased Places by Age</td></tr>
<tr><td></td><td>0 – 4</td><td>5-12</td></tr>
<tr><td>Day Nursery</td><td>235</td><td>0</td></tr>
<tr><td>Playgroup</td><td>0</td><td>0</td></tr>
<tr><td>Childminder</td><td>0</td><td>0</td></tr>
<tr><td>Out of School hours club</td><td>0</td><td>41</td></tr>
<tr><td>Total</td><td>235</td><td>41</td></tr>
<tr><td>No of these children have a disability?</td><td>18</td><td>12</td></tr>
<tr><td></td><td></td><td></td></tr>
</table>
</td><td>DSF-Children In Need Spreadsheet</td></tr>
<tr><td>10.1.13</td><td>Trust usage of Family Centre Places for interventions

84 Referrals in reporting period</td><td>DSF-Children In Need Spreadsheet</td></tr>
<tr><td>10.1.14</td><td>This is intentionally blank</td><td></td></tr>
<tr><td>10.1.15</td><td>Please provide the number of children (if any) subject to a Supervision / Interim Supervision Order at period end (moved from Child Protection section)

5</td><td>DSF -Children In Need Spreadsheet</td></tr>
<tr><td>10.1.16</td><td>During the period, please provide the number of children (if any) that became subject of a Supervision / Interim Supervision Order (moved from Child Protection section)

1</td><td>DSF -Children In Need Spreadsheet</td></tr>
</table>

10.2 Children (NI) Order 1995

Article 18 (2)Schedule 2 Para 1, Article 18 (2)Schedule 2 Para 5(2) ,Article 18 (2)Schedule 2 Para 9, Article 27 (1)(2),Article 27 (1)(2), Article 27 (8), Article 35,Article 36 (1) Article 44,Article 45 (1)(2) ,Article 45 (3)(5)(6)(7)(8), Article 108 (1), Article 118, Article 130,Article 174 ,Article 175, Article 177

CHILD PROTECTION

No data is required for items (10.2.1-10.2.8)– data sourced from HSCB quarterly Child protection Report.

10.2.1 How many children are on the Child Protection Register as at 31st March?
335
Quarterly CP return to HSCB

10.2.2 How many of these children have a learning disability?
0
Quarterly CP return to HSCB

10.2.3 How many of these children have a physical disability?
0
Quarterly CP return to HSCB

10.2.4 Religion of children on the Child Protection Register
Quarterly CP return to HSCB

Religion	Total
Roman Catholic	152
Presbyterian	62
Church of Ireland	6
Methodist	7
Other Denomination	40
None	9
Refused/Unknown	59
Total	335

10.2.5 Ethnic origin of children on the Child Protection Register
(Note new categories now used in quarterly child protection template)
Quarterly CP return to HSCB

Ethnic Origin	Total
White	**283**
Chinese	**0**
Irish Traveller	**0**
Roma Traveller	**0**
Indian	0
Pakistani	3
Bangladeshi	1
Black Caribbean	0
Black African	6
Black Other	0
Mixed Ethnic Group	18
Any Other Ethnic Group	0

	Not Stated: 24 **Total**: 335	
10.2.6	How many registrations have there been during the period? **132**	Quarterly CP return to HSCB/Soscare Reports
10.2.7	How many de-registrations have there been during the period?	Quarterly CP return to HSCB
10.2.8	What percentage of registrations are re-registrations? **19**	Quarterly CP return to HSCB
10.2.9	This is intentionally blank	
10.2.10	For children on the register, how long have they spent on the Register (as at 10.2.1)	Quarterly CP return to HSCB
10.2.11	This is intentionally blank	
10.2.12	This is intentionally blank	
10.2.13	This in intentionally blank	
10.2.14	This is intentionally blank	

Duration		Grand Total
Less than 3 months		7
3 months < 6 months		11
6 months < 1 year		23
1 year < 2 years		39
2 years < 3 years		19
3 years < 5 years		12
Grand Total		111

Duration		Total
less than 3 months		50
3 months < 6 months		72
6 months < 1 year		101
1 year < 2 years		82
2 years < 3 years		21
3 years or more		9
TOTAL		335

10.3 Children (NI) Order 1995

Looked After Children

10.3.1 Provide the current legal status for all Looked After Children at 31st March (excluding any who are LAC on that day only by virtue of a short break arrangement) **875**

DSF – LAC Spreadsheet

Looked After Population March 2014 – March 2021

Looked After Children	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
As at: 31 March	721	742	739	743	766	824	866	**875**
As at: 30 Sept	714	740	763	757	795	826	881	

10.3.2 Ethnic origin of Looked After Children (please provide by new list of ethnic minorities)

DSF – LAC Spreadsheet

Ethnicity	Total
White	751
Chinese	4
Irish Traveller	20
Roma Traveller	3
Indian	0
Pakistani	0
Bangladeshi	0
Black Caribbean	1
Black African	18
Black Other	8
Mixed Ethnic Group	17
Any Other Ethnic Group	30
Not Stated	13
TOTAL	**875**

Religion of Looked After Children

Religion	**Total**
Roman Catholic	395
Presbyterian	181
Church of Ireland	35
Church of England	3
Methodist	3
Other Christian	127
Jewish	0
Muslim	22
Other	19
Not Known	50
Not Completed	15

		None: 15 Refused: 0 **TOTAL: 875**	
10.3.3	Number of Looked After Children (as at 10.3.1) by type of placement at 31st March		DSF – LAC Spreadsheet

Type of placement	Totals
Residential	64
Fostering – (stranger)	231
Fostering (Kinship)	367
Fostering (Independent)	116
Placed at home with parents	70
Placed for adoption	27
Other	0
Total	**875**

10.3.4	Age bands and length of time looked after for all Looked After Children at period end ***See spreadsheet 10.3.4 for details***	DSF – LAC Spreadsheet
10.3.5	Number of children provided with a short break during the period who become Looked After by virtue of the short break arrangement **44**	DSF – LAC Spreadsheet
10.3.6	Number of children accommodated for 3 months or more in a hospital Total – **0** remain at the end of the reporting period. ***See spreadsheet 10.3.6 for details***	DSF – LAC Spreadsheet
10.3.7	Number of children accommodated for 3 months or more in an adult facility. For example Residential Care Home, Nursing Home, Private Hospital **0**	DSF – LAC Spreadsheet
10.3.8	(a) What facilities – statutory, voluntary and private are available to care for these Looked After Children i.e. how many places in residential homes, foster care placements • **40 places in the Trust Statutory 7 mainstream residential facilities;** • **8 regional places for UASC in Aran House;** • **5 (3 available to BHSCT) in the Long term CWD facility;** • **12 (9 available to BHSCT) respite placements;** • **1 voluntary and** • **3 private placements**	DSF – LAC Spreadsheet

<table>
<tr><td></td><td>

- **1 ECR placements**

(b) Provide your number of foster carers (should agree with 10.5.1)
Provide the number of approved places offered (should agree with 10.5.2)
No of foster carers: 572
No of approved places offered:612
</td><td></td></tr>
<tr><td>10.3.9</td><td>
How many Looked After Children have had placement moves throughout the period?
<table>
<tr><th>Placement changes</th><th>0-4</th><th>5-11</th><th>12-15</th><th>16+</th><th>Total</th></tr>
<tr><td>Number who moved once</td><td>5</td><td>25</td><td>14</td><td>19</td><td>86</td></tr>
<tr><td>Number who moved twice</td><td>0</td><td>5</td><td>3</td><td>4</td><td>17</td></tr>
<tr><td>Number who moved 3 times</td><td>0</td><td>0</td><td>2</td><td>3</td><td>6</td></tr>
<tr><td>Number who moved 4 times or more</td><td>0</td><td>1</td><td>0</td><td>1</td><td>8</td></tr>
<tr><td>Total</td><td>5</td><td>31</td><td>19</td><td>27</td><td>117</td></tr>
</table>
Trust must provide an explanation of actions taken to reduce placement moves during the period.

See commentary at 10.3.20
</td><td>DSF – LAC Spreadsheet</td></tr>
<tr><td>10.3.10</td><td>
(a) How many Looked After Children are awaiting assessment or treatment with child and adolescent mental health services at 31st March?

4

(b) How many Looked After Children have been referred for therapeutic services and their waiting time.

65

- **Average Waiting Time – 7 weeks**

See spreadsheet 10.3.10(b) for details
</td><td>DSF – LAC Spreadsheet</td></tr>
<tr><td></td><td>
(c) Please provide actions taken to reduce waiting time.

The current waiting time for CAMHS community is within the elective access target of 9 weeks
</td><td>Data Return 10</td></tr>
<tr><td>10.3.11</td><td>How many Looked After Children are also on Child Protection Register at 31st March?</td><td>Quarterly CP return to HSCB</td></tr>
</table>

	48	
10.3.12	How many Looked After Children are Disabled by major category at period end? **Major Disability** / **Total** Physical (Ex. Sensory) 11 Sensory 4 Learning 69 Chronic illness 2 Autism(ASD)/Asperger's/ADHD 79 Other (undefined) 16 **TOTAL Children With Disability** 181 No Disability known 694 **Total Looked After Children** **875**	DSF – LAC Spreadsheet
10.3.13	How many Looked After Children have a Statement of Educational Needs (SEN) by school status at period end? **Statement of Educational Needs** / **M** / **F** / **Total** Primary school 40 15 55 Secondary school 32 25 57 Special School 40 20 60 **Total** 112 60 **172**	DSF – LAC Spreadsheet
10.3.14	(a) Has each Looked After Child an allocated a named social worker at period end? **No** (b) If no, give number of children and provide an update in the service summary on current position and actions taken **62** - Looked after children did not have an allocated social worker during the period as a result of staff vacancies within the service. A total of 35 cases remained unallocated at the end of the period.	DSF – LAC Spreadsheet
10.3.15	(a) Did each Looked After Child receive a statutory visit by their allocated and named social worker at least once a month during the period? **No** (b) If no, give number of children and provide an update in the service summary on current position and actions taken.	DSF – LAC Spreadsheet

	FS – 12 • 1 child not seen in March 2021 due to them experiencing a family bereavement. • 11 children not seen due to staffing difficulties within the team including vacancies and sick leave. Measures put in place to address this include weekly team meetings to ensure all visits are covered. This has been addressed by the end of the reporting period with 5 out of 6 social work posts filled. **LAC – 60** 60 statutory visits where not completed within the statutory timescale during the reporting period. A combination of staff vacancies, sick leave and redeployment and the resultant caseload pressures within the service have impacted on compliance with this statutory function during the third surge of the covid 19 pandemic. Visits to these children and young people were deferred to take place the following month. In line with the Regional Surge Plan and the Regional Action Card social work teams and line management assessed the need for face-to-face visits in relation to the risks the child faced and the Public Health advice. All of the PSW and SSW worked to ensure that the service was able to respond to any crisis and to implement any actions from the risk assessment. Technology enabled engagement with our children and young people via virtual means and where children and young people were competent in using technology and comfortable communicating with their social worker on their own (age permitting), this was usually facilitated by families. Where it was important to see the child on their own and they were the age where they could use technology, the social worker asked the child to go to a place (mostly their bedrooms) where they could speak. When the risk assessment stipulated that it was critical to see the child on their own and this could not be guaranteed, a face-to-face visit took place.	
10.3.16	No. of Looked After Children Reviews held during the period **884**	DSF – LAC Spreadsheet
10.3.17	Was the case of each Looked After Child reviewed in line with Statutory requirements? **No** If No, please provide number *(in the LAC spreadsheet*) and explain actions taken to address this issue. **(FS) 51** LAC reviews were held outside of timescale and have now taken place. Teams have been reminded about the importance of ensuring LAC reviews take place within the required timescales.	Data Return 10

	Staff illness remains a fluid issue and SSWS are taking appropriate steps to ensure LAC reviews are not postponed because of this reason. Covid19 had a knock on impact on scheduled LAC reviews due to the agreed position during the first lock down regarding routine reviews. These LAC reviews have now taken place. Staffing vacancies continue to be addressed via recruitment campaigns for social workers and this remains an on-going priority. There are weekly Senior Management recruitment meetings to look specifically at the issue/challenge of vacancies and backfill of posts and to continue to agree appropriate actions /ways forward in addressing this issue. **(LAC) - 41** LAC reviews did not take place in line with statutory requirements. 6 due to SW being on sick leave, 34 where delay was due to staff availability as a result of the global pandemic. All meetings were rescheduled at earliest opportunity and all LAC Reviews are now within appropriate timescales **(CWD) – 2** LAC Reviews did not take place in line with statutory requirements due to the Impact of COVID and co-ordination of diaries. The service will now use a tracker to advise compliance and identify visits required before deadlines.	
10.3.18	This is intentionally blank	
10.3.19	This is intentionally blank	
10.3.20	Is there an adequate supply of placements for children to enable placement choice? **No** *(If no, Please explain)* **There is not an adequate supply of placements for children to enable choice. Shortages are particularly found when requiring placements for sibling groups, children with highly complex needs, eg teenagers, pre teenagers, children with complex disabilities, 16/17 years olds with high support needs.** In trying to meet these range of needs the Trust has tried to respond as flexibly as possible through a range of options: • continued use of one of its mainstream children's homes as a home for 8-12 year olds. This has consequently reduced the number of beds available for its usual residential population aged 13-17 yrs. • The Trust is seeking to extend the range of care options for young people age 16 -21 years and have collaborated with the South Eastern Trust to progress the development of flexible outreach support to young people who by virtue of needs, risks or circumstances cannot reside in a shared or group living	Data Return 10

arrangement and who require a bespoke package of outreach support.

- Consider ECR placements for a small group of highly complex young people where their needs cannot be met from within existing provision. The Trust currently is using three ECR placements all of which are out of jurisdiction.
- The Children with Disability Service has been engaged, along with the other Trusts and the HSCB, in the development of a strategic framework for this group of children, which includes consideration of expanding the range of residential provision available. The Trust has had to change the statement of purpose of its short breaks children home, Willow Lodge, to a medium term children's home and currently has two children with highly complex needs placed in it as there are no other placements available.
- There is currently one young person who is on a delayed discharge from Iveagh Assessment and Treatment Centre due to a lack of suitable community accommodation. A Business case has been completed and submitted to the HSCB outlining the need to support the family to move house so that this young person can be returned to their care.

The Fostering Service has undertaken a number of initiatives to help address the shortage of Fostering placements including:

Fostering Service Response - The age profile and needs profiles of young people requiring out of home placement is regularly reviewed and incorporated into recruitment plans with the objective that that the needs of children referred are appropriately met.

The Fostering Service has a dedicated kinship team to enable children to remain within extended family if assessed to be in a child's best interests. A specialist Adolescent Fostering Scheme is in operation that provides placements for young people aged 12-18 years.

All registered foster carers are approved for various age ranges, including sibling groups, and for both short term and long term duration dependent on children's assessed needs and also on the ability of the carers to offer various types of foster care.

The fostering service in partnership with children's disability service has developed a disability scheme which assesses applicants who can meet the very specific needs of children with disabilities. The scheme has three carers (1 f/t, 1shared care and 1 short breaks) who provide placements to children who have been identified as requiring foster placements by the Children's Disability teams.

At the point of referral, attempts are made to match children to carers taking into account carers skills and capacity, child's views,

	geographical considerations, birth family contact, cultural and identity needs and education. In the event of an emergency placement being required, placement choice can be limited and dependent on carer availability at that given time. However no such placements would be made without the agreement of the child's social worker and will be reviewed immediately in terms of attempting to identify a more suitable alternative placement, if required. The Fostering Service is continually promoting and seeking to identify "emergency carers" who are available to provide these type of placements for a minimum of 3 weeks to allow more appropriate matching of placements to occur for any child placed in an emergency however this is dependent on the volume of emergency referrals received into fostering and the amount of emergency carers available is limited. The PACCS service also provides a short break "time out" scheme for young people aged 12-18 years living in the community who are experiencing "crisis". A time out with a PACSS foster carer and the frequency and timescale for time out is again based on the needs of the young person and their families The PACCS service also has a dedicated service for Kinship carers who are experiencing difficulties. Along with providing support this service allows access to the PACCS foster carer Fostering Service has utilized the Extern Time Out service which allows Look After Children a short break when experiencing crisis in placement. This has been extremely beneficial in easing some of the pressures on placements as a result of the Covid pandemic The fostering service have an intensive fostering scheme for children who have more complex, challenging needs. To date, there 7 intensive foster carers approved for this scheme. The type of children placed within this scheme range from having complex disabilities to children who have significant needs due to either their own adverse child hood experiences or as a result of multiple foster placement moves. This scheme will target potential carers for those children who are currently placed in ECR placements outside of the jurisdiction and children within our own specialist unit. The fostering service also has a parent and baby scheme which provides a foster placement to a young parent (up to the age of 21 years old) with their baby, This is an assessed placement which provides support a parent and baby within a community based foster placement for a 12 week period. The Fostering Service had also developed and manages the fostering scheme for the recruitment and support of Carers for	

	Unaccompanied Asylum Seeking Young people. This has been successful in providing care placements for young people from this group and follows a period of assessment of need in a specialist residential Home. In partnership with the new Supported Lodgings Project, Fostering are assisting in the recruitment and the assessment of Host Carers for older young people. This will again provide more diversity and choice on placement options available to young people in care.	
10.3.21	How many exceptions to the normal fostering limit were made to foster care approvals in order for a child to be placed in an emergency in the reporting period? **NONE**	DSF – LAC Spreadsheet
10.3.22	This is intentionally blank	
10.3.23	How many children are deemed to be in an inappropriate placement given their assessed needs? *(Please explain)* **Total: 13** • 3 children placed in emergency placements requiring short-term placements. • 3 children placed in temporary bridging placements and requiring a short-term placement. • 1 child in a temporary bridging placement and requiring a long-term placement. • 4 children placed in short-term placements and requiring long-term placements. • 1 child is a delayed discharge in Iveagh • 1 child is placed in Willow Lodge on a full time basis due to a lack of appropriate community placement	DSF – LAC Spreadsheet
10.3.24	Please provide the number of restraints carried out by staff on young people within **each** Home during the period. ***See spreadsheet 10.3.24 for the details***	DSF – LAC Spreadsheet
10.3.25	Do all looked after children have a concurrent plan by the time of their first 3 month statutory LAC Review ? **No** Two children's care plans are rehabilitation.	Data Return 10
10.3.26	Permanency Planning for Looked After Children at period end ***See Attached Spreadsheet 10.3.26*** **Permanency Plan** | **Total**	DSF – LAC Spreadsheet

	Return to Birth Family	**70**
	Return to Kinship Carers outside LAC system (Friend/Relative/Family Placement)	**3**
	Adoption	**65**
	Long term Fostering (Including Kinship)	**528**
	Supported Living/Independent Living	**22**
	Other	**90**
	Total	**778**
	Number of children not included above as they have been in care for less than 9 months	**97**
	Total	**875**
	Number where plan has been in place for 12 months or more and yet to be achieved	66
10.3.27	This is intentionally blank	
10.3.28	This is intentionally blank	
10.3.29	(a) How many Looked After Children are involved in offending behaviour (are formally cautioned or convicted)	DSF – LAC Spreadsheet

Formal process	M	F	**Total**
Cautioned	9	6	15
Remanded	3	1	4
Convicted	5	0	5
Total	17	7	**24**

and

(b) How many Looked After Children are suspected to use drugs and/or alcohol?

Substance use	**M**	**F**	**Total**
Use Alcohol	1	17	18
Use Drugs	6	1	7
Use Drugs and Alcohol	21	7	28
Total	28	25	**53**

10.3.30	This is intentionally blank	

10.3.31	This is intentionally blank	
10.3.32	What progress are children making at school and what are their examination results – School Year Ended 30th June 2020 (this will be collected in September Data Return only) ***(HSCB will source this directly from DoH)***	DOH
10.3.33	Looked After Children, School Attendance – School Year Ended 30th June 2020 ***(HSCB will source this directly from DoH)***	DOH
10.3.34	(a) Number of children notified to the police as having gone missing from residential or foster care for 24 hours or more? ***(This data will be sourced directly from the Untoward Event Report)***	Untoward Events database, HSCB
	(b) How many Looked After Children have been reported to the Police for reasons ***other*** than having gone missing for 24 hours or more during the period? (This table should be completed for each Residential Facility, it is not required for Foster Carers) ***See Spreadsheet 10.3.34(b)*** **5 children and 23 events**	DSF – LAC Spreadsheet
10.3.35	Number of children accommodated by ELB for 3 months or more by category **0**	DSF – LAC Spreadsheet
10.3.36	(a) Number of Sibling groups accommodated: • Together – 124 • Not accommodation together at period end – 108	Data Return 10
10.3.37	Number of young people admitted to Secure Accommodation and the reasons for admission during the period *This data is sourced directly from Lakewood (it will be forwarded by South Eastern Trust) – after this reporting period the data will be sourced from the Regional Secure panel which is located within HSCB*	Lakewood/ Regional Panel
10.3.38	Please provide report into the operation of the Trusts Restriction of Liberty Panel *This data is collected annually and sourced from a Restriction of Liberty report (it comes in with DSF). The data will be sources from the Regional Secure Panel going forward – panel began on 1.9.19.*	Lakewood/ Regional Panel

10.3.39	(a) During the period how many children or young people became a Looked After Child by age, gender and first placement **Total – 90 (54 Male + 36 Female)** ***See Attached Spreadsheet 10.3.39 for the details*** (b) To your knowledge have any of the children admitted during the period been subject to a full Adoption Order **None** (c) Of those children at 10.3.39(a) admitted to care during the period how many have previously been on the Child Protection Register in the last 2 years from the period end date **47** (d) Number of Children and Young People who became Looked After during the period had a CLA1 form completed and forwarded to School? **15** (e) Can you confirm that all the above admissions to care are properly recorded and do not include what should rightly be reported as a placement move (e.g. a fostering breakdown where the RESWS moves the child to a children's home) **Yes**	DSF – LAC Spreadsheet
10.3.40	(a) During the period how many children or young people became a Looked After Child by age, gender and legal status on admission; ***See Attached Spreadsheet 10.3.40 for details*** (b) (i) Were these admissions planned, unplanned or emergency; (ii) Of those that were unplanned or emergency how many were admitted to kinship foster care? **17** (iii) Of those unplanned or emergency admissions how many were admitted by RESWS? **9**	DSF – LAC Spreadsheet

Admissions	**Total**
Planned	39
Unplanned	16
Emergency	35
Total	**90**

10.3.41 During the period how many children or young people ceased to be Looked After by age, gender and length of time looked after at discharge

98

DSF – LAC Spreadsheet

10.3.42 (a) Of all the children and young people reported at 10.3.41 what was their destination at discharge by age and gender

Destination	Total
Returned to Parents/Siblings	47
Returned to Relatives/friends	17
Adopted	3
Independent living/Tenancy (NIHE/H Assoc./Private etc)	1
Foster Carers (GEM)	14
Jointly Commissioned Supported Accommodation Projects	7
Bed + Breakfast	1
Hostel, Foyer	0
Supported Board and Lodgings	2
Prison, Hospital	0
Other	6
Total	**98**

(b) Of those 16+ year olds who ceased to be Looked After during the period what was their entitlement to Leaving Care Services by age and gender

Category	16		17		Total		
	M	F	M	F	M	F	Total
Number entitled to access Leaving Care Services	2	2	19	12	21	14	35
Number not entitled to access Leaving Care Services	1	1	1	1	2	2	4
Total	**3**	**3**	**20**	**13**	**23**	**16**	**39**

DSF – LAC Spreadsheet

10.3.43 This is intentionally blank

10.3.44 (a) Please provide the total number of children that became subject of a Residence Order during the period.

5

DSF – LAC Spreadsheet

<table>
<tr>
<td></td>
<td>For (a) above please give the number of children that were formerly placed with Stranger (Foster Carers), Kinship (Foster Carers), Residential Care or other placement.

<table>
<tr><th>Placement</th><th>No. of Children</th></tr>
<tr><td>Stranger (Foster Carers)</td><td>0</td></tr>
<tr><td>Kinship (Foster Carers)</td><td>5</td></tr>
<tr><td>Residential Care</td><td>0</td></tr>
<tr><td>Other placement</td><td>0</td></tr>
<tr><td>Total</td><td>5</td></tr>
</table>

(b) How many Residence Orders are in place at period end?

180</td>
<td></td>
</tr>
<tr>
<td>10.3.45</td>
<td>Number of Children or Young People who died during the current reporting period and were Looked After by the Trust by cause/age

0</td>
<td>DSF – LAC Spreadsheet</td>
</tr>
</table>

Note: Sections 10.3.41 to 10.3.43 should include all discharges including those reported in section 10.4

10.4 CHILDREN (LEAVING CARE) ACT (NI) 2002

Article 34E, Article 34F

10.4.1 Number of young people subject to Leaving Care Act by category, age and gender

395

See Attached Spreadsheet 10.4.1 for details

DSF-16+ Spreadsheet

10.4.2 Of those eligible young people reported at 10.4.1 give the Children Order Legal Status at period end.

Age reference table will automatically update as spreadsheets completed.

DSF-16+ Spreadsheet

Legal Status	16	17	Total
Accommodated (Article 21)	5	13	18
Care order (Art 50 or 59)	45	56	101
Interim Care Order (Art 57)	2	0	2
Deemed Care Order	0	0	0
Other	0	2	2
Total	**52**	**71**	**123**

Category	16	17	18	19	20	21+	Total
Eligible	52	71	0	0	o	0	123
Relevant	6	4	0	0	0	0	10
Fmr Relevant	0	0	55	64	71	65	255
Qualifying	0	0	1	3	0	3	7
Total	**58**	**75**	**56**	**67**	**71**	**68**	**395**

10.4.3 This is intentionally blank

10.4.4 This is intentionally blank

10.4.5 This is intentionally blank

10.4.6 Of the young people reported at 10.4.1

(a) What are the social worker and personal adviser arrangements in place for each category of young people?

DSF-16+ Spreadsheet

Category	Named Social Worker only	Named Personal Adviser only	Named Social Worker and Personal Adviser	Awaiting allocation of a social worker	Awaiting allocation of a personal adviser
Eligible	101	0	20	2	103
Relevant	3	1	0	0	6
Former Relevant	5	180	70	0	0
Qualifying	0	4	3	0	0

(b) Of the young people with a named personal adviser, how many have a Person Specific Personal Adviser?

Category	Of the young people with a named Personal Adviser - how many have a person Specific Personal Adviser
Eligible	**14**
Relevant	**1**
Former Relevant	**0**
Qualifying	**0**

(c) How many do not have an up to date Pathway Plan at period end?

Category	**No. without an Up to Date Pathway Plan**
Eligible	0
Relevant	0
Former Relevant	0
Qualifying	0
Total	**0**

10.4.7 Of the young people reported at 10.4.1 how many do not have a completed needs assessment and how long have they been waiting at period end?

DSF-16+ Spreadsheet

Category	No. Without a completed Needs Assessment	<3 Months	3-6 Months	7-12 Months	<1 Year
Eligible	0	0	0	0	0
Relevant	0	0	0	0	0
Former Relevant	0	0	0	0	0
Qualifying	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**

10.4.8 Summary of failure to comply as detailed in 10.4.6, 10.4.7 at period end.

Currently there are 109 young people awaiting allocation of personal advisor, which is an increase of n=47 since the previous reporting period and an increase of n=6 from the same reporting period in March 2020. The Trust acknowledges the continued challenges in meeting this statutory function. Factors influencing the allocation of a personal advisor include, the increased trajectory in the number of looked after children, late entrants into care and the unaccompanied minors. This continued increase in demand on services is compounded by the Trust experiencing challenges with the availability of Personal Advisors in the workforce as a result of recruitment issues and availability of personal advisors capacity, due to clinical vulnerability during the covid pandemic. Within the next review period the Trust will undertake a review of the systems in place to track and monitor the allocation of Personal Advisors, and progress the recruitment of this essential workforce.

It is of note that the Trust has reduced the number of outstanding pathway plans during this reporting period and there is currently no young person without an updated pathway plan.

Data Return 10

10.4.9 Of the young people reported at 10.4.1 what are their living arrangements at period end? Please complete for
(a) Eligible;
(b) Relevant;
(c) Former Relevant; and
(d) Qualifying young people

10.4.9 (a) <u>Eligible</u> Young People - Living Arrangements

Placement Type	16	17	Total
Foster Placement (Stranger)	24	20	44
Foster Placement (Kinship)	14	16	30
At Home In Care	6	8	14
Residential Children's Home	7	15	22
Secure Care	0	1	1
Specialist Residential Placement (NI/UK)	1	0	1
Hospital	0	1	1
Jointly Commissioned	0	5	5

DSF-16+ Spreadsheet

Supported Accommodation Projects			
Unregulated Placement	0	4	4
Other	0	1	1
Total	**52**	**71**	**123**

10.4.9 (b) Relevant Young People - Living Arrangements

Living Arrangements	16	17	Total
Tenancy (NIHE/H Assoc./Private)	0	0	0
At Home with Parents/Siblings	5	2	7
Jointly Commissioned Supported Accommodation Projects	0	0	0
Relatives/friends	1	2	3
Hostel, B+B, Foyer	0	0	0
Supported Board and Lodgings	0	0	0
Halls of residence/Student Accommodation	0	0	0
Prison	0	0	0
Other	0	0	0
Total	**6**	**4**	**10**

10.4.9 (c)Former Relevant Young People - Living Arrangements

Living Arrangements	18	19	20	21+	Total
Former Foster Carers (GEM)	12	15	16	12	55
Tenancy (NIHE/H Assoc./Private)	6	15	27	26	74
At Home with Parents/Siblings	8	12	9	7	36
Jointly Commissioned Supported Accommodation Projects	18	11	3	0	32
Relatives/friends	3	4	5	6	18
Hostel, B+B, Foyer	5	2	3	4	14
Supported Board and Lodgings	2	2	0	0	4
Halls of residence/ Student Accommodation	0	0	1	6	7
Prison	0	0	2	1	3
Other	1	3	5	3	12
Total	**55**	**64**	**71**	**65**	**255**

10.4.9 (d) Qualifying Young People - Living Arrangements

Living Arrangements	16	17	18	19	20	21+	Total
Former Foster Carers (GEM)	0	0	0	0	0	0	0
Tenancy (NIHE/H Assoc/Private)	0	0	0	0	0	2	2
At Home with Parents/Siblings	0	0	0	0	0	0	0
Jointly Commissioned Supported Accommodation Projects	0	0	0	1	0	0	1
Relatives/friends	0	0	0	1	0	0	1
Hostel, B+B, Foyer	0	0	0	0	0	0	0
Supported Board and Lodgings	0	0	0	1	0	0	1
Halls of residence/Student Accommodation	0	0	0	0	0	0	0
Prison	0	0	1	0	0	0	1
Other	0	0	0	0	0	1	1
Total	**0**	**0**	**1**	**3**	**0**	**3**	**7**

10.4.10 Of the young people reported at 10.4.1 what is their current education, training and employment status, and how many are being supported financially at period end?' 10.4.10
(a) Eligible;
(b) Relevant;
(c) Former Relevant; and
(d) Qualifying young people

DSF-16+ Spreadsheet

10.4.10 (a) Education Training and Employment Status of Eligible Young People

ETE Status	16	17	Total	No. Receiving financial support
Secondary Level Education	43	20	63	7
Further Education	3	12	15	8
Training (Govt. sponsored training)	3	14	17	13
Pre-Vocational	0	1	1	1
Employment	0	1	1	0
ETE Inactive	1	15	16	0
Training (Non Govt. sponsored training)	2	7	9	7
Other(Sick/Disabled, Parent, Carer)	0	1	1	0
Total	**52**	**71**	**123**	**36**

10.4.10 (b) Education, Training, Employment of Relevant Young People

ETE Status	16	17	Total	No. Receiving Financial support
Secondary Level Education	6	2	8	0
Further Education	0	1	1	0
Training (Govt. sponsored training)	0	0	0	0
Pre-Vocational	0	0	0	0
Employment	0	1	1	0
ETE Inactive	0	0	0	0
Training (Non Govt. sponsored training)	0	0	0	0
Other	0	0	0	0
Total	**6**	**4**	**10**	**0**

10.4.10 (c) Education, Training, Employment of Former Relevant Young People

ETE Status	18	19	20	21+	Total	No. Receiving Financial support
Secondary Level Education	7	1	0	0	8	5
Further Education	9	6	8	15	38	21
Higher Education	0	3	4	11	18	15
Training (Govt. sponsored training)	13	10	8	3	34	16
Pre-Vocational	0	1	2	1	4	3
Employment	2	12	18	12	44	2
ETE Inactive	16	21	23	17	77	1
Training (Non Govt. sponsored training)	8	9	6	5	28	13
Other	0	1	2	1	4	0
Total	**55**	**64**	**71**	**65**	**255**	**76**

10.4.10 (d) Education, Training, Employment of <u>Qualifying</u> Young People

ETE Status	16	17	18	19	20	21+	Total	No. Receiving Financial support
Secondary Level Education	0	0	0	0	0	0	0	0
Further Education	0	0	0	0	0	1	1	0
Higher Education	0	0	0	0	0	0	0	0
Training (Govt. sponsored training)	0	0	0	0	0	0	0	0
Pre-Vocational	0	0	0	0	0	0	0	0
Employment	0	0	0	0	0	0	0	0
ETE Inactive	0	0	1	3	0	2	6	0
Training (Non Govt. sponsored training)	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0
Total	**0**	**0**	**1**	**3**	**0**	**3**	**7**	**0**

10.4.11 Of the young people reported at 10.4.1 how many were convicted during this reporting period? — DSF16 S/Sheet

In Total:

- **17 Cautioned**
- **10 Formally Remanded**
- **15 Convicted during the reporting period.**

See Attached Spreadsheet 10.4.11 for details

10.4.12 Of the young people reported at 10.4.1 how many have a disability by major disability – physical, sensory, learning, chronic illness, Autism (see definition) and other, type and gender at period end?' — DSF-16+ S/Sheet

Type of Disability	Total
Physical (Ex. Sensory)	7
Sensory	0
Learning	31
Chronic illness	2

Autism(ASD)/Asperger/ADHD	32	
Other (undefined)	9	
No Disability	314	
Total	**395**	

See Attached Spreadsheet 10.4.12 for details

10.4.13 Of the young people reported at 10.4.1 what is their parental status at period end?' — DSF-16+ S/Sheet

Parental Status	No of Young People
Parent	30
Lone Parent	20

10.4.14 'Of the young people reported at 10.4.1 how many are receiving treatment for mental health issues at period end? Of these, how many were new referrals to mental health services during the period? — DSF-16+ S/Sheet

Mental Health Concerns	No. of Young People waiting for or receiving Mental Health interventions/services	Number of new referrals to mental health intervention/services during period (1.10.20 - 31.3.21).
Mental Health Concerns	71	39
Self-Harm	6	4

10.4.15 Number of Young People who are no longer Looked After but who died during the current reporting period and were in receipt of aftercare services by cause/age. — DSF-16+ S/Sheet

- **1 young person died (cancer)**

10.5 FOSTERING

10.5.1	(a) How many foster carers are registered with the Trust at period end? **572** How many of the carers above also provide a GEM placement? **18** Of the carers above how many are Prospective adopters dually approved as foster carers? **35** Of the Prospective Adopters/Dually Approved carers above how many are Concurrent Foster/Adoptive Carers? **3** (b) Please give the number of other foster carers; Independent Provider Foster Carers **83** Carers providing care only to children with a disability and who are not available to provide care for Looked After Children: **3 (1 fulltime carer, 1 shared care, 1 short breaks)** No. of kinship foster care households who are in the process of being assessed as kinship carers for a child/ren placed in their care who have not been presented for approval at the Trusts' Fostering Panel : **73** (c) Please give a breakdown of the number of foster carers de-registered during the period and the reason; **25** • 5 due to placement breakdown • 1 carers moved to adoption • 7 were granted Residence Orders in respect of the Looked After Children placed with them • 5 no longer wishing to foster • 6 Child rehabilitated home • 1 following an allegation	DSF-Foster care Spreadsheet

(d) Please advise of the recruitment process activity during the period;

	Kinship	Non Kinship	Total
Numbers receiving information packs	0	0	0 All enquirers are directed to the HSC website as per regional agreement
Number of Initial Home Visits	0	25	25
Numbers of Households attending Skills to Foster course	0	25	25
Number of Completed Assessments during the period	51	13	64
Number of these assessments that were already approved as Adopters.	0	3	3

(e) Please give the number of regional enquirers received by the Trust

53

10.5.2 For the foster carers return at 10.5.1 how many **places** are they registered for and the number of vacant places at period end. Please also provide the number of fostering households that have no child placed with them at period end.

DSF-Foster care Spreadsheet

714 Places
57 Vacant places
35 Households with no child placed at period end
There are 38 Professional Fee-Paid Carers but only 37 Places

	A fee paid carer who provides intensive short breaks didn't have a child in placement at the reporting point	
10.5.3	How many foster carers have annual reviews outstanding? 39 Please provide the number of viability visits undertaken during the reporting period. (moved from 10.5.1f) 64	Data return 10 DSF-Foster care Spreadsheet
10.5.4	Please provide specific actions being taken by the Trust to ensure outstanding reviews are completed The reduction of outstanding Annual Reviews has been a priority for the service. The level of outstanding Annual Reviews has been linked to staffing depletion within the Kinship team following the retirement of four full time social workers and challenges in recruiting at this time. A strategy is in place that all unallocated kinship cases have been allocated out across all teams within the Fostering Service and nominated social workers must complete the outstanding annual reviews as a priority. This strategy has included the sourcing of additional administrative support and all outstanding Annual Reviews have now been booked and scheduled over the coming weeks for completion. The backlog should be addressed by the end of April 2021.	Data return 10
10.5.5	What action is being taken to maintain and increase the range, diversity and supply of foster care places During this reporting period, the Belfast Trust continues to lead on and manage the HSCNI Adoption and Fostering Service and as such is involved in the 3 work streams that are operational to develop a recruitment and retention strategy. This Central Service promotes collaborative working across all Trusts to develop collectively beneficial recruitment activity. This activity has been significantly impacted by the restrictions of Covid but in the reporting period a number of innovative recruitment activities using virtual platforms have been progressed. This had been achieved through creative use of technology and on line presentations presented by professional staff and compiled in partnership with the Marketing and Communications Departments.	Data return 10

	Due to the standing down of face to face events, the marketing strategy relied on digital and advertising activity and used advertising to thank the commitment and dedication of the foster carers. There has been increased use of other Covid safe marketing tools such as radio interviews, face book and online activity and newspaper articles that seek to capture the interest of people who may be willing to assist in increasing the range diversity and supply of placements to the Trust and regionally. Skills to Foster training has been developed on line and there has been a significant increase of carers undertaking this as the backlog created through Covid restrictions in March 2020, has been addressed and reduced Internally, weekly placement review meetings ensure appropriate placements are made to meet the individual needs of the Looked after Child, matched with the skill base of foster carers to avoid minimum disruption or placement moves when Looked after Children are being matched for placements. These review meetings also take cognizance of Looked after Children placed within private agencies and this is reviewed to ensure there is no “drift” in care planning of children placed outside of Trust placements. Bi-monthly review meetings are also held with private agencies to ensure the needs of children placed with these agencies disruptions in a timely fashion with these agencies to ensure contingency planning is implemented to avoid any unnecessary additional placement moves Regular review of recruitment activity is undertaken to ensure that carers are recruited to meet the needs of children referred i.e. requirement for full time carers, sibling groups, children with learning or disability needs and carers who can provide permanent care. Activity to ensure foster placement supply also includes: • Identification of early signs of potential disruption and timely access to therapeutic and support services. • Ensuring foster carers are fostering within their agreed registration to avoid overload and potential disruption. • Timely referral of children to permanence panel. This enables regular monitoring of care plans,	

	exploration of potential permanence options for children, thus reducing multiple moves. • Quarterly review meetings with Adoption to ensure children requiring adoptive placements that are currently within short term foster placements are identified and approximate timescales given to ensure projected availability planning for fostering and placements required. • Ensuring timely delivery of permanence plans. • Involvement in the on-going development of therapeutic model of care to identify long term foster placements to meet the needs of children aged 8-12 in Osbourne House. • Recruitment of Intensive foster carers who foster children with significant and complex disabilities and also young people who are on the higher threshold of risk presenting behaviours. • Recruitment of parent and child foster carers who assess a parent's capacity to parent their child through a 12 week assessment period.	

10.5 PRIVATE FOSTERING

The Children Order (NI) 1995 - Part X

[redacted]

10.5.6	What steps has the Trust taken to encourage notifications? **0**	DSF-Foster care Spreadsheet
10.5.7	How many Private Fostering Arrangements under Article 106 are in place within the Trust as at the 31st March? **0**	DSF-Foster care Spreadsheet
10.5.8	How many Private Fostering notifications under Article 106 has the Trust received during the period? **0**	DSF-Foster care Spreadsheet
10.5.9	Please provide DOB and Date notification was received in respect of each child/young person reported at 10.5.8 **0**	DSF-Foster care Spreadsheet
10.5.10	Of the notifications received (10.5.8) how many has the Trust accepted? **0**	DSF-Foster care Spreadsheet
10.5.11	Of those notifications not accepted please summarise reasons and action taken by the Trust **0**	DSF-Foster care Spreadsheet
10.5.12	Number of appeals made during the year under Article 113 **0**	DSF-Foster care Spreadsheet
10.5.13	Are supervisory visits undertaken in accordance with Regulation 3(1)(a) and (b) as a minimum to children privately fostered? Please provide details of any circumstances where the Regulation has not been adhered to. **0**	DSF-Foster care Spreadsheet
	Notifications under Regulation 4 of the Children (Private Arrangements for Fostering) Regulations (NI) 1996	
10.5.14	How many notifications has the Trust received in respect of children being adopted from abroad i.e. Intercountry Adoption within the period. **0**	DSF-Foster care Spreadsheet
	Please specify the child's DOB and the date the Trust received each notification	DSF-Foster care Spreadsheet

10.6 Adoption (NI) Order 1987
Adoption (Intercountry Aspects) Act (NI) 2001

Article 3(as amended by HPSS Order 1994), Article 11

10.6.1	(a) Number of enquiries, by type, received by the Trust and what prompted their initial approach? **41** • 23 - Central Website • 3 - Newspaper Advertisement • 1 - Radio Advertisement • 14 – 'word of mouth' (f) Please provide the waiting time from initial inquiry to commencement of training **3 -more than 1 month < than 3 months** **7 -more than 3 months < less than 6 months** **5 -more than 6 months < than 12 months** **3 -more than 1 year**	DSF-Adoption Spreadsheet
10.6.2	Number of domestic applications for assessment received by the Trust by civil status of applicant **Household type** / **No.** Single carer: 3 Cohabitating heterosexual couple (where this is a joint application): 0 Cohabitating same sex couple (where this is a joint application): 0 Married: 6 **Total: 9**	DSF-Adoption Spreadsheet
10.6.3	Number of Prospective Domestic Adopters awaiting assessment at period end, length of time waiting, and reason waiting **10** **3 – waiting less than 3 months (No Social Worker available)** **5 – waiting between 3-6 months (No Social Worker available)** **2 - Applicants not ready to proceed**	DSF-Adoption Spreadsheet
10.6.4	Number of inter-country applications for assessment received by the Trust by civil status of applicant ***(to be completed by NHSCT on behalf of the region)***	DSF-Adoption Spreadsheet
10.6.5	Number of Prospective Inter-country adopters awaiting assessment at period end ***(to be completed by NHSCT on behalf of the region)***	DSF-Adoption Spreadsheet
10.6.6	Of all adoption assessments (both domestic and inter country) completed during the period please give details of the outcomes **9 completed**	DSF-Adoption Spreadsheet

<table>
<tr><td></td><td>

- **1 counselled out in assessment process**
- **7 Households approved as Dual Carers/ Concurrent Carers**
- **1 Household approved – previously Foster Carers**

</td><td></td></tr>
<tr><td>10.6.7</td><td>Number of looked after children freed for adoption and not yet placed with their prospective adopters as at 30th September; and duration of wait since freeing order as granted

0</td><td>DSF- Adoption Spreadsheet</td></tr>
<tr><td>10.6.8</td><td>(a) Activity under the Adoption (NI) Order 1987 during the period; Of the number above please give the number who were adopted in a Hague designated country and therefore not through the Courts in NI and have had their Article 23 reports completed in the time period;

0
Please provide the number of Freeing Orders made during the reporting period;

8 (Article 18 without Agreement)

(b) Of those children who were adopted this period please give the length of time from becoming looked after (last episode) to going to live with the family who went on to adopt them.

• 6 months < 1 yr =1
• 1< 2 years = 2</td><td>DSF- Adoption Spreadsheet</td></tr>
<tr><td>10.6.9</td><td>Please provide the number of children who, at period end, had received a best interest decision for adoption and had not been placed with approved adopters (either adopters, dual approved carers including concurrent carers) and the duration of that wait

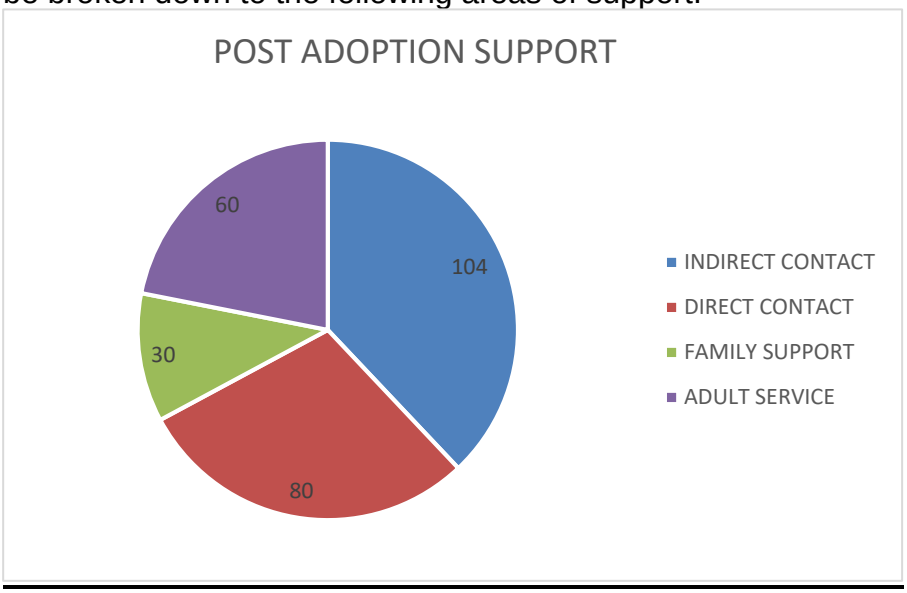
<table>
<tr><th>Children who have received a best interest decision and have not been placed with approved adopter.</th><th colspan="2">1-4 years</th></tr>
<tr><th></th><th>M</th><th>F</th></tr>
<tr><td>Less than 1 month</td><td>1</td><td>0</td></tr>
<tr><td>More than 1 month less than 3 months</td><td>4</td><td>1</td></tr>
<tr><td>More than 3 months less than 6 months</td><td>2</td><td>2</td></tr>
<tr><td>More than 6 month less than 12 months</td><td>1</td><td>4</td></tr>
<tr><td>1 year or more</td><td>0</td><td>2</td></tr>
<tr><td>Total</td><td>8</td><td>9</td></tr>
</table>
</td><td>DSF- Adoption Spreadsheet</td></tr>
<tr><td>10.6.10</td><td>How many children are in receipt of an Adoption Allowance at 30th September and how many households is this?

91</td><td>DSF- Adoption Spreadsheet</td></tr>
</table>

10.6.11	Of the number at 10.6.10 how many commenced during the period and how many households is this? **7 Households (8 children)**	DSF-Adoption Spreadsheet
10.6.12	Details of recruitment, assessment, training, support for prospective adopters **Analysis** Belfast Health and Social Care Trust continue to receive enquiries that progress to initial social work visits, preparation to adopt training and then on to assessment. Enquiries during the COVID-19 pandemic to adoption services have risen dramatically. To accommodate the increasing numbers the preparation to adopt course was facilitated virtually through Microsoft Teams in October 2020 and again in March 2021. This course is intensive and usually takes place over two and a half days. Due to the virtual nature of the course delivery, this timescale was amended to 5 morning sessions. The course covers the following areas: The adoption assessment Legal context Routes to adoption Contact Attachment Trauma Therapeutic parenting Children's needs and experiences Separation and loss Telling Post adoption support Resources Adoption services have responsibility for the recruitment, assessment and support of concurrent carers. There is a high demand from social workers for concurrent placements and the numbers of carers open to considering concurrency as their preferred adoption pathway is steady. The Trust have in the last reporting period approved 4 couples for concurrency and made 2 concurrent placements. There are 15 assessments of prospective adopters currently ongoing. Adoption services has a small bank of experienced staff who assist in the completion of adoption assessments. This has reduced the length of time prospective adopters have to wait to be assessed. This has also enabled Belfast Trust to create a pool of approved prospective adopters who can meet the needs of our	Data Return 10

	adopted children and reduce the need to place children in cross Trust placements. In the reporting period there are 11 prospective adopters on our adoption register awaiting a placement. All our approved adopters who are approved by our adoption panel as concurrent/dually approved carers are offered additional training which incorporates the Skills to Foster course. Adoption services also have an established "in house" learning and development programme for prospective adopters who have completed the preparation to adopt course. This takes place bi monthly and covers the following topics: The Importance of Play Attachment and Trauma Transitions/Preparing for placement Medical and developmental conditions of children Understanding behaviours Telling and Life story work In addition to these, Belfast Trust invite our approved adopters when they receive a placement to participate in our Nurturing Attachments programme. All of our approved adopters avail of regular support from their social worker and are signposted and referred when necessary to TSS, Trauma Centre, TESSA, Child care centre and Adoption UK support groups and training opportunities. Adoption services in Belfast also facilitate a bi-monthly support group for adoptive mums at all stages of the placement process (concurrent/dually approved/placed for adoption/adopted) which is led by the adopters. Feedback from this group is very positive and has led to improvements in our service design and delivery. Eg development of a buddy scheme, family fun days, young person's support group etc.	
10.6.13	Details of Post Adoption Support - this section should include data in respect of the number of and action taken in respect of placement breakdowns both pre (i.e. where adoption is the Care Plan) and post Adoption Order	Data Return 10
	Analysis The Belfast Trust Post Adoption Team continue to strive to provide a high quality post adoption service to ensure stability and positive wellbeing for adopted children and their families. The Post Adoption Team is passionate about delivering a service that not only recognises the needs of children and their parents but also provides a continuum of support that extends to adult adoptees and their birth relatives.	Data Return 10

274 clients are availing of post adoption support services. This can be broken down to the following areas of support:



Indirect contact

104 children are currently being supported with indirect contact arrangements. During the reporting period, 50 exchanges occurred. There arrangements are managed by a social worker within the team and involves the administrative role of exchanging letters between adoptive parents, adopted children and birth relatives. The service also offers support to all persons involved in the arrangements to write letters and to manage the range of emotions that may be triggered when letters are exchanged. A high number of birth parents avail of this support.

Direct Contact

60 families are receiving support with direct contact arrangements. Contact whilst beneficial for children, can also be challenging for all those involved. High levels of support is required to ensure contact is a positive and purposeful experience for all those involved. The supports provided include:

- Supervising/Monitoring contact.
- Preparation work with adoptive families on how best to support their child before and after contact occurs.
- Preparation and support work with birth parents and relatives to manage their emotions and feeling in managing contact arrangements.
- Helping the adults involved remain empathetic and understanding of each person's role in the child's life.
- Reviewing contact arrangements
- Assessing risk

Over half of the families receiving support with post adoption contact arrangements also availed of a family support service in addition to this.

Family Support Service

A family support services has been provided to **30** families.

The service strives to provide a provision of a mix skill set amongst the team to provide both practical and therapeutic support to families. Services vary in kind and intensity dependent upon the presenting need and fragility of the family situation at point of referral. Provisions provided during the reporting period have included:

- One to one support and guidance in helping parents to respond to their child's behaviours using a therapeutic model of parenting.
- Emotional support to parents in times of stress
- Educative work with extended families on how best to support adopted child and their parents.
- Direct work with children in the areas of life-story work, managing anxiety and providing a therapeutic space to explore thoughts and feelings.
- Working with schools to provide advice on how best to support children in the school environment.
- Assistance in accessing other services such as TESSA, Extern, CAMHS.
- Consultations with Trust psychology services to review families' support needs.
- Support to birth family wishing to establish contact with adopted children.
- Accessing specialist assessments.

The Pandemic has placed significant stress on parents as they manage the emotional impact of this event on their children as well as the impact on themselves. In response to the increasing pressures on parents, the Post Adoption Service has offered 10 parents the opportunities to avail of a 6 week mindfulness course aimed at helping relieve stress. It is anticipated that this will commence in May 2021.

Training

During the reporting period, Life story training was provided through MS Teams. 10 families availed of this training and feedback provided by attendees was very positive. This course was offered to address a presenting challenge that the service identified as emerging among adoptive parents. There was a lack of confidence and knowledge about sharing information relating to a child's early life experiences and it was identified that parents

	were also emotionally impacted by having to fulfil this parenting task. Parents identified as most in need of this training were offered it first and it is the plan to offer this training to all adoptive parents following an Adoption Order being granted. The Service is committed to improving parent's awareness of the supports available to them and being proactive in encouraging parents to avail of support at the earliest opportunity. A Post Adoption Team Manager, now attends the Preparation to Adopt Course to outline the services available to parents and vitally begin the early development of growing a positive mind-set regarding accessing support and availing of training prior to challenges arising. It is important for parents to understand the goal of the team to equip them with the skills to meet the challenges that are specific to parenting through adoption, so they feel confident in their ability to respond when such challenges arise. A post adoption support leaflet has been devised and is now circulated to all adoptive parents following an Adoption Order being granted. The Post Adoption Team managers continue to attend all placement review meetings to establish relationships with families before an Adoption Order is secured. The Post Adoption Team strives to ensure all families who require support, receive this at the earliest possible opportunity. All children known to the Adoption team, have a post adoption support plan devised prior to an Adoption Order being granted. The information is maintained on a database and parents are invited by the Post Adoption Team to have their child's support plan reviewed annually. The effectiveness of reviewing annually all post adoption support plans, to address the challenge the Service faced with regards to parents not accessing support early when difficulties arose ,is still being measured given the infancy of this new initiative. The team continues to work towards expanding therapeutic services available to families through developing the skills and expertise within the team. In November 2020 a further 2 members of the post adoption team were trained in DDP Level 1. As a result of this additional training, families accessing a parenting support service have been provided with opportunities to engage in one to one sessions with a social worker using DDP principles. To-date, this model of support appears to be effective particularly in working with fragile families. The team will continue to evaluate over the coming year, the benefits of using DDP informed practice as a planned intervention for working with adoptive parents. In February and March 2021 all members of the post adoption team attended training on therapeutic Life Story work with younger children and 3 members of staff attended training on therapeutic	

	Life Story work with teenagers. This facilitated staff delivering life story training to adoptive parents as outlined in this report. Many of the families that the team work with, report concerns about their child's emotional development. This is not unexpected give the complex trauma adopted children experience prior to being placed for adoption. There is much greater awareness within all Services for LAC and adopted children, of the importance of delivering trauma informed integrated services. The Post Adoption Service continues to strive to provide a holistic and multidisciplinary response to the support provided to families in need. The team work closely with the Trust therapeutic service to provide opportunities for families to have both social work and psychology support through combined one to one support sessions with parents when relevant. Consultations held also includes other disciplines such as mental health services, schools, occupational therapists, to ensure collaborative working and the best available knowledge/expertise from a range of disciplines to facilitate the child's recovery and build resilience. **Adult Services** The team is currently providing a service to **60** adult service users. This involves both adult adoptees and birth relatives wishing to learn more about their origin or birth relatives wishing to search for an adoptee. **Duty System** The Post Adoption Team operate a duty system Monday – Friday 9-5pm which can be accessed by adoptive parents in the Belfast Trust area. This can be used as a one off period of support / advice regarding a specific parenting issue or to make a self-referral for more intensive support. Referrals from other professionals requesting support for a child can be made through the duty system also. The duty system can also be accessed by adult adoptee's or birth relatives requiring a service or by other professionals wishing to make a referral on behalf of an adoptee or birth relative. **Adoption Breakdowns** There has been no adoption breakdowns in the reporting period.	
10.6.14	This is intentionally blank	

10.7 EARLY YEARS

10.7.1 Please provide the current early years provision / places, registrations and de-registrations
Include Number of Approved Home Child Carers

DSF-Early Years Spreadsheet

Sector	Total number of services	Total number of placements
Day Nursery	101	4430
Out of School within Day Nursery	57	1567
Total Day Nursery Places		**5997**
Stand-Alone Crèche	15	207
Stand-Alone Playgroup	49	1412
Stand-Alone Out of School	58	1955
Childminder	260	1575
Approved Home Child carers	65	0
Holiday Scheme	7	216
Two year old Programme	24	312
Total	**636**	**17671**

10.7.2 Registration issues and commentary as at period end
(If any challenges or issues please provide a brief analysis)

Data Return 10

As a result of Covid restrictions we are working through a backlog of inspections.

10.7.3 Total number of annual Inspections required, number carried out, number outstanding and time outstanding as at 31st March

DSF-Early Years Spreadsheet

Sector	No Requiring Inspections	No Inspections carried out	Inspections still to be carried out
Day Nursery	103	22	81
Crèche	15	3	12
Playgroup	50	7	43
Out of School	59	9	50
Childminder	283	142	141
Holiday Scheme	8	0	8
Two year old Programme	24	4	20
Total	**542**	**187**	**355**

** Number of inspections carried out remotely only – **50**

<table>
<tr>
<td>10.7.4</td>
<td>Number of outstanding applications for each of the above categories as at 31st March?

<table>
<tr><th>Sector</th><th>0-3mths</th><th>4-6mths</th><th>7-9mths</th></tr>
<tr><td>Day Nursery</td><td></td><td></td><td>1</td></tr>
<tr><td>Crèche</td><td></td><td></td><td></td></tr>
<tr><td>Playgroup</td><td></td><td></td><td></td></tr>
<tr><td>Out of School</td><td>1</td><td></td><td></td></tr>
<tr><td>Childminder</td><td>1</td><td>3</td><td></td></tr>
<tr><td>Holiday Scheme</td><td></td><td></td><td></td></tr>
<tr><td>Two year old Programme</td><td></td><td></td><td></td></tr>
<tr><td>Total</td><td>2</td><td>3</td><td>1</td></tr>
</table>
.</td>
<td>DSF-Early Years Spreadsheet</td>
</tr>
<tr>
<td>10.7.5</td>
<td>Number of current applications being assessed at period end and duration of assessment

2

2 childminders being assessed and duration of assessment is between 4- 6 months</td>
<td>DSF-Early Years Spreadsheet</td>
</tr>
</table>

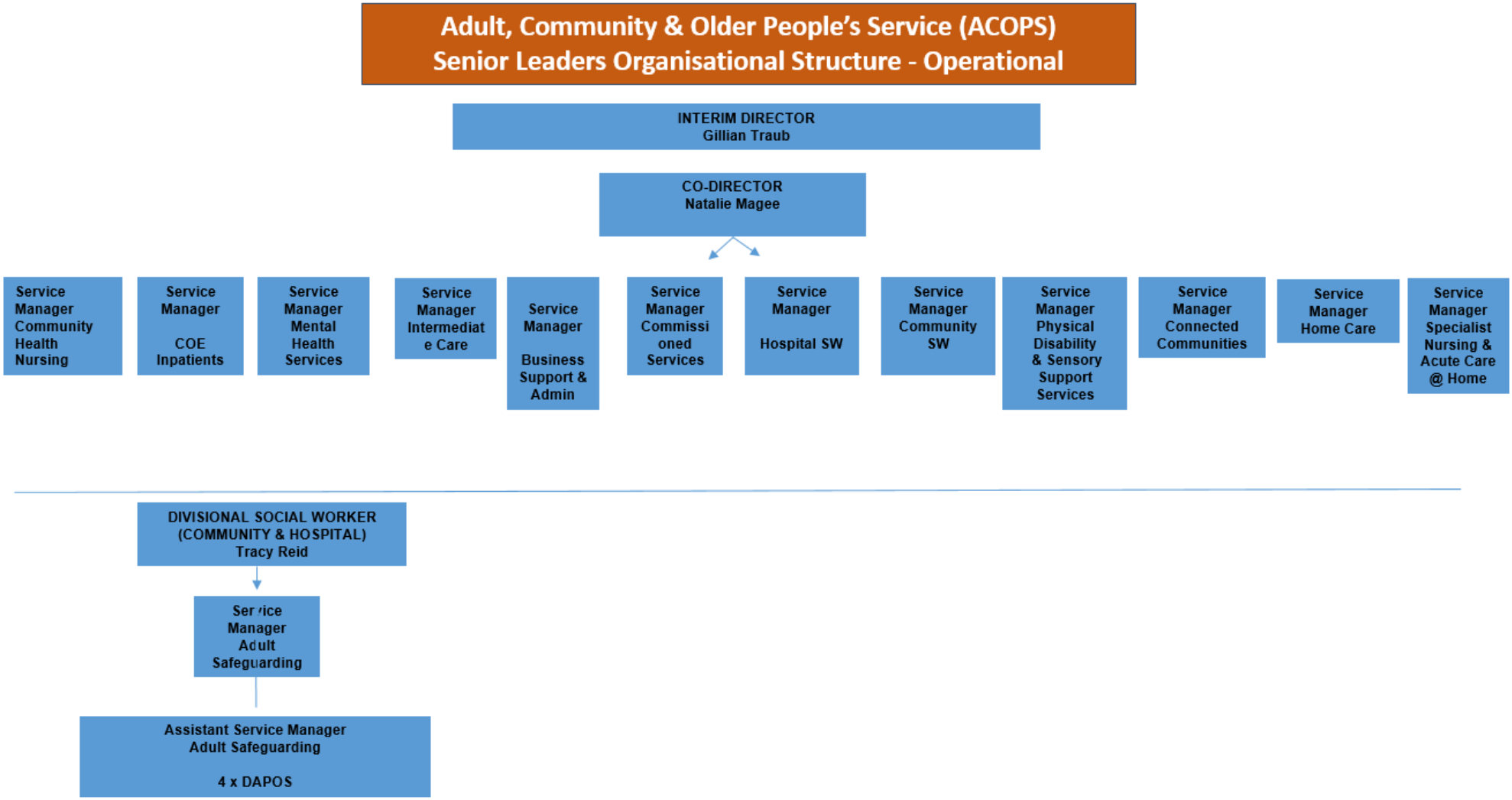
	10.8 Complaints & Representation	
10.8.1	Does the Trust have an appropriately authorised and experienced children's complaints officer? Yes/No **Yes**	Data Return 10
10.8.2	Does the Trust have an independent advocacy service for children and their families? Yes/No Children, parents and carers are encouraged to access a range of independent advocacy provision including: the Northern Ireland Commissioner for Children and Young People; the Commissioner for Complaints; VOYPIC; the Children's Law Centre; and the Patient Client Council in pursuance of any complaint in respect of services provided by the Trust. The Trust has engaged VOYPIC to provide an advocacy service to its residential units. Trust foster carers access the advocacy and representation services of the Fostering Network.	Data Return 10
10.8.3	Please confirm arrangements are in place to ensure that all complaints – both formal and informal – from children and their families are recorded and dealt with? We can confirm arrangements are in place to ensure that all complaints, formally and informally are recorded and dealt with from children and their families. All complaints received are dealt with in accordance with the Trust's Complaints Procedure and the Handbook of Policy and Procedures Volume 5 Children Order (NI) 1995, Representation and Complaints. The Trust's Corporate Governance processes provide robust reporting and scrutiny arrangements in relation to individual Directorate's management of complaints and arrangements for the dissemination and sharing of learning emerging from complaints	Data Return 10
10.8.4	Please confirm whistle-blowing arrangements are in place to ensure that concerns raised by staff working in children's services are recorded and dealt with? The Trust can confirm that whistle –blowing arrangements are in place. The Directorate of Children's Community Services has two whistle blowing champions. The Trust's Whistle Blowing Policy provides the framework within which concerns raised by staff are	Data Return 10

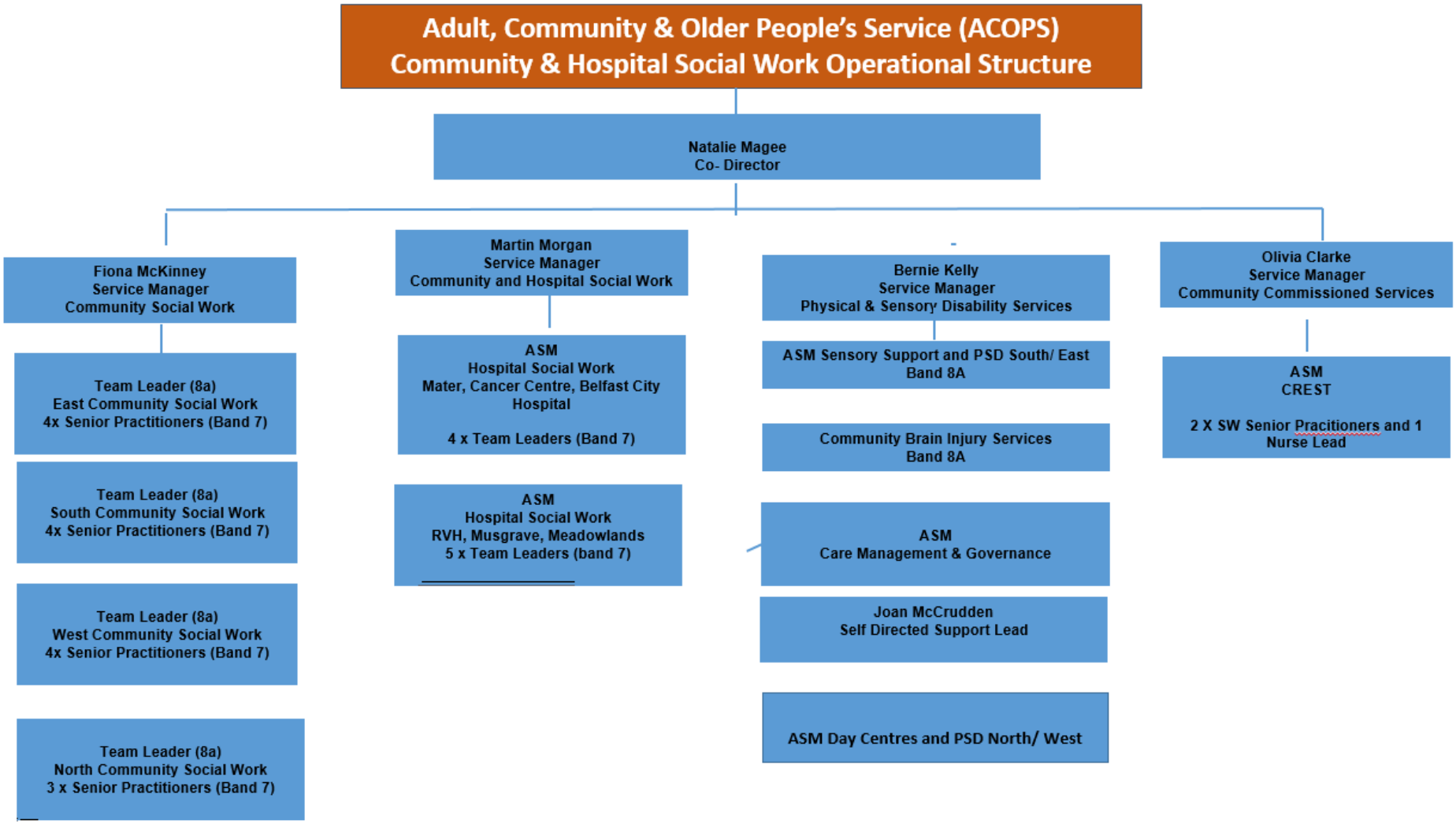
	recorded and dealt with. The Policy fully adheres to the requirements specified in the Public Interest Disclosure (NI) Order 1998		
10.8.5	This is intentionally blank		
10.8.6	This is intentionally blank		
10.8.7	This is intentionally blank		
10.8.8	This is intentionally blank		
10.8.9	This is intentionally blank		

10.9 SEPARATED CHILDREN

10.9.1	Number of separated children referred to Gateway Teams by status of children for this period (self-reported age at presentation)	HSCB Separated Children Database

Appendix 1: Directorate/Programme of Care Structure Chart - Older People's Services




Adult, Community & Older People's Service (ACOPS)
Community & Hospital Social Work Operational Structure
Natalie Magee
Co- Director
Fiona McKinney
Service Manager
Community Social Work
Team Leader (8a)
East Community Social Work
4x Senior Practitioners (Band 7)
Team Leader (8a)
South Community Social Work
4x Senior Practitioners (Band 7)
Team Leader (8a)
West Community Social Work
4x Senior Practitioners (Band 7)
Team Leader (8a)
North Community Social Work
3 x Senior Practitioners (Band 7)
Martin Morgan
Service Manager
Community and Hospital Social Work
ASM
Hospital Social Work
Mater, Cancer Centre, Belfast City Hospital
4 x Team Leaders (Band 7)
ASM
Hospital Social Work
RVH, Musgrave, Meadowlands
5 x Team Leaders (band 7)
Bernie Kelly
Service Manager
Physical & Sensory Disability Services
ASM Sensory Support and PSD South/ East
Band 8A
Community Brain Injury Services
Band 8A
ASM
Care Management & Governance
Joan McCrudden
Self Directed Support Lead
ASM Day Centres and PSD North/ West
Olivia Clarke
Service Manager
Community Commissioned Services
ASM
CREST
2 X SW Senior Pracitioners and 1 Nurse Lead

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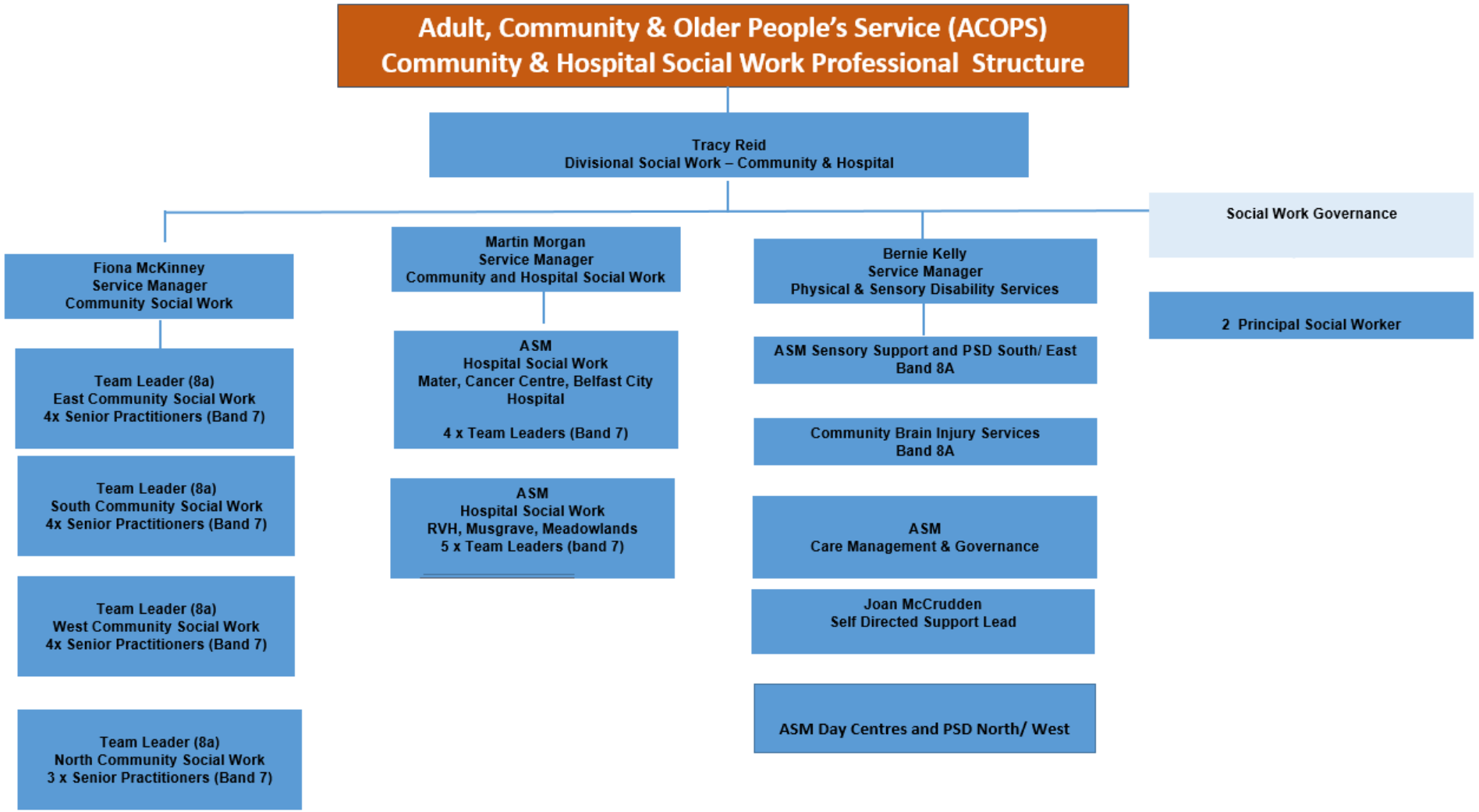
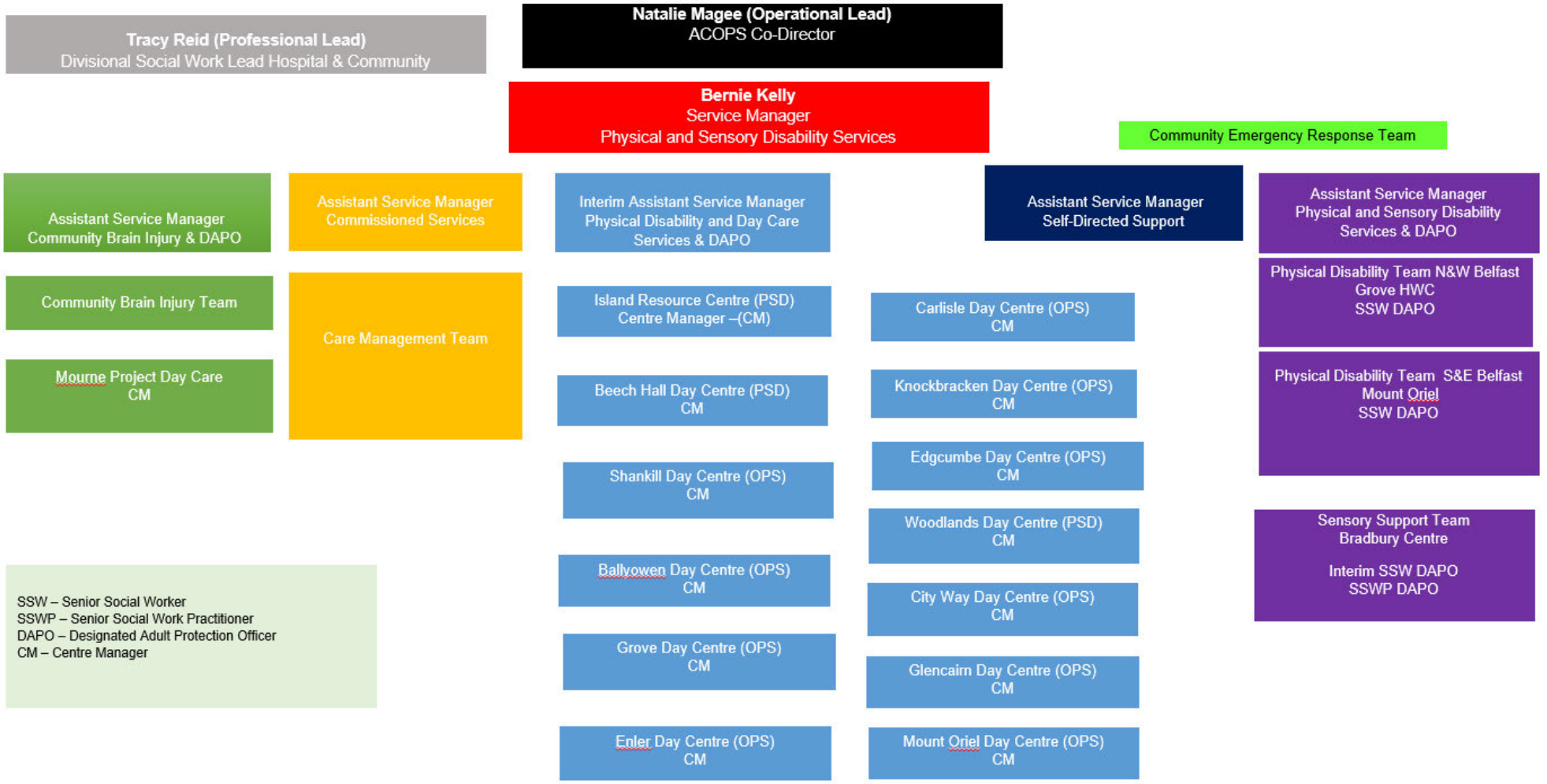
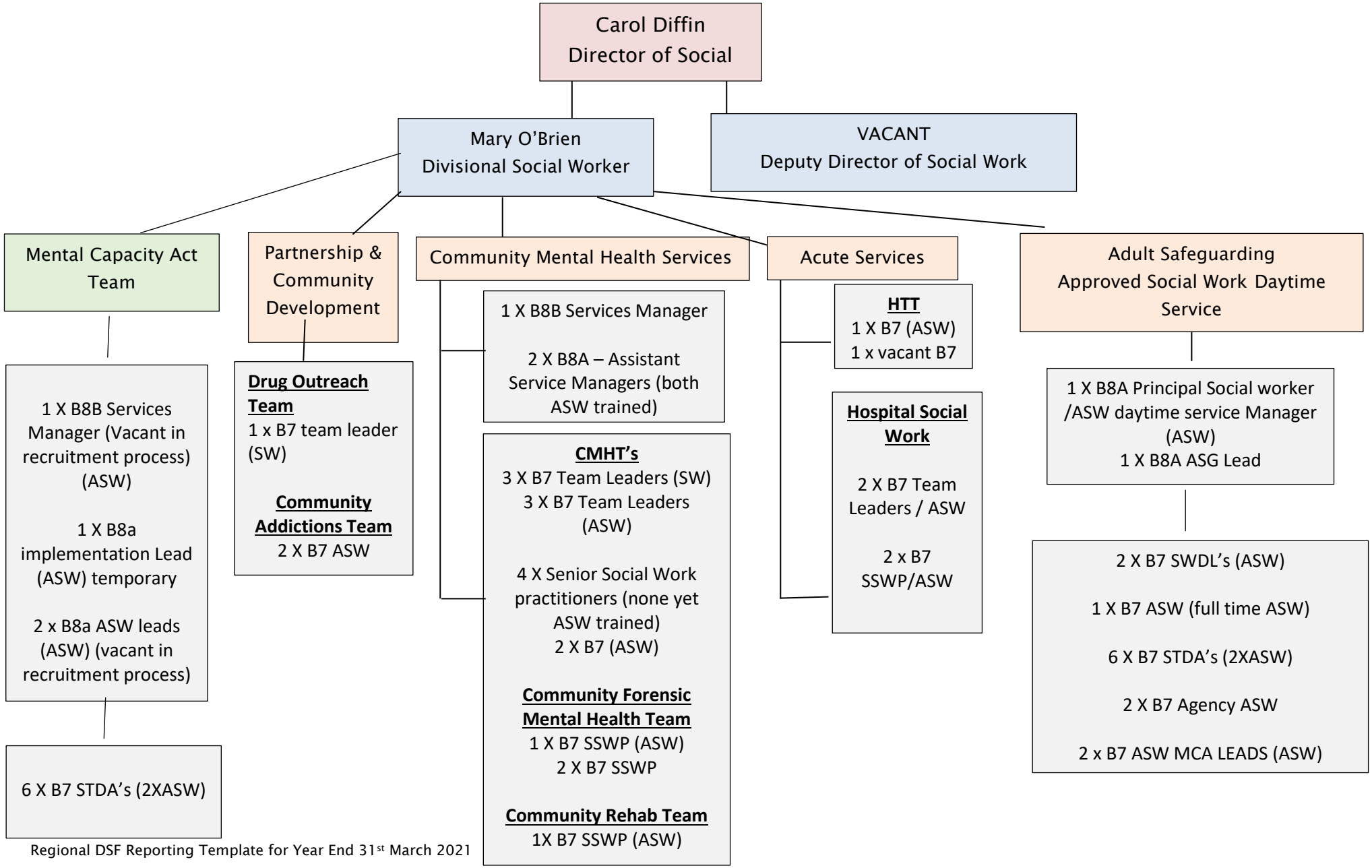
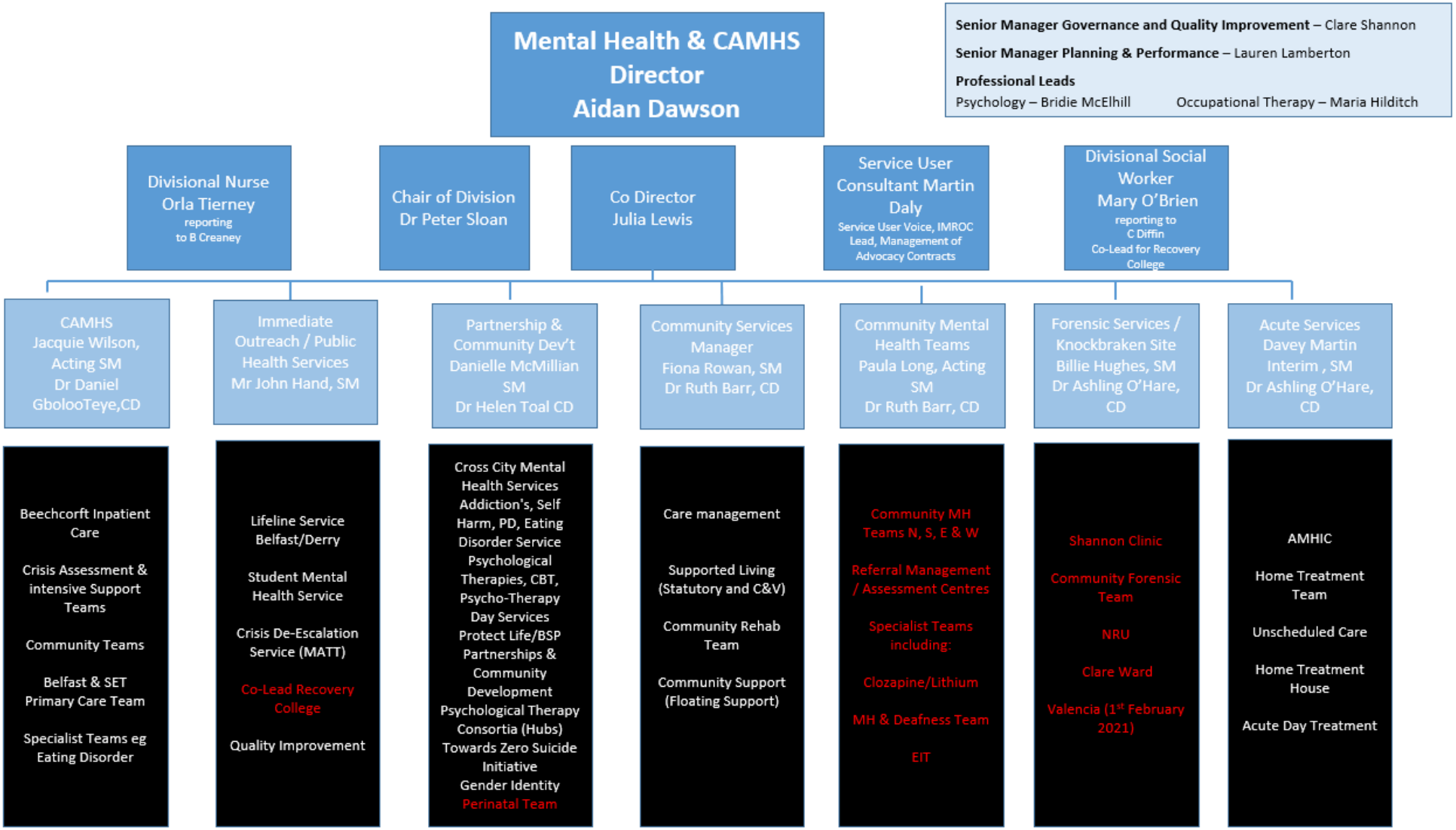


Appendix 2: Directorate/Programme of Care Structure Chart - Physical and Sensory Services

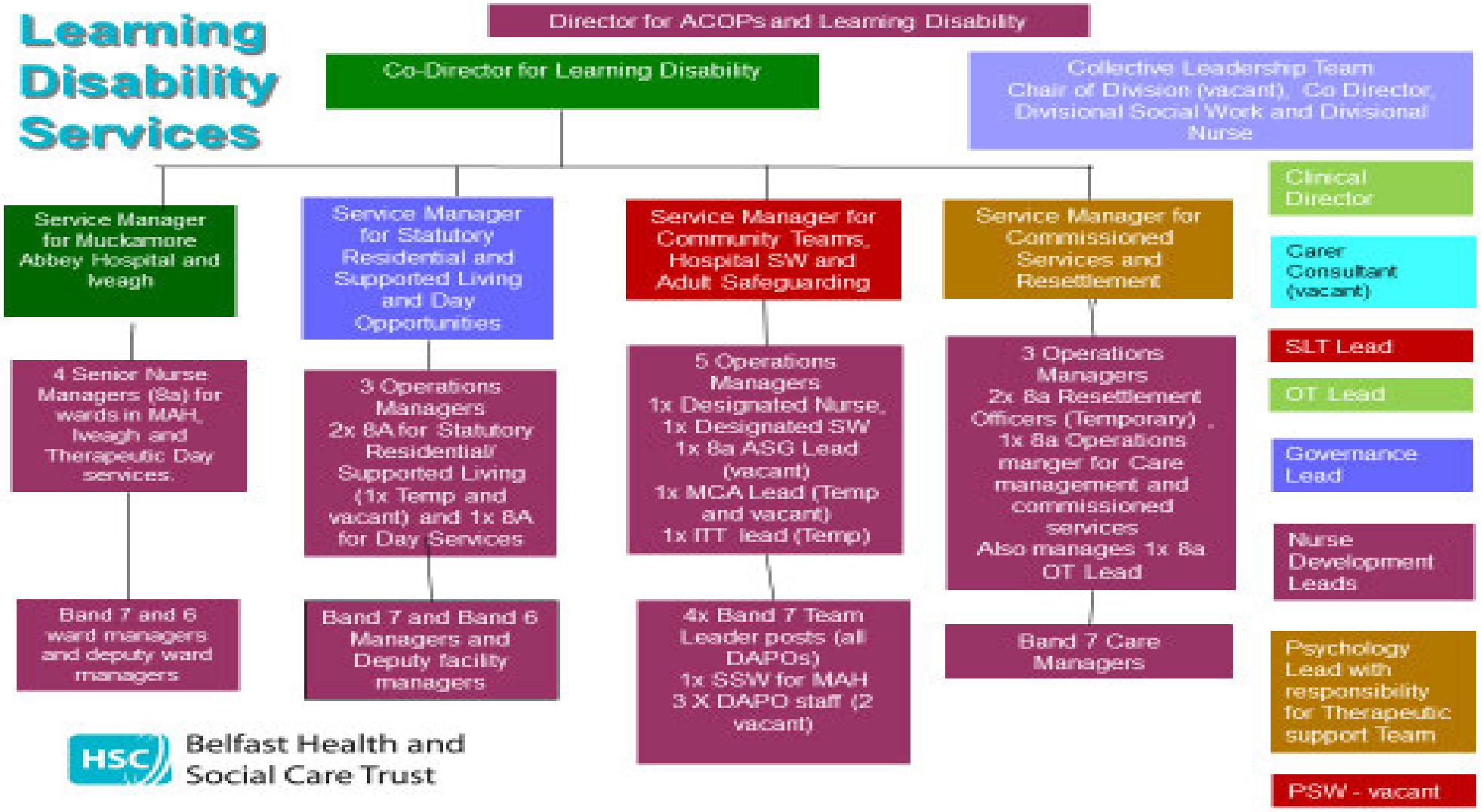


Appendix 3: Directorate/Programme of Care Structure Chart - Mental Health Services

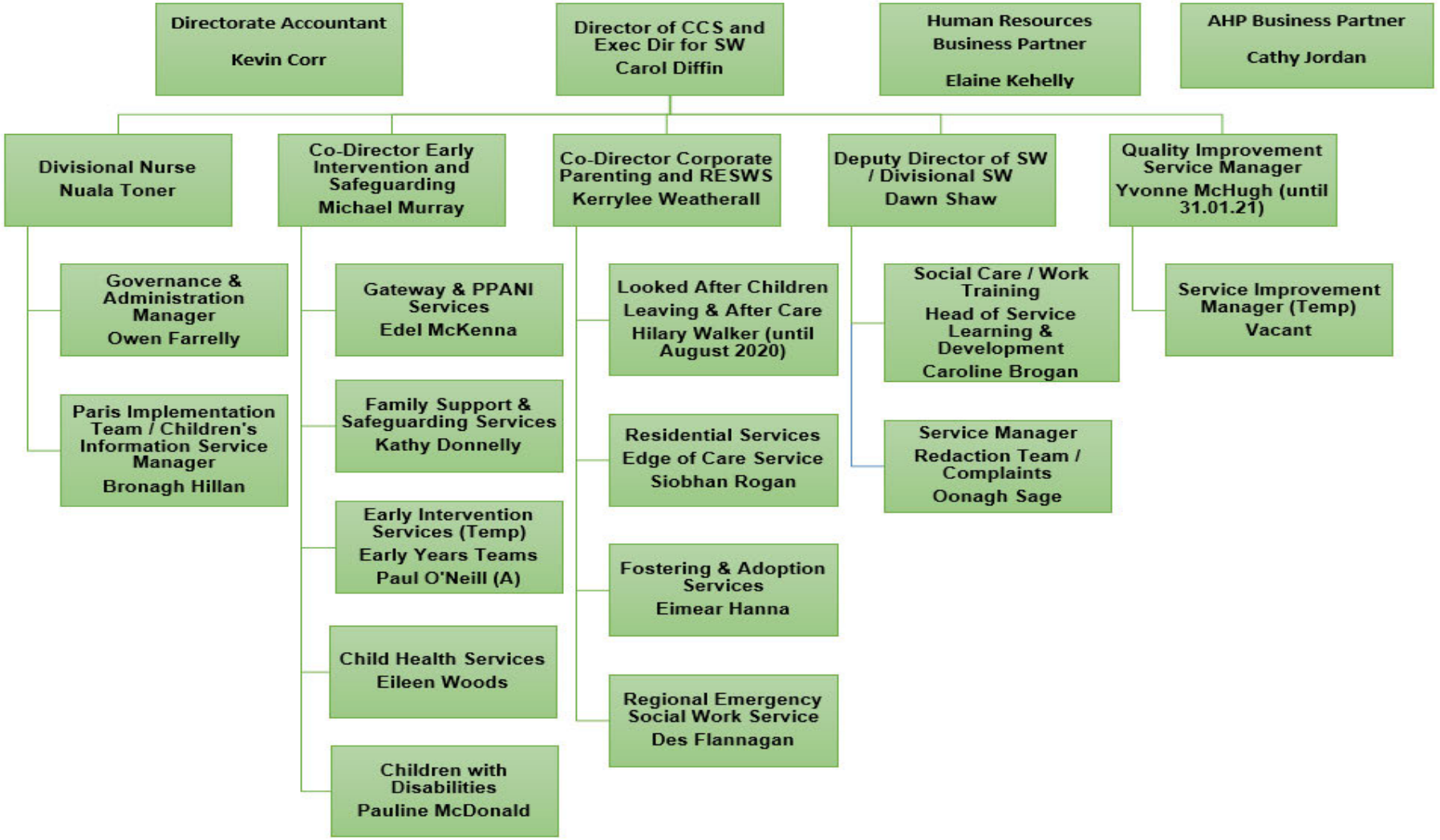



Mental Health & CAMHS Director
Aidan Dawson
Senior Manager Governance and Quality Improvement – Clare Shannon
Senior Manager Planning & Performance – Lauren Lamberton
Professional Leads
Psychology – Bridie McElhill
Occupational Therapy – Maria Hilditch
Divisional Nurse Orla Tierney reporting to B Creaney
Chair of Division Dr Peter Sloan
Co Director Julia Lewis
Service User Consultant Martin Daly Service User Voice, IMROC Lead, Management of Advocacy Contracts
Divisional Social Worker Mary O'Brien reporting to C Diffin Co-Lead for Recovery College
CAMHS Jacquie Wilson, Acting SM Dr Daniel GbolooTeye,CD
Immediate Outreach / Public Health Services Mr John Hand, SM
Partnership & Community Dev't Danielle McMillian SM Dr Helen Toal CD
Community Services Manager Fiona Rowan, SM Dr Ruth Barr, CD
Community Mental Health Teams Paula Long, Acting SM Dr Ruth Barr, CD
Forensic Services / Knockbraken Site Billie Hughes, SM Dr Ashling O'Hare, CD
Acute Services Davey Martin Interim , SM Dr Ashling O'Hare, CD
Beechcorft Inpatient Care
Crisis Assessment & intensive Support Teams
Community Teams
Belfast & SET Primary Care Team
Specialist Teams eg Eating Disorder
Lifeline Service Belfast/Derry
Student Mental Health Service
Crisis De-Escalation Service (MATT)
Co-Lead Recovery College
Quality Improvement
Cross City Mental Health Services Addiction's, Self Harm, PD, Eating Disorder Service Psychological Therapies, CBT, Psycho-Therapy Day Services Protect Life/BSP Partnerships & Community Development Psychological Therapy Consortia (Hubs) Towards Zero Suicide Initiative Gender Identity Perinatal Team
Care management
Supported Living (Statutory and C&V)
Community Rehab Team
Community Support (Floating Support)
Community MH Teams N, S, E & W
Referral Management / Assessment Centres
Specialist Teams including:
Clozapine/Lithium
MH & Deafness Team
EIT
Shannon Clinic
Community Forensic Team
NRU
Clare Ward
Valencia (1st February 2021)
AMHIC
Home Treatment Team
Unscheduled Care
Home Treatment House
Acute Day Treatment

Appendix 4: Directorate/Programme of Care Structure Chart – Learning Disability Services



Appendix 5: Directorate/Programme of Care Structure Chart – Children's Community Services



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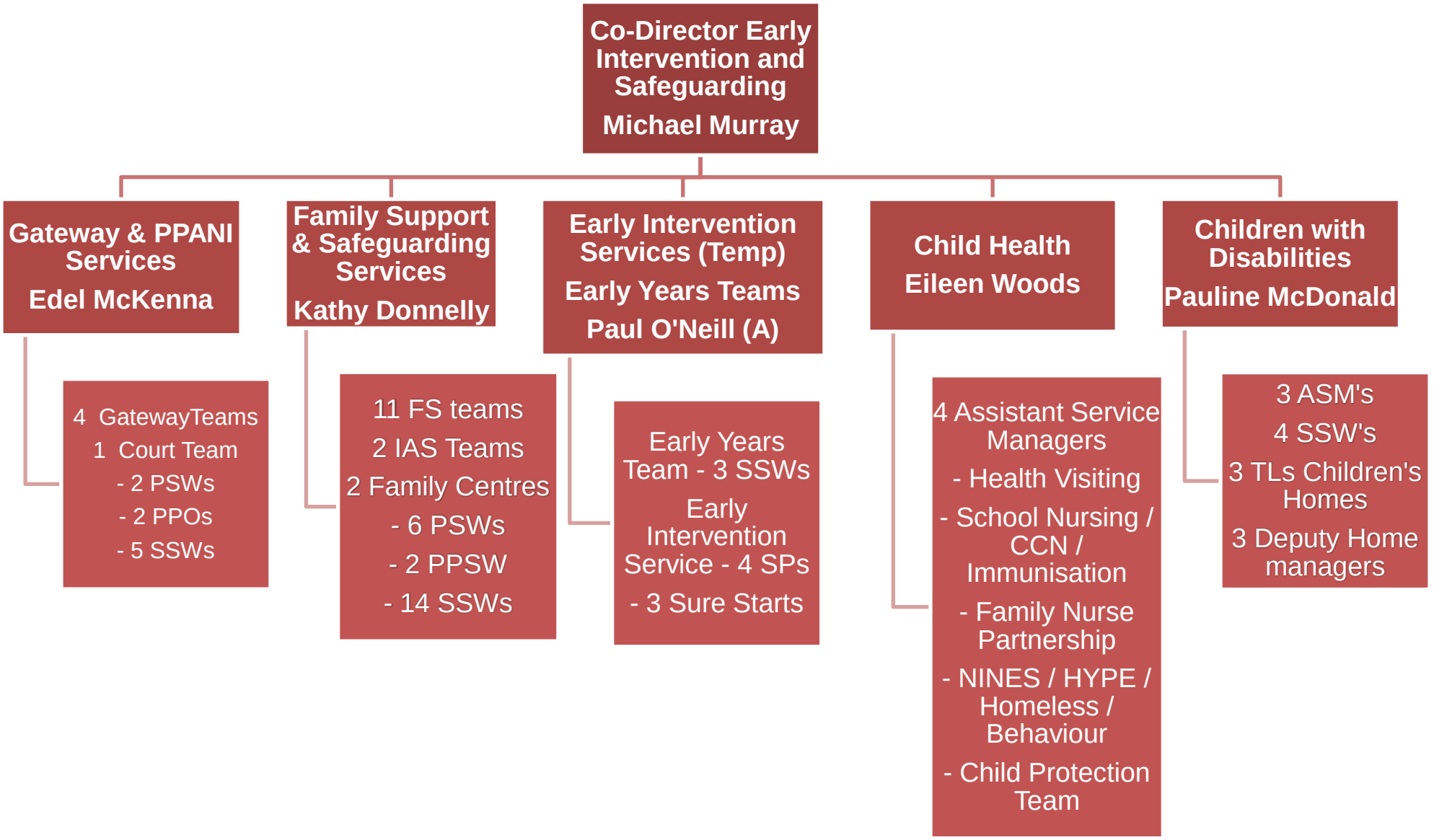
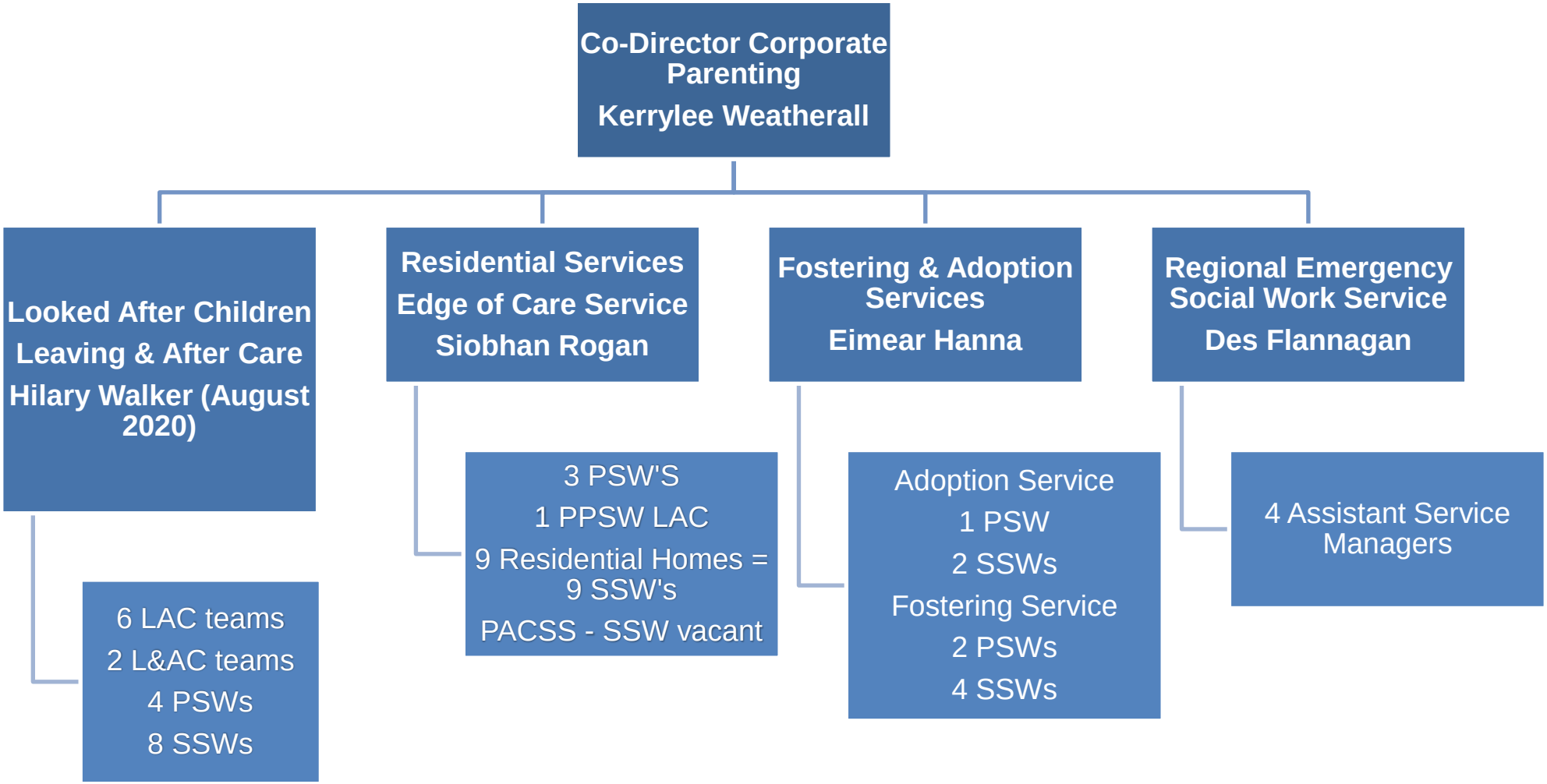
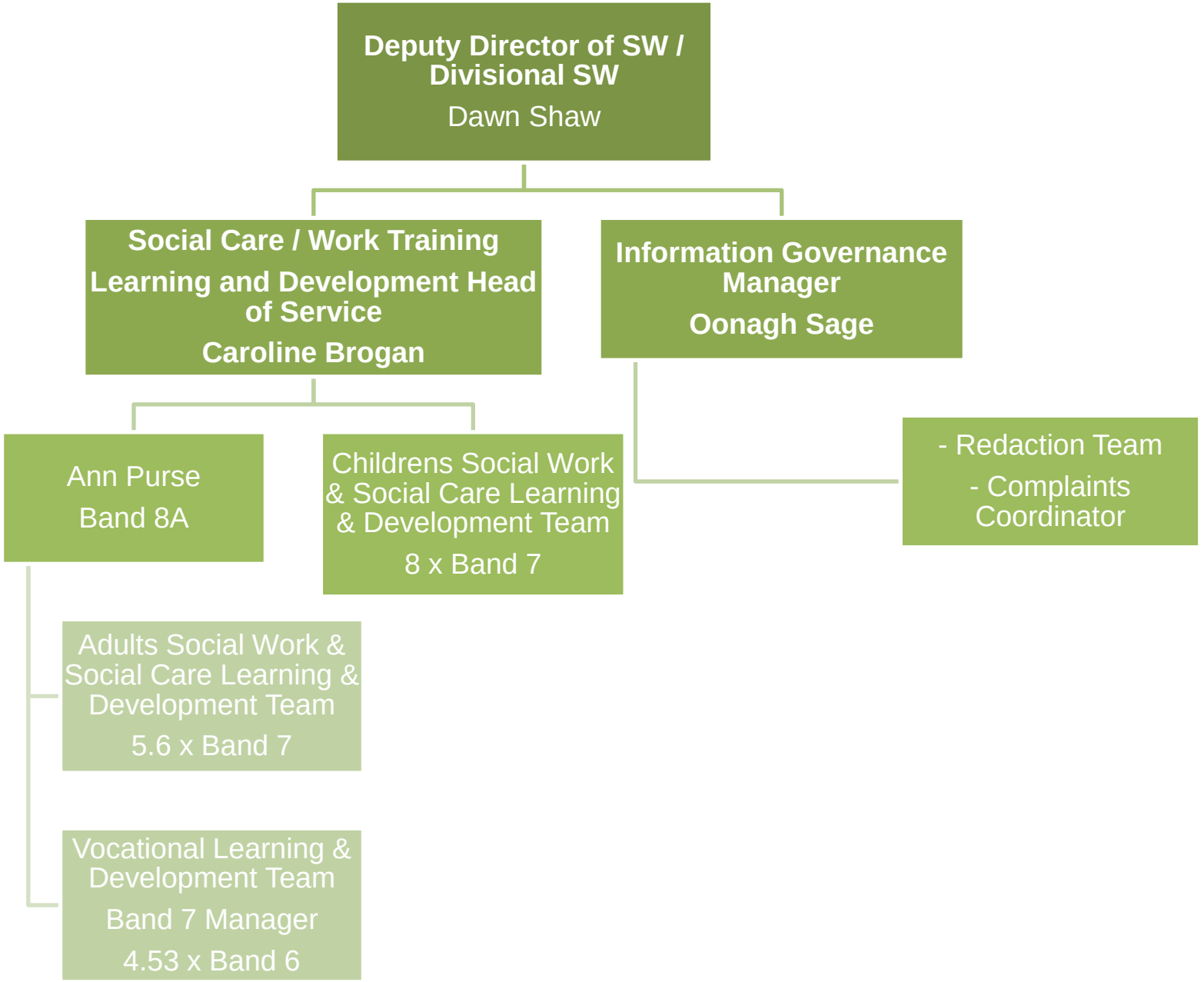


MAHI - STM - 097 - 5466




Deputy Director of SW / Divisional SW
Dawn Shaw
Social Care / Work Training
Learning and Development Head of Service
Caroline Brogan
Information Governance Manager
Oonagh Sage
Ann Purse
Band 8A
Childrens Social Work & Social Care Learning & Development Team
8 x Band 7
- Redaction Team
- Complaints Coordinator
Adults Social Work & Social Care Learning & Development Team
5.6 x Band 7
Vocational Learning & Development Team
Band 7 Manager
4.53 x Band 6

BELFAST HEALTH AND SOCIAL CARE TRUST

2.6 Progress Update on DSF Plan

This Section is for the Programme of Care to record their progress with the actions identified at the beginning of this reporting period (cross reference with section 1.3)

	CHILDRENS SERVICES		
2.6	**Issue/Action Agreed at DSF meeting in October 2020**	**Progress Update**	**RAG Rating**
	Issue: Detention under MHO **Update at DSF meeting – 5.10.20** Legal advice has been sought with regards to all these children. There are 2 delayed discharges and there is due to be a JR Hearing in November. The Children's Law Centre have raised issue with the level of consultation with the families. This is refuted by the Trust. These circumstances outline the lack of community resources, both locally and regionally and as such it urgently requires a clear action plan, involving HSCB, Trust and DoH. **Action:** • HSCB, Trusts and DoH to continue to work on development of community resources	**Updated on 5th May 2021** The Trust submitted two Business Cases to HSCB which addressed the specific assessed needs of 2 YP who were Delayed Discharge within Iveagh Ctr during the reporting period. One YP has since been discharged and has now transitioned to Adult Services however there are on-going court proceedings regarding suitability of placement. The second YP remains a delayed discharge and there are on-going discussions with DOH regarding the release of capital funding. The Trust is fully engaged with the Children Disability Reform Group and work is being led on by HSCB to develop a Regional Operational Framework for Disability Services. Whilst resourcing remains a significant challenge the recommendations in the framework outline a wide ranging and ambitious reform and modernisation agenda for CwD services. One of the strategic themes will focus on the approach to residential	

	Update at DSF Planning Meeting 17.06.21 One of the children has now went home. The other child is deemed to require a bespoke property. Revised IPT to be submitted to HSCB. Meeting with DoH regarding costings due this week. Potential contingencies being explored. HSCB are concerned with regards to extended timeframe in addressing this, though are satisfied the Directorate has appropriate oversight through the children's team and agreed that given this is an individual case and with concern regarding confidentiality this would be removed from the action plan and managed within current structures through the children's team. RAG Rating changed from Amber to Green	provision and how to support CwD effectively in out of home placements.	
	Issue: Children with a disability **Action:** The Trust is working with the HSCB to address these shortfalls and to carry out a further assessment of need to inform commissioning priorities. Individual business cases have been developed in relation to young people who are delayed discharges from Iveagh. The Trust also continues to fund a private placement for one young person who was not accepted by the ECR panel but whose needs could not be met within the existing residential or fostering provision. **Update at DSF meeting – 5.10.20**	**Updated on 5th May 2021** The Trust is currently updating its CWD Edge of Care/ placement requirement data base and will share this information with HSCB when complete. The Trust is keen to see progress in the development of a fully funded reform and modernisation programme as referenced above. The Trust is fully engaged in discussions with DOH to release Capital funding for one YP who remains a delayed discharge from Iveagh. There remains the potential this case will be returned to Court if funding is not made available soon.	Amber

	Trust have been looking at this over the last 4 years and there still remains a significant service gap across the region for children with a disability. **Action:** • HSCB, Trusts and DoH to continue to work on development of community resources • To discuss where CwD are positioned within the DoH	One CWD LAC is placed in an Out of Jurisdiction placement due to the lack of suitable placements within NI. The Trust is also seeking a therapeutic ECR in respect of another child whose needs cannot be met within NI. The Trust has made 3 other emergency placements during the Pandemic, 2 fully accommodated within Willow Lodge, thus initially reducing and now pausing Short Breaks provision to families of Children in Need. This has resulted in high levels of unmet need despite the deployment of SDS and Article 18 Payments to offset pressures. The Trust continues to advise DOH of the need to place CWD services within Children's and not Learning Disability service division and is committed to a child centred integrated approach to the delivery of Children's services. CWD Service has reviewed the needs of all young people over 16 and identified within that group those requiring Deprivation of Liberty Safeguards. The service subsequently referred 39 young people to the Trust's MCA Team and Social Workers have assisted this team in the completion of the required processes and documentation. The service has itself completed the process for 9 young people and a further 15 DOLS will be complete for a further 15. By 31/5/21 all those who require DOLS will have had the process completed	

	Update at DSF Planning Meeting 17.06.21 HSCB and Trusts are still unaware of the consequences or impact arising from the Girvan case relating to Educational application to the MCA and this will need to be kept under review. The HSCB notes: • the Trust have reported no CWD on the CPR • Trust report the highest number on ASD waiting list • highest per capita SEN statements • highest level of Children on high level DLA. • Trust report a decline in number of CWD but increase in pressure in this The HSCB notes the work the Trust had undertaken during COVID to support CWD when special school provision was removed. RAG Rating remains Amber	and ready for DOLS Panel consideration. All eligible staff have completed the required training and a tracking system is in place to ensure that those who become eligible have the process completed in a timely way. Attendance at Special Schools to which YP cannot consent and which have locked doors have been included in any DOLS process	

	Issue: Personal Advisors **Update at DSF meeting – 5.10.20** Current number of young people without a personal advisor is 72. Two new staff members have been recruited and the Trust have an action plan which aims to reduce this number to 9 without an advisor in 3 months. **Action**: • Trust to provide HSCB with an update at midyear point **Update at DSF Planning Meeting 17.06.21** Current position: there are currently 109 young people without a personal advisor. Trust did not provide an action plan for 2021/22 outlining how they were to address their failure to comply. Numbers have increased since DSF meeting last year. RAG Rating increased to Red	**Updated on 5th May 2021** Broader workforce issues have impacted progress in relation to this area of work in addition to the challenges arising from the management of the Covid-19 pandemic. Factors influencing the allocation of a personal advisor include, the increased trajectory in the number of looked after children and late entrants into care. Within the next review period the Trust will undertake a review of the systems in place to track and monitor the allocation of Personal Advisors, and produce an action plan to address this failure to comply. The HSCB have also outlined a review of Leaving Care Services as one of the priority areas of work to be progressed in 2021/22.	

	Issue: Unaccompanied minors **Update at DSF meeting – 5.10.20** Trust confirmed that Home Office funding is utilised directly on young people. Over the last 7 months £20k spent to date – areas of expenditure inc. accommodation, travel, clothing, heating, activities etc. There was a downturn in numbers arriving in NI during the first period of lockdown, however this has begun to increase and current numbers are around one per week. It is anticipated that these numbers will increase due to Brexit and the new protocol of a 'duty system' across all 4 nations. The Trust awaits outcome of the DoH Workshop on how this will be implemented and arrangements around this. **Action:** • To be kept under review during 2020/2021 **Update at DSF Planning Meeting 17.06.21** HSCB are satisfied with the actions and progress with this issue. RAG Rating to remain Green	**Updated on 5th May 2021** The HSCB have agreed a protocol with the five HSCTs to accommodate children arriving in the region should the Trusts residential home (Aran House) be full at the time of their arrival. Funding has been secured from the DoH to develop the regional model for UASC; this currently is being consulted upon and will be implemented as agreed. Home Office funding continues to be applied for and utilised appropriately in line with the requirements of the provision. A regional workshop will be scheduled once arrangements in relation to the National Transfer Scheme are endorsed at Executive / Ministerial level in NI – no further action is required at this stage.	

	Issue: Early Years, Outstanding Inspections **Action:** There is a plan in place to reinstate the Inspections in line with the regional resetting of services and the Early Years plan to have these completed by the end of September. **Update at DSF meeting – 5.10.20** COVID planning started significantly earlier than lock down on 23rd March. Trust confirmed they were on target before COVID and have had an action plan in place. The Trust advise that these inspections and registration should now be completed and up to date. **Action:** • Trust to confirm current numbers. • Trust to forward Action Plan referenced	**Updated on 5th May 2021** The initial pause on all inspections in the first 6 months of the pandemic (when many settings were closed), coupled with the requirement for an inspector to only complete one inspection per day, has created an unavoidable impact on the ability of all Trusts to complete annual inspections of each registered setting. Trusts have worked extremely well together to agree a regionally consistent approach to meeting their statutory duties and ensure that settings were operating safely during the pandemic, through regular communication and advice. The Trust has adhered to the regional direction from DoH / HSCB regarding the relevant Covid guidelines and moved (as per the regional agreement) to a staggered inspection process from December 2020 with observation visits being deferred until after the lockdown period. Inspections resumed in March 2021. 187 Inspections have been carried out during the reporting year with 355 outstanding inspections as of 31/03/21. The Trust will assess the capacity to complete all other outstanding inspections in line with the DoH guidance. Where they cannot be completed the settings will be risk assessed taking account of the information obtained from remote inspections. Where the risk assessments identify concerns, follow up visits will be completed.	Amber

	Update at DSF Planning Meeting 17.06.21 355 inspections are outstanding and there is a Regional action plan is in place. Trust have staff in place to facilitate 2 inspections a day. Trust to provide local action plan RAG Rating remains amber	The Trust action plan referenced in October 20 had been developed prior to the second lockdown in December 2020 and is therefore no-longer applicable/ relevant.	
	LAC & Leaving Care **Issue: 29 LAC Statutory Visits not completed** **14 CwD Statutory Visits not completed** **Issue: 76 Statutory Reviews not completed** **Update at DSF meeting – 5.10.20** Delays are due to staff vacancies. The Trust also advise that the numbers of children in care has risen, putting increased pressure on the service. **Action:** • Trust to ensure compliance during 2020/2021 • To be monitored during 2020/2021 and reviewed by the Trust and the Social Care lead. • To be addressed through AD Group	**Updated on 5th May 2021** Compliance in respect of statutory visiting has been impacted during the reporting period due to a combination of staff vacancies, sick leave, caseload pressures and redeployment during the third surge of the Covid-19 pandemic. Technology enabled a blended approach to be used incorporating both virtual and face to face visits (risk assessed in line with PHA guidelines). Social work mangers ensured the service was able to respond to crisis and implement actions arising from risk assessments. At the end of March 21, there were 35 unallocated cases within the LAC teams and 92 unallocated cases within CwD due to the issues noted above	

	Update at DSF Planning Meeting 17.06.21 As of 31/03/21 there are no outstanding LAC reviews. It is important to note that in terms of LAC reviews due there were 1389, of these 535 (39%) were outside timeframe. Statutory visits – HSCB recognise that Covid has presented significant challenges. 72 children did not have their stat visit. Data to be confirmed 35 Unallocated LAC 92 Unallocated in CwD	and from the increase in numbers of looked after children within the Belfast Trust over a number of years. The Trust are managing these cases via the duty social work system and there are escalation procedures in place and oversight by the Head of Service. 3 x Social Workers have been recruited and will take up post in relation to existing vacancies within the next 2 months. Within CwD 4 x Senior Practitioners have been appointed and will take up post within the next two months. The unallocated cases will be assigned to these staff members. It is envisaged the 3 x further vacancies in LAC will be filled through the regional recruitment campaign being completed in May 21. Whilst there is no additional funding available the directorate has secured agreement to go at risk and create an additional LAC Team to address the capacity issues on a longer term basis with recruitment for a SSW and 5 x SWs posts being progressed.	

	Given the ongoing concerns regarding LAC reviews outside timeframes, statutory visits not completed and unallocated SW figures, this issue requires further monitoring and will be carried forward to 2021/22 RAG Rating reduced to amber		
•	**Issue: Care Pathway Project Review - clarify when report is to be available** **Update at DSF meeting – 5.10.20** The Review Report has been forwarded to the HSCB just prior to the meeting. This needs to be reviewed by the Social Care Lead and outcomes discussed with the Trust. **Action:** • HSCB to review report and outcomes • Trust to provide update on progress of recommendations contained within the report.	**Updated on 5th May 2021** The Care Pathway Project Review Report and accompanying presentation was received by the HSCB on 4th October 2020. Recommendations relating to Personal Advisors is noted separately in this action plan as detailed above. The aims of the Care Pathways Review have been achieved. Importantly, Looked After Children have less transition points in their care journey with access to key professionals at an earlier stage to support them through these fewer transitions. Similarly, professionals have more robust processes in place to promote more streamlined case transfer of young people coming into their service area, which prevents delay at key transition times. The review recommendations from this review which will be taken forward in • Partnership with the service user groups in respect of informing and co-producing improvements for practice with staff,	Green

	Update at DSF Planning Meeting 17.06.21 HSCB satisfied with actions taken. Will not be taken forward to 2021/22 RAG Rating remains Green	Reviewing methodologies to improve the retention of personal advisors.	
•	**Issue: Numerous placement moves for children** **Update at DSF meeting – 5.10.20** Recruitment difficulties, more break down of placements. Have put some Band 4s in to support children. Kinship placements breaking down. Inescapable pressures used to fund this area. Placing children with very complex needs that are not ready for fostering. Foster carers are overstretched. Considering bringing back the Leads Model and considering all options. Trust is looking at a regional group to look at the development of this. **Issue: What plans have the Trust in place to recruit locally so statutory duty to LAC can be met and some placement choice afforded to minimise disruptions.** **Update at DSF meeting – 5.10.20** The Trust has very close links with TSS. This situation reflects the pressures across fostering currently. An inescapable pressure paper has been submitted to the DoH by the Trust for a wraparound support service for foster carers. The Trust has also a significant challenge in meeting	**Updated on 5th May 2021** The Trust is working in collaboration with the Early Intervention and Support Service to progress a quality improvement project which aims to provide increased support to placements under pressure, improve stability and prevent breakdown. In addition, a new agreement has been reached with Extern to provide 2 placements per week for short breaks which enhances existing provision. The Trust works collaboratively across the region to progress the recruitment planner for foster carers and track the outcomes of this work. Across corporate parenting LAC and Fostering Teams B4 support staff are being utilised to support children in care (these posts are currently unfunded). The annual recruitment planner has been collaboratively worked up on and outlines a	

	the needs of 8-12yr old children. A bespoke residential unit has been established, as some of these children are not able to manage foster placements and require a therapeutic residential placement before being considered for fostering. **Action**: • To be reviewed during 2020/21 and update provided to HSCB **Update at DSF Planning Meeting 17.06.21** HSCB acknowledge the measures the Trust have put in place to address this issue, however this will require further monitoring during the next reporting period. RAG Rating remains Amber	number of complimentary local and regional recruitment events. The rebuild planning will promote the resuming of face to face recruitment events in addition to those which are occurring virtually. The Regional Assistant Directors for Corporate Parenting and HSCB have agreed to review commencing a regional piece of work to develop a proposal for a skill/fee based fostering framework. The framework will be aligned to the DoH Strategic Direction and priorities for improving outcomes for LAC, placement choices and regional equity. The proposed framework will be presented to CSIB for approval upon completion and may require additional investment and a bridging approach between current practice and full implementation of a new model. The operation of the home for younger children remains in place for those whose needs have been assessed as best met within the home whilst they are being considered for fostering.	

•	**Issue: Impact of vacancies on the delivery of services** **Update at DSF meeting – 5.10.20** HSCB considering setting up further meetings in relation to the impact of COVID. Significant pressures within Early Years and it was suggested by the HSCB that Una Lernihan to link in with this meeting also. There are 49 AYEs in post but they need extensive support and are on reduced caseloads. The Trust Learning and Development teams are providing additional support to AYE's. Trust have also put their learning and development modules on line to improve training opportunities and supports for staff. There are currently 35 vacancies across children's services, and 65 vacancies across adults and children's. The Trust held a Workforce workshop in February with HR. Whist there are local workforce issues, this is also a regional matter and the Trust await the DoH Workforce Review. **Action:** • Workforce planning to be kept under review during 2020/2021, to include vacancy numbers • Await outcome and Recommendations of DoH Workforce Review.	**Updated on 5th May 2021** The number of vacancies has had a significant impact on the delivery of services, the full extent of this is likely to be more fully realised in the coming months as we rebuild our services. Many duties which were previous paused during the pandemic, for example contact, or significant reduced, for example face to face visiting will now resume therefore placing additional demand on teams who have depleted staff and have been carrying vacancies for a sustained period. The impact of the growing proportion of AYE staff located across our front line services should not be under-estimated. These staff require high levels of supervision, mentoring and support as they remain in the consolidation stage of their professional development. The number and complexity of cases that they hold has to be protected however the consequent impact is reduced levels of throughput of cases. The DoH Workforce Strategy remains in draft form and will be circulated to Trusts upon completion. The Trust review vacancies and workforce pressures via weekly meetings with Co-directors, HOS, HR colleagues, & Learning & Development team. A regional recruitment campaign is underway for social workers and subsequent	

	Update at DSF Planning Meeting 17.06.21 Trust are getting 56 staff from recent Regional recruitment. They have also had 2/3 rounds of recruitment. 9 Senior Practitioners are now post from unallocated funding, and a Band 5 recruitment officer. In addition the Trust are recruiting an additional LAC SW team (6 SW and 1 SSW). HSCB are satisfied that locally within the Trust actions/measures are in place to review and address this issue. RAG Rating reduced to Green	Belfast Trust local recruitment is being planned across all services areas. The HSCB are currently working to scope the existing number of vacancies across children's services with a position report being compiled for presentation to CSIB in May 21.	

	Issue: Iveagh delayed discharges Update at DSF meeting – 5.10.20 Trust confirmed there are 4 patients in Iveagh, 2 from BHSCT (one of which is a voluntary patient). Legal opinion is being sought in relation to the judicial review. One of the BHSCT patients is 17 year old and transition process needs to be progressed urgently. Children's services have a business case with HSCB. **Action:** • Ongoing discussions with Adult Services • Trust to update HSCB on progress of discharges	Update: There are currently 2 patients whose discharge has been delayed in the Iveagh Centre. (1 WHSCT, 1 BHSCT). One of the main challenges faced by Iveagh continues to be the lack of community options for young people in the community. This has led to delayed discharges, which reduces the hospitals ability to function effectively for assessment and treatment. More comprehensive planning with community colleagues continues to be a focus for the clinical team; however, this is influenced by the regional nature of the service. There have been 5 Judicial Reviews in the past year in relation to children who are delayed discharge in hospital. These issues have been escalated to the Executive Team within BHSCT and with all other Trusts. The HSCB and DOH are also aware of the issues of delayed discharge along with the RQIA and the Children's Commissioner. Judicial Reviews occurred in March 2021. It was agreed that the following action would be taken: • The Iveagh Operational Policy will be reviewed so that it better reflects the statutory duties on the Trust where the child ordinarily lives to ensure care planning is in place and where	

	Update at DSF Planning Meeting 17.06.21 With regards to delayed discharge this has been referred to and will be addressed by Children's Team. No updated information available from Trust at pre-planning meeting. Will require further follow up with the Trust and to be carried forward to 2021/22 RAG Rating to remain Amber – Transferred to Children's Section from Learning Disability	discharge cannot be effected that escalation arrangements are explicitly stated. • Iveagh would contribute to a standing forum chaired by the HSCB involving the five Trusts as required to monitor the issue of delayed discharge from Iveagh Centre and any action that may be required. Following the RQIA inspection on 8th, 23th September and 7th October 2020- 12 QIPs are also being actioned as outlined in section 2.5.	

2.6	**Issue/Action Agreed at DSF meeting in October 2020**	**Progress Update at 31st March**	**RAG Rating**
	Mental Health Issues		
	Issue: The project to amalgamate primary care and recovery services is in process and has been delayed due to the current Covid19 arrangements. Update at DSF meeting – 5.10.20 Ongoing service improvement project has being progressed over the last 2/3 years. This has made significant improvements including:	This is not specific to delegated statutory functions. Project management is in process for the amalgamation of primary and recovery Community Mental Health Teams within BHSCT with one team amalgamating currently.	

	• Introduction of telephone triage, advice and guidance function for GPs • Amalgamation of teams – issue re flow through teams, they have introduced a RAG rating system for all teams • All Teams now have a duty system • GP alignment for integrated teams • All teams are co-located • Working on case load weighting • Established clear pathways • Dedicated e-mail line Workforce challenges remain with 18 vacancies in Social Work posts and therefore high levels of agency staff in place. **Action:** • HSCB and Trust to determine if there is regional learning coming from these improvements which can be shared across Trusts. **Update at DSF Planning Meeting 17.06.21** Vacancies now reduced to 4, and recruitment process ongoing. HSCB satisfied with actions RAG Rating remains Green	Addressed with only 5 vacancies currently and recruitment process completed.	
	Issue: Completion of ASW reports within 5 day timescale 9.3 – 91.5% (283/309) of ASW reports were completed within the required timescale of 5 working days		

	Update at DSF meeting – 5.10.20 The Trust report a slight improvement in compliance, however there does remain concerns in relation to this. Delays can, in part be attributable to staff absence, annual leave etc. Duty Rotas are reviewed to minimise impact. If a report is not completed within 5 days the Trust follow up. The ASW role remains a challenging one, and coupled with multiple functions (DAPO, JP etc) it is increasingly difficult to retain staff as it is becoming an increasingly unattractive post. **Action:** • Trust to review the multiple functions and determine how ASW role can be enhanced to ensure appropriate levels of staff are available. **Update at DSF Planning Meeting 17.06.21** HSCB satisfied with actions taken by the Trust in ensuring compliance. Trust are almost at 100% compliance. RAG Rating remains Green	During the current reporting period, there were only 2 reports that were not received within the regional standard of 5 working days. The reason for same was due to one ASW being on sick leave due to contracting coronavirus and the second ASW was covering urgent sick leave. Therefore the assessment and report completion was unplanned in their diary and needed to be fitted in within planned substantive post workload. This is a significant improvement in timescales aided by a reduction in the rota frequency of the full time ASW staff member (was on rota 4 out of 5 days per week and reduced to twice weekly), as report completion was being delayed by multiple assessments and only one day planned for admin. The current reporting system also identifies reports that may be outside the 5 day timeframe. ASW staff have also been made aware of the necessity to complete on time.	
	Issue: CAMHS **Update at DSF meeting – 5.10.20** The Trust report that workforce is the most significant issue and there is currently recruitment ongoing. HSCB raised the Improvement plan in place re Beechcroft and asked the Trust to update on this. This was not provided at the meeting and needs to be forwarded as soon as possible.	The Workforce issue in CAMHS is in relation to the availability of nursing staff and therefore not subject to DSF notation.	

	Action: • Written update on improvement plan required • To be discussed further at Regional CAMHS meeting **Update at DSF Planning Meeting 17.06.21** HSCB satisfied with actions taken by the Trust in ensuring compliance RAG Rating remains Green	RQIA inspection, took place on the 15th and 16th March 2021. See summary in section 2.3.	
2.6	**Issue/Action Agreed at DSF meeting in October 2020**	**Progress Update at 31st March**	**RAG Rating**
	Learning Disability		
1.	**Issue: Domiciliary Care waiting list** **Update at DSF meeting – 5.10.20** Trust confirmed there are issues around complex cases and geographical location. They have 20 on the waiting list as of DSF meeting date, mostly around small packages (shopping / showering etc). Continue to use SDS. Similar issues as in OPPC. **Action**: • To be reviewed alongside the Domiciliary Care issues outlined in OPPC **Update at DSF Planning Meeting 17.06.21** Trust have not yet confirmed updated figures. They are also to update on project looking at increasing flexibility/capacity.	**Update:** There are currently 12 cases on the waiting list (08.04.21 update). The Learning Disability Service is represented on a project group to implement time bands for care packages in order to provide more flexibility in the system and to increase package availability. It is hoped that this will go live on 10.05.21**.**	

	No updated information available from Trust at pre-planning meeting. Will require further follow up with the Trust and to be carried forward to 2021/22 RAG Rating to remain Amber		
2.	**Issue: Potential failure to provide people deprived of their liberty with adequate legal safeguards.** **Update at DSF meeting – 5.10.20** Trust have carried out scoping exercise. They have 647 community DOLs to be completed. There are a number outstanding within Muckamore and these will be completed by the end of November. There remains a challenge in securing medical reports from GPs as recognised regionally. Trust LD service currently has 100 emergency orders in place which will all require a DOLS review. There is a significant resource implication associated with this. LD service is also experiencing a challenge in getting appropriate numbers of ASWs in the service. **Action**: • To be kept under review during 2020/2021	**Update:** MCA training has been completed across the service area. A service area steering group has been established and a data base to monitor progress. This is a complex area of work within Learning Disability and is more time consuming given the nature of our service users, many of whom have communication difficulties and behaviours, which challenge. This has been further exacerbated by COVID as there are difficulties communicating using PPE and virtual means. A MCA action plan was devised. There were no additional resources available although we were able to temporarily fund an 8a MCA lead (which we were unable to backfill), release one practitioner from each community team to solely undertake MCA work (again difficulty backfilling fro the agency) offer overtime and invite retirees to return to assist is in the process. It is anticipated that a further Social	

		Worker will join this team in July 2021 for 2 days per week. In addition, as this is new legislation, there have been many challenges in implementing it and frequent legal advice has had to be sought on many occasions. [redacted] To date there have been no service users in receipt of a trust panel authorisation where the Trust has felt that a declaratory order is necessary. This will remain under review. The MCA Central team have commissioned a number of medical staff to complete sessional work carrying out Form 6 assessments, which has assisted with the process. The service area has also been able to avail of a STDA from the central area to assist with MCA work. To date the service area has carried out 179 assessments- 103 Trust Panel applications; 40 service users were deemed to have capacity; and 36 are awaiting a panel hearing. All patients in Muckamore who are not detained under the MHO and who are deemed to lack capacity regarding those aspects of their care	

	Update at DSF Planning Meeting 17.06.21 Trust have an action plan in place which indicates compliance in Legacy and Review cases by December 2021. HSCB are not confident in Trusts ability to meet the anticipated deadline of December. RAG Rating remains Amber	arrangements amounting to DOLS have a Trust Panel Authorisation in place. The first Trust Panel Authorisations are now at renewal point and this is putting further pressure on teams to meet this legal requirement. Of the authorisations in place the Attorney General has referred 23 to the Review Tribunal. The required Rule 6 report is also creating additional workload for the teams as there is usually a 10 day turn around required for these. Given the increased workload, lack of additional resource and ongoing challenges associated with the fluidity of this new legislation and emerging case law the service area is unlikely to meet the target of completing all DOLS by end of May and reviewing them by end of November. A proposal has been put forward for additional funding and the action plan is continuously reviewed. This risk has also been placed on the risk register. The service area continues to only have a small number of ASW staff working within the area and this continues to present challenges in terms of having this expertise in the service area. Attempts to encourage staff to undertake the ASW training have been unsuccessful within the service area.	

4.	**Issue: Accommodation needs for those being discharged from Muckamore Abbey Hospital** **Update at DSF meeting – 5.10.20** Trust confirmed there are 4 PTL patients currently. A pivotal staff member has been on sick leave and is now leaving the service. This has had a significant impact and is a central factor in the delays. Recruitment for this vacancy is now underway. They confirmed 13 delayed discharges - 5 planned, 8 unplanned. A number of service users have been moved to Bradley Court. Trust have had Initial discussions with RQIA to consider a residential living scheme around the Muckamore area, though this is in its very early discussion stage. **Action:** To be kept under review during 2020/2021 and update provided to HSCB	**Update:** There has been active planning for the discharge of patients from the hospital into appropriate and sustainable placements and a number of patients have already been placed successfully in the community from the hospital. Since April 2020- March 2021 there have been 6 successful discharges and 3 patients are currently on trial leave. Three BHSCT patients have been discharged- two patients were discharged to specialist nursing and one to the community with family. In relation to the 16 current BHSCT patients- • 3 have a definite plan to be settled in the community • 1 is being considered for Mallusk. • 1 is being considered for an onsite proposal • A business case is currently being developed for 6 patients • 3 patients are being for forensic business case • 2 patients are on trial leave In relation to the remaining 20 NHSCT patients- • 7 have a definite plan • 9 have no plans • 1 is being considered for onsite proposal	

		• 1 patient is being considered for Cherryhill • 1 patient is being considered for forensic business case • 1 patient is also on trial leave In relation to the 8 SEHSCT patients on site- • 1 has a definite plan • 2 have no definite plan • 1 is currently on home leave with discharge imminent • 2 patients are being considered for forensic business case • 1 patient being considered for on site proposal • 1 being considered for Mallusk. There is one remaining WHSCT patient who is on Article 15 leave since March 2021. There is also one SHSCT patient who has a placement identified but does not wish to leave the hospital. It is hoped that Mallusk will be opening in the Summer of 2021 and it will provide a placement for 7 hospital patients. Within the Trust the Planning Officer post was vacant for some time and this delayed progress in relation to the development of business cases. This post has now been filled and the progression of business cases is being taken forward.	

		There also continues to be a lack of community placements for patients with complex needs. A number of families have also requested that CCTV is in place within community facilities before their loved one is discharged. An accommodation workshop was held and the Learning Disability Division are updating the Accommodation Plan for the period through until 2025. The plan will further identify accommodation requirements at a population level and has included inpatients in Muckamore Abbey Hospital. The Service area is engaged with potential providers across all sectors in exploring potential options. Supported Housing Schemes continue to be developed through Business Cases to Supporting People for capital expense only / revenue neutral. These will be for developments within the next 2-3 years. Any additional accommodation needs are being considered within a procurement framework as part of the Regional Learning Disability Operational Group with the HSCB and in partnership with BSO. The business case for five Lanthorne (Cedar) Supported Living Development for Community service users is being progressed. The business case for an extension of a forensic scheme is being progressed for four MAH patients and there are plans to have an additional two to	

	Update at DSF Planning Meeting 17.06.21 HSCB are concerned as the Trust have not provided sufficient detail or no detail on issues raised. No updated information available from Trust at pre-planning meeting. Will require further follow up with the Trust and to be carried forward to 2021/22 RAG Rating remains Amber	eight placements (dependent on the site) for community service users. Following a failed community placement the BHSCT in January 2020 agreed to seek a bespoke assessment for an inpatient in Muckamore and commence a single action procurement regionally and nationally to seek a provider who could meet his needs. The single action procurement process was commenced in December 2021. If successful, it is envisaged that this methodology will also be applied to other individuals with high levels of support needs.	
5.	**Issue: Recruitment of SW staff to strengthen the workforce** **Update at DSF meeting 05.10.20** As outlined in other programmes, workforce issues continue to be a significant challenge. This is further exacerbated with Covid and likely to impact on services for the remainder of the year. There is a regional issue with workforce and a local one. The Trust continues to progress their workforce planning and undertake recruitment exercises. **Action:** • To keep the workforce pressures under review • Await outcome of DoH Workforce Review	**Update:** An 8B SW service manager with responsibility for ASG, hospital SW and the MDT community teams has been appointed and commenced employment on1.9.20. 8A Principal Social Work post has now been agreed and is currently being processed for recruitment. Securing the 8A Adult Safeguarding lead post last year was extremely helpful to the service area especially given the ongoing complexities associated with adult safeguarding in the service	

		area. Unfortunately, this person left post in September which has placed significant pressure on the service area, The newly appointed ASG Lead is due to take up post on the 1.6.21. The SSW Band 7 post in MAH which was vacant since July 2019 was also successfully recruited in June 2020 There has been some difficulties recruiting SW into B7 team leader posts. A number of the Team Leader posts were temporarily recruited by existing staff within the service area. Two Band 7 Team leader posts which were vacant were successfully recruited. One permanently took up post in July 2020 and the other is covering the post temporarily. One team leader retired and this post is also backfilled temporarily. It has now been agreed , give the pressures experienced in relation to Adult safeguarding that these new team leaders will be recruited from a SW background. Due to issues raised by Staff Side the Team leader job description is currently being desk topped. Three Senior Practitioners Band 7 have been recently appointed with DAPO responsibilities (Temporary). Two of these staff have only recently been trained as DAPOs. The third Senior Practitioner post (temporary) has only recently been appointed and is yet to be trained as a DAPO and take up post. These Senior Practitioner posts are	

	Update at DSF Planning Meeting 17.06.21 HSCB acknowledge the Trust are continuing to make progress, and are satisfied that these are appropriate actions and do not require this to be carried forward to 2021/22 RAG Rating reduced to Green	currently being progressed through HPRTS to be recruited permanently. Additional funding had been secured through IPTs to permanently recruit an additional Senior Practitioner Band 7 with DAPO responsibilities and 2 SW Band 6 with IO responsibilities. These posts are currently being progressed through HRPTS to be recruited permanently. Given the current risks associated with the delivery of Adult safeguarding across the service area a proposal to proceed at risk with expanding the ASG workforce is currently being considered. The DoH Regional Workforce Review in relation to social work across all programmes of care including Learning Disability is ongoing. Discussions have commenced within the Belfast Trust regarding a regional approach to recruitment of Social Workers. While the premise for regional recruitment has some benefits, there are concerns in relation to the standards applied to job descriptions/ interviews particularly around specialist areas/posts.	

2.6	**Issue/Action Agreed at DSF meeting in October 2020**	**Progress Update at 31st March (as per update meeting on 8 March 2021)**	**RAG**
Older People's Service			

Issue: Adult Safeguarding - Decrease in the number of Joint Protocol cases **Update at DSF meeting – 5.10.20** Whilst the Trust continued to make Adult Safeguarding referrals to PSNI under the Joint Protocol guidance, the police are increasingly advising it will be a single agency response. This is a regional issue and as such will require engagement with PSNI to address. This alongside other challenges in Adult Safeguarding need to be taken forward regionally through the NIAS forum. Action: • Trust to continue to liaise with PSNI and address concerns regarding decline in JP investigations. • Regional response and engagement with PSNI through NIAS forum **Update at DSF Planning Meeting 17.06.21** HSCB are satisfied with actions taken. RAG Rating remains Green	The Trust continues to make Adult Safeguarding referrals to PSNI under the Joint Protocol guidance, but it remains the issue that the police are increasingly advising it will be a single agency response. As previously stated this is a regional issue and as such will require further engagement with PSNI and will be taken forward through the newly-established Interim Adult Protection Board. The Gateway Team continue to liaise with PSNI on a case by case basis to determine whether the threshold for Joint Protocol is met. The PSNI are members of both the Transformation Board and the Interim Adult Protection Board and therefore going forward there will be opportunities to discuss and agree the way forward regarding the Joint Protocol **Update from Meeting on 8 March 2021:** • Regional approach noted	
Issue: Domiciliary Service Provision **Update at DSF meeting – 5.10.20** Home Care in OPPC requires reform. There have been a number of reforms over the years but they have not achieved the aim of improving the service and managing the flow from hospital discharge.	It remains the position of the Division (OPS and PSD) that there continues to be an over dependence on the independent sector for the provision of domiciliary care. However there has been a significant and sustained of	

Until the Reform is successfully implemented there will continue to be an over reliance on the private sector. Trust advised the procurement process is restrictive and impacts on the progress of reforming the service **Action**: • Wider Regional Review and Reform of Domiciliary Care is underway, and will be kept under review during the next reporting period (2020/2021). **Update at DSF Planning Meeting 17.06.21** HSCB notes Trust have not adequately discharged their statutory functions. At 31st March 2021 there were 278 (1588.75 hours) people waiting on care package being put place RAG Rating remain Amber	>65% reduction in the level of unmet need across the Division at the end of this reporting period The Division has established an oversight group for the purpose of moving forward with the reform of Statutory Homecare. However, some identified key activities have been delayed due to the operational challenges associated with COVID. The Division await further regional reform and will implement as required any new recommendations arising from this.	
Issue: Continuing Healthcare CHC **Action:** The Trust awaits Department of Health Policy Guidance Update at DSF meeting – 5.10.20 Current policy position as outlined in the Care Management Circular sets out expectations on the Trust in relation to CHC. Trust confirmed there is no equality of	The service area have recently been found to have failed to put in place an operational policy for the purpose of assessing Continuing Health Care needs. The Trust welcomes the clarification of a regional position in relation to this matter and this significantly reduces this risk.	

access due to lack of clarity. HSCB acknowledged that whilst the Policy does not have sufficient detail, it does confirm that the Care Management Circular sets out expectations on the Trust in relation to provision of CHC. **Action:** • HSCB to follow up Ministerial approval on the Guidance **Update at DSF Planning Meeting 17.06.21** DoH lead. Clarification has been received. No further action, will not be carried forward to 2021/22 RAG Rating to remain Green	**Update from Meeting on 8 March 2021:** • DoH revised circular awaited Raised at fortnightly Directors Meetings (DoH in attendance)	
Issue: Mental Capacity Act **Update at DSF meeting – 5.10.20** Medical staff have been recruited and ongoing recruitment is taking place to increase capacity. Trust confirmed this issue is on their risk register. Trust confirmed there are 'cross Trust' issues which are presenting practical difficulties. This is a challenge across all programmes of care. An early alert has gone to DoH. Trust confirmed they will not be able to meet the December deadline. **Action** • Trust to confirm actual numbers of backlog and action plan • Regional discussion and agreement to any extension to the December deadline	Older People's Services has been challenged in the availability of sufficiently experienced/ qualified staff to meet the scale of the demand arising from legacy cases. Although progress has been made, there are still significantly high levels of legacy cases, that require assessing for Trust Panel Application process. Within this service area, suitably qualified staff have been redeployed to prioritise this work and overtime rates had been offered, but staff have been reluctant to take up this offer. As of reporting, it is recognised that this programme of care will not meet its obligations in relation to MCA by May 2021. This has been recorded on the Trust's principal risk register	

	Update at DSF Planning Meeting 17.06.21 HSCB note the Trust are not compliant with their statutory duties. Outstanding legacy cases in OPPC report 675 cases outstanding as at 30th April 2021 RAG Rating remains Red	and an early alert has been sent to the Department of Health **Update from Meeting on 8 March 2021:** This remains an area of very high risk for the Trust. CEx is aware of the concerns	
2.6	**Issue/Action Agreed at DSF meeting in October 2020**	**Progress Update at 31st March**	**RAG Rating**
	Physical & Sensory Disability		
	Issue: Domiciliary Service Provision **Update at DSF Planning Meeting 17.06.21** HSCB are satisfied that they Trust have appropriate plan/actions in place and are confident of reaching compliance during 2021/22	The number of people awaiting a package of care (29/03/2021) within PSD has significantly reduced to 27. The service area has structures in place for monitoring of SDS and PSD continues to meet DOH targets year on year.	

	RAG Rating updated to Green		
	Issue: Continuing Healthcare CHC **Update at DSF Planning Meeting 17.06.21** DoH lead. Clarification has been received. No further action, will not be carried forward to 2021/22 RAG Rating remains Green	Physical & Sensory Disability services continues to be challenged in relation to historical cases for this matter. However, the clarification of the policy position is welcomed and significantly reduces this risk. The Ombudsman is currently investigating one case in relation to CHC.	
	Issue: Mental Capacity Act **65 Legacy Cases** **Update at DSF Planning Meeting 17.06.21** Trust continue to make progress in reaching compliance and are on track for completion of actions to address this issue.	The service area had a total of 65 legacy cases, which require Trust Panel Applications. This has been a significant area of learning for the social work staff and staff continue to develop experience in this area.	

	RAG Rating reduced to Amber		

RAG Rating	
Completed/Confident of Delivery on Actions	
Work in progress and on track for completion within agreed timescales	
Not Complete/ Not on track for completion within agreed timescales	

This is to confirm that the above Action Plan has been reviewed and signed off by the Social Care and Children's Directorate on 17/06/21. Any outstanding issues requiring further progress will be reviewed at the DSF Meeting with the Belfast Trust on 25.06.21 and these alongside any new issues will be presented in the 2021/22 Action Plan.

Signature  (Brendan Whittle)
(Director of Social Care and Children & Executive Director of Social Work)

Date 28 June 2021

MAHI - STM - 097 - 5502

Health and Social Care

Directorate of Hospital and Community Care

Directed Statutory Functions

Composite Report

1st April 2021 – 31st March 2022

ABBREVIATIONS

ASW	Approved Social Worker
AYE	Assessed Year in Employment
CAMHS	Child and Adolescent Mental Health Services
CRIT	Central Returns Information Template
CSIB	Children's Services Improvement Board
DAPO	Designated Adult Protection Officer
DOH	Department of Health
DoL	Deprivation of Liberty
DSF	Delegated Statutory Functions
GEM	Going the Extra Mile
IO	Investigating Officer
LAC	Looked After Children
MCA	Mental Capacity Act
NIASP	NI Adult
NICCY	NI Commissioner for Children and Young People
OCP	Office of Care and Protection
OPPC	Older Peoples Programme of Care
PD	Physical Disability
PSNI	Police Service for Northern Ireland
QI	Quality Improvement
RQIA	Regulation and Quality Improvement Authority
SBNI	Safeguarding Board for Northern Ireland
SDS	Self Directed Support
STDA	Short Term Detention Authorisers
VOYPIC	Voice of Young People in Care

Introduction

This is an overview report under the Scheme for the Delegation of Statutory Functions. It has been prepared by the SCCD/SPPG Directorate of Social Care and Children.

For the reporting period 2021/2022 the Director of Social Care and Children Services, SCCD/SPPG can advise that each Trust has delivered reasonable compliance with their Delegated Statutory Functions. As we are all aware this has been another particularly challenging year, and there are a number of areas, as outlined in this report and the attached Action Plans which the Trusts will be required to progress during 2022/2023. The Social Care and Children's Directorate will work closely with each Trust and monitor their progress on the actions identified

This introductory section outlines the background and purpose of the Directed Statutory Function process, provides an update on the review of this process including the development of an Outcomes Framework for Social Work in Northern Ireland.

The report then moves into each Programme of Care; Children's Services, Learning Disability, Mental Health, Older People, Physical Health and Sensory Impairment and Adult Safeguarding. Each of these programme areas provides a general overview of the current challenges across the region. There is then a breakdown of the more pertinent issues relating to each specific Trust.

The reader is then taken to the Regional Action Plans and Local Trust Action Plans in Appendix 4 & 5. Specific areas of concern or issues relating to the Trusts' compliance with their Statutory Functions as outlined in the main body of the report are recorded in these action plans for 2022/23 with clear actions and timeframes against each issue.

Background

The Strategic Planning and Performance Group (SPPG) and Trusts apply a set of principles to govern the Discharge of Statutory Functions. These state that the Discharge of the Delegated Functions should:-

- minimise disruption to existing arrangements for service delivery;
- ensure clarity as to who is actually responsible on the ground in any particular case;
- be consistent with the strategic commissioning role of the SCCD/SPPG;
- preserve the operational freedoms of the Trusts.

The individual Trust Delegated Statutory Functions reports that have been submitted by each Trust are available, but they represent only the beginning of a process of dialogue with the Trusts that continues throughout the year. Action plans have been developed with each Trust on the basis of their report and an overarching action plan has been prepared by the SCCD/SPPG to take account of regional/cross cutting issues. The progress against the action plans will be monitored and reviewed. This report provides the SCCD/SPPG with an overview of the current issues and is supplemented by a statistical report which is appended.

The Scheme for the Delegation of Statutory Functions sets out the arrangements between the Health and Social Care Board (hereafter referred to as 'the Board') for the discharge, under The Health and Personal Social Services (Northern Ireland) Order 1994 of relevant Personal Social Services (PSS) functions by Health and Social Care Trusts on behalf of the Health and Social Services Boards. These functions were transferred to the Health and Social Care Board under Section 24 of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

The Scheme describes the fundamental principles, values and accountability relationships which will underpin the delivery of services. It specifies within the Personal Social Care Services programmes of care, including general services to people in need, the powers and duties which the SCCD/SPPG has delegated to the Trusts.

To assist the implementation of the 1994 Order, the, then Department of Health, Social Services and Public Safety (DHSSPS) provided guidance on the accountability framework and on the arrangements which should exist between the Department, Boards and Trusts.

This has been supplemented by the guidance set out in Departmental Circulars, Circular (OSS) 3/2015 HSC Statutory Functions and Circular (OSS) 4/2015 Professional Oversight of the Discharge of Delegated Statutory Functions. Following migration from HSCB to SPPG in April 2022 these Circulars have been replaced by Circular (OSS) 02/2022 and Circular (OSS) 01/2022 and will inform DSF reporting from 2022/23 onwards.

Accountability is a key element in the Discharge of Statutory Functions and is part of the main provisions within the Scheme.

Trusts, as corporate entities, are responsible in law for the discharge of statutory functions delegated to them. The SCCD/SPPG is responsible for commissioning services to meet the needs of their populations and spending monies allocated to them to secure the delivery of Health and Personal Social Services in line with the Scheme for the Delegation of Statutory Functions. The 1994 Order requires the Trust to specify how it will discharge statutory functions in line with Departmental and SCCD/SPPG guidance and current good practice.

The Trust is accountable to the SCCD/SPPG for the effective discharge of statutory functions delegated to them as well as the quantity, quality and efficiency of the service it provides.

The SCCD/SPPG also has a role in quality assuring the discharge of those relevant functions which they have delegated to Trusts.

The SCCD/SPPG and the Trusts have adopted a partnership approach to promote the welfare and safeguarding of children and vulnerable adults and maintains its responsibility to keep the Department informed of the outcome of the quality assurance arrangements in respect of Trusts' discharge of relevant functions.

Reporting

The SCCD/SPPG has agreed the monitoring arrangements with the Trusts together with the information that will be provided and at what intervals. The SCCD/SPPG requires that the Trusts will produce an annual report in the specified format on how the Trust has discharged their functions no later than the end of May each year.

The SCCD/SPPG has also agreed arrangements to ensure that at the midpoint of the year the Director of Social Care and Children receives a report from the Trust Social Care Governance Officer on behalf of the Executive Director of Social Work.

This annual report (1st April 2021 – 31st March 2022) highlights issues and trends and in particular drawing to the Director's attention any emerging breaches of statutory functions which require immediate action, updates on the Trust Risk Registers and the reporting requirements under Corporate Parenting duties.

Review of Delegated Statutory Function Reporting Process

Over the past 2 years the Social Care and Children's Directorate has completed a review of the reporting processes of the Delegated Statutory Functions. The purpose of the review was to streamline the reporting and ensure relevant, accurate and focused overviews were provided by each Trust. This enables a more targeted analysis of both the narrative and the data supplied by each Programme of Care. In doing so both the SCCD/SPPG and each Trust can identify challenges and areas where there are difficulties in meeting statutory functions. This ensures robust actions are put in place to comprehensively address these pressure points.

Alongside the review of the reporting process the Social Care Directorate have continued work on an Outcomes Framework for Social Work in Northern Ireland. This is a significant piece of work and will compliment the DSF process through the provision of qualitative information to sit alongside the current data and narrative provided by the Trusts. The Framework will bring the voice of those with lived experience into the DSF process. This is a vital component of service improvement and we look forward to providing updates on progress during the next reporting period. An initial pilot has been completed in children's services. It is anticipated that learning from this will be applied to 2022/23 DSF Report

The final area of this review is the improvement of our data collation. Currently Trusts have to use manual collation in some areas, and the current processes are lengthy and complex. As Encompass is developed across HSC Trust services will be incorporated into the new system. Until this IT development is complete there will continue to be challenges in data collation until the Trust services are fully operational with the new system. SPPG have made improvements to the statistical report to include a greater emphasis on comparative analysis both in terms of the last 5 years figures and across Trusts to provide a regional perspective.

SPPG have completed a review of workforce data currently collated through DSF (see appendix 3) and have collaborated with the DOH Workforce Review and Strategy in sharing of this data source in order to improve regional reporting. In addition SPPG have worked with each Trust to develop a regional children's workforce monthly report. This has been a very positive development and has made a significant impact in real time analysis of workforce pressures. It is anticipated that this work will be extended to incorporate adult services workforce.

Action Plans

A further development in the Delegated Statutory Functions process has been to review and improve the action plan and the governance arrangements around these. In previous years the action plan was 'rolled over' year on year. This led to a dilution of the plan, with unclear actions, a lengthy and unmanageable document, and insufficient progress reporting with many issues and associated actions remaining on the plans for a number of years.

This reporting period has utilised the new action plan process. Both the Regional Action Plan and the Local Trust Action Plans are included at the end of this report (appendix 4 & 5). Both these plans outline the issues identified through the DSF process. These are determined through interface meetings with the Trusts, the information contained within the Trust DSF Narrative and Statistical Report, Directorate DSF Planning Meetings and agreed with the Director of Social Care Directorate and the Executive Directors of each Trust at the DSF Trust meetings in June.

Progress updates for both the Regional and Local Action Plans are scheduled for September 2022, and March 2023. Interface meetings between the Directorate Social Care Leads and the Trusts are scheduled throughout the year to coincidence with the progress points. Each Programme Manager in the Directorate will update

on progress related to each action and report this to the Director of Social Care. Any concerns or delays in progress at any point during the year will be escalated by the Directorate to the respective Executive Director.

Audit

In accordance with the 2021/22 annual internal audit plan, BSO Internal Audit carried out a review of the governance processes and management of delivery of the Delegated Statutory Functions (DSF) for Looked After Children (LAC) Services in HSCB during August and September 2021.

The audit focused on processes in place within the Directorate of Social Care and Children, and specifically considered governance around statutory functions and management of delivery of the Looked After Children Services. It included consideration of what works well in terms of delegated responsibility now and any issues that need addressed going forward. Testing covered completion of the 2020/21 Delegated Statutory Functions reporting period, and the initial processes in developing the 2021/22 Delegated Statutory Functions objectives and action plans.

The audit found there to be a satisfactory system of governance, risk management and control with no significant findings in this report impacting on the assurance provided.

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CHILDREN'S SERVICES

Introduction

The full impact of the pandemic on children, young people and their families, has yet to be recognised but the last year has continued to be a very demanding one for Children's Services where demand has increased at the same time as unprecedented staffing challenges. Children who initially disappeared from view at the beginning of the pandemic began to re-emerge demonstrating an increased need for family, child and adolescent support, including as a result of domestic violence, substance misuse and child and parental mental health issues, exacerbated through the pandemic.

Challenges

Increase in the Looked After Children Population and Placement Sufficiency

On 31 March 2022 there were 3624 looked after children in Northern Ireland representing a further increase of 94 children from the previous 12 months. This also demonstrates a further year on year increase in the number of looked after children and cumulatively represents a 44 percentage increase in the looked after population since 2011. This reflects an increase in the overall number and rate of children in care in the UK. In addition the number of unaccompanied minors from other countries arriving in Northern Ireland is continuing to increase and Trusts can struggle to find appropriate placements for these vulnerable young people

This continued and growing pressure on the looked after children system in Northern Ireland, and in particular on the availability of placements has resulted in an increase in the number of children in inappropriate placements. At the end of March 2022 there were 91 children deemed to be in an inappropriate placement, indicating a rise of 62 children from the previous year.

However it is important to note that the number of children being received into care has not increased substantially over the years. For example in 2014 -2015 844 children became looked after and 825 were discharged from care in the same period. However in 2021 - 2022 899 children became looked after but only 777 were discharged in the same period. Therefore the increase in looked after children population is not solely due to an increased number of children becoming looked after but rather from the fact that they are remaining looked after for longer periods of time. Securing both the number and quality of family placements to meet the

needs of the growing looked after child population, whether they are teenagers or babies is a very significant challenge for Trusts. The rise in the number of children in residential placements has resulted in many cases from the number of children in foster placements that have disrupted due to pressures. The percentage of children in residential care remains relatively small, however it has increased from 166 children to 241 representing an increase from 5.3% of the looked after children population to 6.7% over the last five years.

On a positive note of the 899 children who became looked after in 2021/22, 431 were initially placed in kinship foster care (48%) as with a further 256 being placed in traditional foster care placements. The mobilisation of kinship care to meet the placement needs of children potentially brings many advantages for children but also brings its own unique challenges for the fostering services as they strive to adapt to meet the needs of these carers and support them to care for traumatised children.

Referrals to Children's Social Services and Children on the Child Protection Register

The full impact of the pandemic on children's wellbeing and subsequent increase in the complexity of children's social work cases has yet to be measured. Research indicates pressures including increased mental health problems among parents and children, parental substance misuse, neglect and emotional abuse, non-accidental injury, self-harming in young people, acute family crisis situations and escalation of risk in existing cases. It was of concern that in the first year of the pandemic in 2020/21 there was a 5% decrease in the number of referrals to social services. However referrals to children's services rose by 9% this year in 2021/22 to 34,969 which represented not just a return to but an increase of 1084 (3%) on the number of pre COVID referrals in 2019/20.

The number of children in the child protection register has continued to increase with 2,346 children on the register in March 2022 indicating an increase of 48 from the previous year, but of even greater significance a 15% percentage (n=306) increase from the previous 10 years (as there were 2040 on the child protection register in March 2012). The increase has not been steady over the years with some fluctuations. The highest proportion of children on the child protection register are aged between five and 11 however it is of note that 9.6% percentage (n=227) are particularly vulnerable to abuse or neglect due to being under the age of one year.

Unallocated Cases

Of particular concern is the exponential 191.3% increase in unallocated cases in children social services from April 2021 to March 2022. The extent of the increase was not the same across Trusts with the BHSCT and the NHSCT experiencing the largest percentage increase. Furthermore the pressures were not experienced in the same service areas. The majority of unallocated cases in both the BHSCT (73%) and the SEHSCT (41%) were in Children with Disability services NHSCT and SHSCT experienced the pressure of unallocated cases more in their Child protection/Family Intervention services. Trusts have put in place a range of processes to triage referrals, and where possible work with other agencies to put in place monitoring or support, however this remains an area of risk. Unallocated cases are a direct consequence of staff vacancies and the difficulties in recruitment and retention.

Staffing Challenges

The greatest challenge for Trusts Children's Social Services in delivering on their statutory duties is securing and retaining professional social work and social care staff. This is also in the context of increasing demand for services as indicated above. Recruitment and retention of social work staff is consistently extremely difficult in particular areas of children's social services, namely Child protection/Family Intervention teams, 14/16+ teams, Children with Disabilities teams etc. Where teams are staffed there is a preponderance of newly qualified and inexperienced staff. Although it must be noted that there are significant vacancies across all areas of children's services, where previously there would not have been issues with retention e.g. fostering and adoption teams. Workload pressures and excessive caseloads are among reasons given for those leaving the service. Trust are putting strategies in place to recruit and retain staff including introducing a skill mix, additional administrative support, better support for frontline social workers etc. Progress was made in the last quarter of 2021/22 when the overall vacancy rate fell from 34.1% at the end of February to 29.8% at the end of March. However by the end of March one in four posts in Family Intervention Teams in Northern Ireland were unfilled with more than two in five posts in residential care also being vacant. The real challenge will be not only recruiting but retaining staff in these critical and demanding posts.

Children's Disability

There was an increase in the number of children in need that were recorded as having a disability from 4,545 at Mar 21 to 4,601 at March 22. The number of unallocated cases in children's services has risen significantly this year by **1,025** to **1,613.** Of those **724 of the** unallocated cases where with children with a disability representing 44% of the total. At 31st March 2022, there were 90 children on the Child Protection Register with a disability. Most of these children (76%) had a learning disability.

The repurposing of short break units to place children who need to become looked after has meant that short break services have been curtailed. This has happened in 4 of the 5 Trusts and is a focus of the regional AD Disability group for action with monthly position monitoring taking place and on the agenda of this group. This reflects the on-going challenges in responding to the needs of young people with complex presentations.

Two short break units were closed by RQIA during 21/22 and SPPG is working with Trusts to restore services.

The reform initiative for disability services-Framework for Disability Services- sets out a comprehensive reform agenda which needs to be signed of by DoH policy colleagues.

A Threshold to services paper has been prepared and will be shared with all Trusts for agreement to improve regional consistency

The detailed position with unallocated cases in children with a Disability services is as follows and will be a specific focus for 22/23-

	CWD Unallocated	**Total Unallocated**
Belfast	545	745
Western	54	133
Southern	18	311
South Eastern	104	254
Northern	3	170

The position with regard to workforce vacancies is set out below

Trust	Vacancies in CWD as a percentage of workforce vacancies
Belfast	32%
Western	Not available
Southern	11%
South Eastern	40%
Northern	28%

Both the vacancy position and the unallocated position require monitoring and improvement and there will be ongoing work with the HSCT's re workforce challenges.

Breach of CAMHS waiting times

At March 2022 the CAMHS waiting list had increased by 817 to 2,106; of those waiting the number breaching the 9 week target had increased by 519 to 929

The children who were LAC and CIN within this cohort of waiters had increased from 38 at 31 March 2021 to 127 at 31 March 2022. This number includes children waiting for Step 3 and Step 2 CAMHS services.

The regional mental health unit Beechcroft had 81 admissions during the year but noted that 25 under 18s were admitted to adult wards when no bed was available in Beechcroft. Of the admissions to Beechcroft 22% of the young people were looked after and 27% were known to family support services. The highest admission reasons related to Eating Disorders and Suicidal Ideation. Improvement and consistency in CAMHS crisis and in- patient services is manged through the Managed Care Network.

Capacity issues in Beechcroft have led to young people with complex presentations being managed in the community.

Waiting Times for Autism Services

In 2021/2022 ASD services were still being adversely impacted by Covid restrictions. ASD referrals for diagnostic assessment increased by 49% from the previous year (2020/21 had seen a 25% decrease in referrals). The increase in referrals, in conjunction with the number of ASD diagnostic assessments being greatly reduced for most of the year; as assessment and observation could not be completed whilst wearing PPE as it interferes with monitoring facial expression and eye contact; has impacted the waiting times for a diagnostic assessment. Overall referrals waiting for an assessment increased by 30% in year to 6660. Whilst covid restrictions have still not been fully removed services have adjusted assessment and observations by for example using adjoining rooms with two-way mirrors. Demand for ASD assessment continues to increase by approximately 12% per year, SPPG are working closely with Trusts to develop more integrated pathways across children's services to help meet this demand.

The flow of work to Trusts in 21/22 is illustrated below.

Trust	Referrals	Accepted referrals
Belfast	1511	1018
Western	1038	748
Southern	896	821
South Eastern	1115	634
Northern	2041	1991

In terms of waiting times and specifically breaches of the 13 weeks the trended position is set out below. There has been an increase in total waits as well as increases in breaches of 13 week target.

Children's ASD Diagnostic Waiting Times at 31st March each Year - 2018 to 2022					
Year End	**31-Mar-18**	**31-Mar-19**	**31-Mar-20**	**31-Mar-21**	**31-Mar-22**
Total Waits	**2265**	**2242**	**3601**	**5124**	**6660**
Breaching 13 weeks	**1271**	**1110**	**2366**	**4080**	**5276**

Analysis of Individual Trust DSF Reports

The following analysis is broken down into the following areas (where applicable):

- **Key Issues and Service Pressures**
- **Risk Issues and Governance**
- **Professional/Workforce Issues**
- **Service Developments and Innovations**

BELFAST HEALTH AND SOCIAL CARE TRUST

Key Issues and Service Pressures

- **Unallocated cases / Stat Visits / Stat reviews**

Throughout the reporting period BHSCT has experienced increased demand on all services across Children's Teams has been noted due to the overall numbers of referrals and admissions to care, coupled with high levels of vacant posts. Particular challenges have been noted within LAC services with unallocated cases and statutory reviews and visiting timeframes being exceeded. The workforce position has been reported to the Trust's Risk Register and a Business Continuity plan was agreed by the Trust Board in January 2022 to prioritise services for those children and families at greatest risk. Further work is required to stabilise the workforce and this will be also influenced by ongoing engagement with the ongoing Regional Independent Review of Children's Services.

- **Placement Moves**

The Trust have noted increasing complexity among the identified needs of children being admitted to care and growing numbers remaining in care for extended periods. There is a pressure highlighted due to lack of appropriate placements, and acknowledgement of the complexity of needs children being admitted to care.

Risk Issues & Governance

- **Delayed discharges from Iveagh / Short Breaks**

The Trust continues to be involved in Judicial Review proceedings regarding a delayed discharge from Iveagh. It is likely the situation will be resolved within the next reporting period as the Trust has sourced suitable accommodation for the young person concerned.

The repurposing of the Trusts Short Breaks accommodation for children with disabilities has continued to impact on service provision. More appropriate long term placements are required to address the provision of care for children with complex, long term emotional and behavioural needs.

- **Provision of Personal Advisors**

The Trust's review of their service model for Leaving and After Care was paused due to staffing pressures but should recommence as a matter of urgency. Recruitment to Personal Advisor posts continues to be progressed but full compliance with statutory function has not been achieved.

Professional / Workforce Issues

- **Vacancies / Recruitment**

The Trust has engaged in regional recruitment for Band 5/6 Social Workers and continues to work collaboratively with Department of Health colleagues to progress actions from the Workforce Strategy.

Similar to other Trusts, workforce challenges both in recruitment and retention have impacted on statutory functions within this reporting period.

The Trust are consciously addressing the imbalance in skill mix with a high number of newly qualified staff being supported via recruitment of an enhanced number of senior practitioners. There has also been additional support sessions provided by the Learning and Development Team to newly qualified staff.

- **Service Development and Innovations**

The Trust have established an Out Of Hours Looked After Children's Team via the redeployment of some staff and utilising the workforce appeal. This has mitigated some of the pressures in relation to allocation of social workers to LAC children and the meeting of statutory review and visiting requirements.

The Trust have formulated a robust service action plan to address key areas outlined during a risk based audit in relation to kinship foster care arrangements; and are aiming for a service compliance date in December 2022.

NORTHERN HEALTH AND SOCIAL CARE TRUST

Key Issues and Service Pressures

A steady rise in the number of families in need of social work intervention, pressures on mental health services for children, and a rise in domestic violence, placement challenges and poverty have all resulted in increased demand for social work services. This coupled with social work staff shortages are having a significant impact on the Trusts ability to deliver its statutory functions. In particular:

- **Increase in Children in need referrals and unallocated cases-** additional 470 cases led referred compared to previous yearto 328 children referred for assessment of which 167 are unallocated
- **Reduction in availability of short breaks for Children with disabilities-** compared to 2019/20 there has been a reduction of 634 overnights provided
- **Number of Looked after children awaiting CAMHS assessments have increased -**28 LAC were waiting on assessment, this increased from 3at 30th Sept 2021

Risk Issues and Governance

The Executive Director of Social Work presents twice yearly to Trust Board regarding the Annual and Interim Statutory Function reports this includes the 6 monthly Corporate Parenting Reports. It is the Executive Director of Social Work and Assistant Director of Social Work Governance responsibility to provide professional Leadership and to ensure the maintenance of professional Standards and regulatory issues pertaining to the delegated statutory function. The Trust confirmed there are mechanisms in place within each division to assure that this is the case. The Trust has a Social Care Governance meeting that meets 8 times per annually, specifically focusing on the Social Work Workforce and on the delivery of Social Work Services. The Executive Director of Social Work chairs this meeting and areas of development, improvement and risk relating to delegated statutory functions are progressed in this forum. Emerging pressures and risks associated with statutory functions are reported directly into the Trust's

Standard's and Compliance Committee, the Executive Director of Social Work and Assistant Director of Social Work Governance are members of this committee.

Professional/Workforce Issues

Workforce difficulties are reported in recruitment and retention, work is ongoing to strengthen the supply, recruitment and retention of social workers to deliver safe, high quality social work services. The Trust is currently focusing on 4 key areas that are connected to the OSS DoH SW Workforce Review to ensure an adequate supply of social workers and improve and strengthen the workplace supports and practice for every social worker.

1. **Safe staffing levels-** Trust is involved in working groups to develop regional consistency in numbers, deployment and use of social work practitioners to ensure

2. **Manageable / normative caseloads**-The Trust has established work to pilot an evidenced based model to measure a balanced workload for social work staff

3. **Career progression & skills mix-** The Trust is considering mechanisms to implement a career-planning framework setting out pathways for career progression supported by relevant development and CPD opportunities. Work has been undertaken to review skill mix and ensure teams under significant pressure are enhanced with additional B4/B5 support roles.

4. **Widening access to options for Employment Based pathways in Family and Childcare to improve supply** The Trust is especially focused on reviewing pathways into social work, including, a career progression pathway for social care workers that includes access to a social work qualification and the development of a Trust wide social work bank.

Service Developments and Innovations

The Trust continues to operate a number of learning groups that are actively taking forward improvements within the following practice areas which connect to elements of our statutory functions:

- Think Family Approaches
- Sharing to Safeguarding Protocols
- Carer's Assessments

- Domestic Violence Training
- Improved interagency working with PSNI

Escalation processes for repeat MRAC & DV referrals

SOUTH EASTERN HEALTH AND SOCIAL CARE TRUST

Key Issues and Service Pressures

- **Children with a disability and complex needs.**

Trust noted an increase in demand with 189 unallocated cases in Children with Disabilities teams . The provision of services to children with disability and their families has been flagged as an area of significant pressure, which has been further exacerbated as a result of COVID19. The Trust is developing a strategy to meet present and future needs of children with complex health needs and disability including the need for short breaks.

The Trust highlighted the impact of the temporary repurposing of some units from short break provision to residential and acknowledged the consequent pressure on families due to the reduction in short break provision. The reduction in provision led to pre-action letters from parents

- **Placements for Children with Complex Needs**

The Trust also continues to experience challenges around meeting the needs of Looked After Children and has reported a growing need for specialist child specific placements and additional extra contractual arrangements (ECR) to meet the needs of some small number of children

- **CAMHS - Inpatient provision**

The Trust noted the increase in young people requiring to be assessed for detention under the Mental Health Order. The Trust has also reported an increase in demand for young people requiring an assessment from CAMHS and admission to the Regional Child and Adolescent In Patient Unit at Beechcroft in BHSCT. Capacity for admission to the unit is impacted by an unanticipated reduction in the overall number of beds available and is further impacted by a surge in demand for placements. This matter remains under review with SPPG working with the Trusts to monitor this area of concern.

- **Residential Care**

A review of residential care was progressed within the reporting period and progress has been made in relation to enhanced governance reporting arrangements and SAI reporting. SEHSCT provide the Regional Secure Care Unit at Lakewood and have experienced additional demand for the 16 commissioned beds.

- **Provision of Personal Advisors**

The Trust acknowledges that all young people who require a Personal Advisor under the Leaving Care Act currently do not have one. Recruitment and retention of personal Advisor's remains a challenge and this will require improvement and continual monitoring to ensure effective discharge of statutory functions.

Risk Issues and Governance

- **Unallocated Cases**

Trust notes that this remains a challenge and requires improvement and monitoring. Whilst the significant pressures regarding unallocated cases are readily acknowledged, the Trust has developed a very clear plan to assist in addressing this issue.

- **Residential and Secure Care**

The Trust experienced a major outbreak of Covid – 19 across many of its' children's residential homes and the regional secure care service. This could have led to closure of essential children's services but a number of innovative mitigations were put in place to protect the service and provide additional staffing to maintain services.

Professional/ Workforce Issues

- **Recruitment**

Trust continue to experience the on-going issues re recruitment and retention of social workers in children's services.

Service Developments and Innovations

The development of the innovative partnership with Greenhill YMCA to increase short breaks service for children with disabilities has been a particularly innovative development.

SOUTHERN HEALTH AND SOCIAL CARE TRUST

Key Issues and Service Pressures

- **Workforce Pressures / Service Delivery**

The Trust's reported workforce difficulties have significantly impacted upon service delivery within Safeguarding, Family Support and Corporate Parenting, resulting in a significant number of unallocated family support cases, and limited placement availability and options for Looked After Children and Young People.

- **Unallocated cases**

Unallocated cases are subject to reporting and monitoring however given current workforce challenges there have been increasing numbers across Children's Services within the reporting period. The Trust maintains its focus on ensuring that all Looked After children and young people have an allocated social worker. For a short period there were 4 unallocated Child Protection cases which has since been resolved.

- **Short Break provision / Recruitment**

The Trust's recruitment drive for Band 5 Children's Nursing staff for Short Breaks provision for children with disabilities has been partially successful, and continues to impact on the Trust's ability to provide their full complement of service provision for children with disability and complex needs.

Risk Issues & Governance

- **Placement provision for LAC**

The Trust continue to experience challenges in relation to foster carer recruitment and retention. The impact of the Covid 19 pandemic has caused some people to re-evaluate their lifestyles and led to the exit of some experienced foster carers over the past year or requesting de-registration.

- **Dual Registration**

An additional challenge arising in 2021/22, has been the need for Social workers fulfilling their statutory duties in ROI to have dual registration with NISCC and CORU as an outcome of Brexit. The Trust's shared border with ROI results in a number of children and young people with significant links in both jurisdictions. The CORU registration process is lengthy, complex and impacts on the completion of case work in relation to these families. The Trust continues to liaise with colleagues in TUSLA and seek appropriate assistance as required.

Professional / Workforce Issues

- **Professional Development**

The Trust displayed an enhanced focus on the development of knowledge base for the existing social work staff. There was an acknowledgement of a shortage of Practice Learning Opportunities for Student Social Workers and a Task and Finish group was developed specifically to increase the practice profile and availability of sites and on-site facilitator provision.

- **Recruitment**

The Trust took part in regional recruitment of Band 5/6 Social Work staff with a drive to address the vacancies particularly within the Gateway and Family Intervention Services.

Service Development and Innovations

- **Kairos**

The Trust has fully operationalised the Edge of Care service with a multi-disciplinary skill mix of professional staff, and has utilised a co-production approach with parents and young people to further assist in its future service delivery.

- **Concurrent care approach**

Following a successful Early Intervention Transformation project the Trust established a small team to pilot a concurrent care approach within Looked After Children service focusing on infants and young children. There are measurable outcomes in terms of achieving permanency in a timely manner through focused

assessments and effective decision making. In addition, the team have developed a small play park to enhance the quality of family time for parents and children.

WESTERN HEALTH AND SOCIAL CARE TRUST

Key Issues and Service Pressures

- **Workforce Pressures / Service Delivery**
  In April 2021 more than one in four social work posts (band 5-7) were vacant across children's services in the WHSCT. This compared to an even worse position in BHSCT and SEHSCT where more than one in three posts were vacant. By March 2022 the overall vacancy rate in Children's Services in the WHSCT had decreased slightly to 23.3% although significant progress was made in certain areas of the service e.g. Gateway teams which had a vacancy rate of 34% in April 2021 reduced to 15% by March 2022, in contrast the vacancy rate in Child Protection/ Family Intervention teams had risen slightly to 26%.
- Workforce challenges sit alongside increasing demand for services. Children on the child protection register and children in the looked after system had both increased over the reporting period. In March 2021 there were 529 children on the Child protection Register, an increase of 11 from the previous March but confirming the continued upward trend from 2011 when there were only 235 on the Register.699 children were looked after the WHSCT in March 2022, an increase year on year from 647 (8%) in March 2019.

Risk Issues & Governance

- **Unallocated Cases**

Unallocated cases in children's services rose by 71% (78 t0 103) in the reporting period in the WHSCT with a significant increases in unallocated cases at Gateway services which increased from 16 to 74. The Trust is proactively working on reducing the numbers of unallocated cases. A Senior Practitioner Band 7 has been placed in Gateway services and cases are monitored on a weekly basis.

- **Looked After Children Placements**

The increase in looked after children gives rise to a number of challenges including securing placements that can provide stability and meet the children's needs, whether this is with extended family or in another placement. Increase in the number of looked after children is associated with challenge in meeting statutory functions from completion of LAC reviews or statutory visits within required timeframes, or the appointment of personal advisors for those aged 16 plus eg 135 Looked After Children Reviews were not completed in the required timescale and 32 children did not have a named social worker. Combined with workforce difficulties it impacts on the quality of work with children and families. Lack of capacity to prvide support to foster placements makes disruption more likely for the children.

- **Dual Registration**

WHSCT social workers also experience the same challenges as the SHSCT in relation to dual registration with CORU to work with children from their Trust area placed in the Republic of Ireland (see section on SHSCT).

- **Children with Disabilities and Autism Services**

In common with some other Trusts two short breaks facilities were closed but are due to be re-opened by July 2022 and work is being progressed to open up a further unit. There has also been a big increase in assessments for autism and this has led to a major capacity issue for the Trust. (748 referrals accepted in year, service has capacity to complete 420 assessments)

Professional / Workforce Issues

The Trust is focussed on providing high quality experiences for social work students to enhance success of recruitment of newly qualified social workers
The Trust took part in regional recruitment of Band 5/6 Social Work staff and also the NISCC Workforce Appeal but results were very disappointing with very few additional staff being secured in front line teams.

- **Service Development and Innovations**

The WHSCT developed a pilot in Enniskillen where they experienced particular pressures so they put one children's services team in place covering all children's cases, rather then the usual division between Gateway, Family Intervention and Looked After Children teams. Initial results are positive and the Trust may decide to

put a further pilot in place in the future. In addition they have put in place an out of hours team to manage some of the unallocated cases. This has been successful but the Trusts are mindful of the potential for burn out for members who also work during the day.

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ADULT LEARNING DISABILITY SERVICES

Introduction

All Health and Social Care Trusts have continued to manage the impact of Covid-19 across the system which has challenged the HSC workforce in an unprecedented manner since 2020.

Each Trust has however made progress in the rebuilding of services, particularly day services, to provide pre-pandemic levels of support to individuals and carers. This continues as work in progress across the region and Trust Day Service rebuild plans continue to be monitored closely by SPPG and DOH.

Progress has been made in relation to the areas identified in Trust DSF Action Plans for 2021/22 and Trusts have sought both creative and innovative approaches to service challenges.

Current issues in relation to Muckamore Abbey Hospital (MAH) have impacted on Learning Disability services across the Region. This is most notable in relation to hospital admissions, specifically for NHSCT and SEHSCT, as neither of these Trusts have access to local specialist Learning Disability in-patient provision.

MAH hospital resettlement for individuals with complex needs remains a challenge for Trusts due to lack of appropriate accommodation and support. The provision of legacy information, required to support the MAH Public Inquiry, has also had a direct impact on current workforce and resources.

Service pressures also continue to be evidenced across Trusts in relation to requirements for the implementation of Mental Capacity Act Legislation; this includes the direct impact MCA has on the ASW service within each Trust.

Challenges

All five Trust Learning Disability services reported service pressures, issues and challenges regarding the areas as identified below.

- **Acute Inpatient admissions to Muckamore Abbey Hospital.** Three out of the five HSC Trusts identified issues with the availability of acute Learning Disability inpatient hospital provision. This has resulted in individuals being admitted to adult Mental Health In-patient wards where they may be more appropriately placed with specialist Learning Disability Provision. This continues to challenge an already stretched Mental Health system.
- **Lack of availability of Bespoke Community Placements and Accommodation/Resettlement.** Trusts referred to challenges pertaining to securing bespoke community placements and accommodation due to a limited pool of housing options and care providers.
- **Adult Safeguarding**- Trusts have noted an increase in Adult Safeguarding referrals and have noted the workforce implications.
- **Mental Capacity Act Legislation** – Trusts report that the implementation of the Mental Capacity Act has significantly challenged a range of services including Learning Disability services. Trusts report that they have not been adequately resourced to meet the work required to enact the legislative requirements.
- **Day Services** – Each Trust has encountered challenges in the provision of day care and day opportunities as a result of infection control requirements relating to the Covid-19 pandemic. Rebuild planning continues within each locality and is monitored closely by SPPG and DOH.
- **Approved Social Work Service (ASW)** – All Trusts noted capacity issues in respect of ASW services. Current challenges within ASW services are due to a number of factors including; lack of in-patient provision, which requires an increased conveyance period thus reducing the amount of available ASWs at any one time; impact of MCA legislation on ASW workloads; ASWs of retirement age leaving the service; lack of suitable new candidates for the ASW role.
- **Workforce issues**. A number of challenges have been identified in respect of the workforce, including capacity issues within the ASW service, Safeguarding roles, and workforce capacity within in-patient provision, namely MAH and Lakeview Hospital in WHSCT.

Analysis of Individual Trust Reports

The following analysis is broken down into the following areas (where applicable):

- **Key Issues and Service Pressures**
- **Risk Issues and Governance**
- **Professional/Workforce Issues**

Belfast Health and Social Care Trust

BHSCT Key Issues and Service Pressures

- **Domiciliary Care Waiting List –** The Trust has identified capacity issues in relation to domiciliary care for people with a Learning Disability. The waiting list for this service has increased from the previous DSF reporting period (17 individuals). This appears to be attributable to the decrease in Day Service provision due to the Covid-19 pandemic. The Trust has put contingency measures in place which include; enhanced access to Care Providers through the utilisation of the Care Bureau Brokerage and a time bands system to enable more flexibility in accessing packages. Key workers also maintain contact with families to discuss alternative supports such as SDS/ Direct Payments, carer assessments and community/ voluntary sector. In addition the Trust has developed a Day Service Rebuild Plan which hopes to positively impact on referrals made for domiciliary care.
- **Muckamore Abbey Hospital (MAH) In-Patient Admissions –** The Trust reports that capacity remains limited for in-patient admissions for individuals who require assessment and/or treatment to the Regional facility. This is due to current staffing levels. Lack of admissions to MAH has a resultant impact on other Trusts which are unable to access to the facility, it also directly impacts on admissions to Mental Health in-patient services, with a number of individuals being placed within Mental Health wards when they most benefit from specialist Learning Disability in-patient provision.
- **Accommodation needs for those being discharged from Muckamore Abbey Hospital –** The Trust reports continued delays in identifying appropriate accommodation for adults with Learning Disability and complex needs being discharged from Muckamore Abbey Hospital.
- **Provision of Day-care –** The Trust advises that during this reporting period the Covid-19 pandemic and infection prevention control measures have continued to impact on the provision of Day Care across adults services. Day Care

Services are working towards a return to pre-pandemic levels and prioritising those in greatest need. Within Learning Disability services Occupational Therapists normally based in Day Centres, offer a range of out-reach activities and many service users are opting for Direct Payments or domiciliary care as an alternative to day-care.

- **Adult Safeguarding (ASG)** BHSCT report an increase in referrals to adult safeguarding- this may in part be due to the historical and ongoing concerns regarding the Muckamore Abbey Hospital Inquiry. The Trust Adult Safeguarding Committee has developed an action plan to address areas of deficit in respect of adult safeguarding and is being overseen by the Interim Deputy Executive Director of Social Work.

BHSCT Risk Issues and Governance

- **Domiciliary Care Waiting Lists-** Increased waiting times for domiciliary care for service users and carers is of concern within BHSCT. The Trust reports that mitigation measures are in place and this risk sits on the Corporate Risk Register. Monthly unmet need audits are undertaken in both Learning Disability services to ensure packages are still required and ensure services are targeted to those at greatest risk.
- **Muckamore Abbey Hospital In-Patient Admissions –**Limited capacity for in-patient admissions for individuals who require assessment and/or treatment to the facility presents a risk to individuals and families within BHSCT. This also impacts on individuals within other HSC Trusts who require access to this regional facility.

BHSCT Professional / Workforce Issues

- **Mental Capacity Act (NI) 2016 Phase 1 (MCA)**
  BHSCT report that the implementation of the Mental Capacity Act has significantly challenged the Learning Disability Division. The Trust reports that the service area has not been provided with any additional resource to meet the work required to enact the legislative requirements. Therefore in the context of vacancy levels across teams, MCA work continues to prove challenging.
- **Approved Social Work (ASW)** The lack of qualified ASW staff within the Learning Disability Division with expertise relating to risk assessment and key legislation i.e. the Mental Health (N. Ireland Order) 1986, Mental Capacity

legislation and Human Rights legislation continues to present challenges. The Learning Disability Division relies upon colleagues in other programmes of care to provide support in relation to required MCA activity.

- **Muckamore Abbey Hospital –** A recent RQIA inspection of the facility noted that there continues to be a shortage of staff across all professions and grades within the hospital. Particularly noted were the challenges in maintaining Learning Disability nursing staff. These staffing challenges have a direct impact on the ability to receive in-patient admissions required under mental health legislation.

Northern Health and Social Care Trust

NHSCT Key Issues and Service Pressures

- **MAH Resettlement** – Resettlement of patients from Muckamore Abbey Hospital to bespoke placements in the community is a challenge for the Trust. However NHSCT continues to proactively find solutions to this ongoing challenge and updates SPPG at agreed intervals on the progress for those service users who have been unable to transition into a community placement thus far.
- **Access to Learning Disability In-Patient Beds -** Access to specialist Learning Disability in-patient beds within Muckamore Abbey Hospital continues to impact on NHSCT.A three bedded unit within Holywell Hospital is currently being developed for patients within NHSCT and SEHSCT. Trust will provide SPPG with regular updates and timelines for opening
- **Safeguarding -**The Trust has indicated an increase in referral numbers- this has been impacted upon by Covid-19. Consideration by NHSCT is required in respect of workforce and resource implications to adjust to this increased demand.
- **Day Care –** The Trust is currently progressing remobilisation of Day Care to pre-pandemic levels. Regular updates are being provided to the Minister of Health to ensure pre-Covid-19 activity levels are achieved. The Trust report they will not achieve 100% uptake of pre pandemic day services as some service users do not wish to return to day service supports.

NHSCT Risk Issues and Governance

- **Muckamore Abbey Hospital Resettlement** – Resettlement of patients from Muckamore Abbey to bespoke placements in the community continues as an area of identified risk for the Trust. However NHSCT continues to proactively

find solutions to this ongoing challenge and updates SPPG at agreed intervals, on the progress for those service users who have been unable to transition into a community placement.

- **Lack of Learning Disability In-Patient provision –** Continued limited admission to Muckamore Abbey Hospital presents an ongoing risk to individuals requiring a specialist in-patient service for assessment and treatment. Progress is ongoing in relation to the development of a 3 bedded unit within Holywell Hospital as a solution to required admissions.
- **Day Care and Day Opportunities** -The programme has encountered challenges in the provision of day care and day opportunities as a result of infection control requirements relating to the Covid-19 pandemic.

NHSCT Professional / Workforce Issues

- **ASW -** In addition to ongoing workforce pressures within the ASW service, specific issues have been noted in relation to the ASW and Learning Disability which centres on the lack of Learning Disability beds for patients assessed as requiring in-patient treatment under the Mental Health Order. Learning Disability services have relied on Holywell Hospital Adult Mental Health Service providing a bed for those in need of a hospital admission.
- **MCA impact –** Activity required in relation to the Mental Capacity Act has impacted greatly on the ASW workforce across all Teams including Learning Disability, this includes completing legacy day care applications for DOLS, Extension reports, Rule 6 reports and attending subsequent Tribunals.

South Eastern Health and Social Care Trust

SEHSCT Key Issues and Service Pressures

- **Re-start pressures; COVID 19 and related workforce services** Learning Disability services continue to work hard and deliver services to the population despite significant workforce's challenges that have impacted on the timescales to revert supports back to pre-covid arrangements. The Trust has signalled their concern by placing the issue of vacant posts on the corporate risk register.
- **Approved Social Work Service (ASW)** Currently the Trust ASW workforce is reduced, reporting seven retirees during the review period. However the ASW programme has now increased intake to seven per year due to demand. Optimistically the profile of the workforce has changed based on age; this is a critical development in planning for the future. The Trust has appointed an

Interim ASW Co-Ordinator which proved beneficial to delivery of the service. This staff member is due to return to their substantive post, however the ASW Group would be keen to have this role fulfilled. Given that there is no specific funding for this post it remains a cost pressure.

- **Transitions** Complex transitions from Children's Services to Adult Services for young people, specifically for those who do not have a moderate or severe Learning Disability diagnosis and require a therapeutic wraparound service. This is acknowledged as a deficit in service delivery.

SEHSCT Risk Issues and Governance.

- **Implementation of Mental Capacity Act -** The Trust acknowledged their preparation for the implementation of the MCA however they did not anticipate the additional work relating to the Attorney General role and noted capacity issues within the workforce.
- **Conveyance -** The Trust noted conveyance difficulties in relation to the Mental Health Order specifically with PSNI colleagues understanding respective roles within the legislation. The Trust has been involved in the regional review of the inter agency conveyance protocol alongside all stakeholders. In addition steps have been taken to the upscale local interface meetings with the PSNI in order to improve fluency of the process. The Trust currently uses a specialist taxi service on occasions as a conveyance contingency measure.
- **Access to inpatient beds** The Trust reports an inability to access specialist MAH in-patient assessment and treatment beds. This has impacted on the overall acute bed capacity issues with four patients requiring admission to Adult Mental Health Wards. On these occasions the Trust has provided Learning Disability support to staff to these units. The Trust has acknowledged a need to analyse and capture the data relating to declined responses from MAH. The Trust continues to promote and ensure the safety of adults who require mental health support. The resettlement programme at MAH is prioritised. Positively there are ongoing discussions with the Northern Health and Social Care Trust regarding the stepping up of three beds at the Holywell Site. Progress has been made and estates will have completed their work by September 2022.

SEHSCT Professional Workforce Issues

The Trust reports vacancies as outlined in the corporate risk register with this, low morale has been identified alongside difficulties overall within recruitment and retention.

- **Adult Safeguarding** There has been an increase Adult Safeguarding issues during this review period. This is a challenge from a workforce perspective.

Southern Health and Social Care Trust

SHSCT Key Issues and Service Pressures

- **Community Based Accommodation** A lack of available community based accommodation for young people and adults with disability who require either specialist or bespoke arrangements, remains challenging in the delivery of effective care. Whilst the innovative accommodation panel helps support this issue it does not fully address the lack of physical accommodation.
- **Muckamore Abbey Public Inquiry** Staff have been released to undertake the review of service user records to support the MAH Public Inquiry. This has an obvious impact on the available workforce.

SHSCT Risk Issues and Governance

- **Implementation of Mental Capacity Act (MCA)** The Trust report that MCA has not been sufficiently funded therefore this has impacted on the current workforce and subsequent service pressures. Currently there are higher levels of vacancies across learning disability services and new but inexperienced staff. Fortnightly operational meetings are in place to assess the ongoing challenges however maintaining core work remains a challenge.
- **Annual Reviews** The Trust acknowledged an increase in outstanding reviews during the review period due to COVID related absence/vacant posts and MCA workload.

SHSCT Professional Workforce Issues

- **Approved Social Work (ASW) Service** the Trust report significant stresses on the ASW daytime rota. The current action plan is making progress and is inclusive of the new quality standards and five year role out of such.
- **Overall Workforce** The recruitment and retention of social work staff onto the Learning Disability teams is more challenging compared to other teams. The lack of availability of social workers through Bank and Agency has only compounded the problem, resulting in many vacancies remaining unfilled

throughout the year. This in turn increases the pressure on staff in post. There are currently 9.5 WTE vacant posts across community teams. The Trust has employed a number of AYE Social Workers from the last year's final placements pool of students. The Disability Service is keen to support and develop AYEs and there are support measures in place to support AYE workforce. AYEs however have a protected caseload and are unable to undertake Mental Capacity Act responsibilities, nor the role of Investigating Officer.

- **Impact of Mental Capacity Act** - The Trust reports that lack of sufficient investment to discharge the functions required under the legislation has impacted greatly on the Learning Disability workforce. Although staff have discharged duties relating to Phase 1 legacy cases, the workforce will be challenged again in relation to Phase 2 of the legislation. Heads of Service for Community Disability Teams meet fortnightly with Human Resources Recruitment Support Officer to monitor, review and progress all vacancies including social work vacancies. Despite these measures, workforce pressures remain a significant challenge.

- **Impact of Covid on Day Care staff and Management** The current pandemic period has been particularly challenging for Service Users and carers due to the disruption of Day Care provision and normal routines. Service Users have had to comply with Covid restrictions and remain at home when in close contact with a Covid positive other. The staffing of day services has been impacted on due to infection control measures.
- **Adult Safeguarding** The Trust report that the required 6-8 weekly supervision for DAPOS has significant impact on the current service.

WESTERN HEALTH AND SOCIAL CARE TRUST – Adult Learning Disability

WHSCT Key Issues and Service Pressures

Adult Learning Disability Services are experiencing a number of pressures, some in common with other Trust areas as well as some that are more locally focused, these include;

- **Accommodation** There continues to be considerable challenges linked to cross-department responsibilities around accommodation that supports a strategic approach to the range of housing needs for the Learning Disability population generally and for those with more complex presentations in particular. Client specific presentations related to a forensic history or behaviours that challenge continue to experience additional difficulties in achieving appropriate accommodation and community support options, particularly within the local Trust area.
- **Delayed discharges from Lakeview Hospital** - consistently at least 50% of the inpatient population during 2021/22, this remains a pressure impacting negatively on bed capacity. Patients with an Autism presentation tend to be over-represented in the delayed patient population.
- **Placements out- with Northern Ireland** The Trust currently has 8 service users placed outside of Northern Ireland, 2 of who are within the extra contractual referral (ECR) process. The impact of such physically distant placements on families is considerable. In each situation, the individuals' unique presentation has been assessed as not being compatible with existing local provision, highlighting the importance of ongoing strategically driven approaches to accommodating and supporting our most complex service users within Northern Ireland.
- **Impact of Covid-19** There is increasing awareness of the impact of Covid both from a service user and carer perspective particularly in relation to mental health and well- being.
- **Transitions** There has been an increase in the number of young people transitioning from Children's to Adult Services with complex health and behavioural presentations. There are high financial costs associated with support packages especially when complex health care needs present. Increased frequency of such young people being managed separately from their peers in the school settings, compounds the challenge in securing suitable day care services within existing provision.

WHSCT Risk Issues and Governance

- **Lakeview Hospital -** Two unannounced RQIA Inspections have been made to Lakeview Hospital, in August 2021 and February 2022. The matters highlighted at Lakeview Hospital are being addressed through an Improvement Plan and have inherent support from relevant social work colleagues to support the

necessary professional development, competence and confidence of the nursing staff team.

- **Judicial Reviews -** There have been 2 Judicial Reviews instigated during the reporting period, both relating to young people recently transitioned to Adult Services and where challenges pertained to meeting assessed needs in community environments.
- **Adult Safeguarding activity has increased** over the year (referrals have increased by 85% and the number of investigations commenced in year have increased by 110%) and is more in line with pre-Covid levels of activity. The Trust note that taking account of improvements required from the RQIA Inspections at Lakeview Hospital, all Adult Safeguarding activity is delivered and managed consistently, with positive working relationships in place with colleagues in the Adult Safeguarding and Protection Service.

WHSCT Professional/ Workforce Issues

- **Working Patterns -** The Trust notes a growing interest in flexible working opportunities, including requests for compressed hours. While being in line with the Trust's newly updated Flexible Working Policy and being a desired position within the Service, there is a need for ongoing monitoring of any potential impact on service delivery.
- **Workforce issues, particularly in the independent sector** have been noted in Providers' ability to deliver services in the reporting year- the impact of more recent financial investment remains to be seen.
- **Recruitment issues in Psychiatry** Additionally in the WHSCT there are workforce pressures associated with psychiatry recruitment generally and those with experience in learning disability specifically. Learning Disability Services currently have only 1 permanent Consultant in post- attempts to recruit permanently and through use of Locum for the outstanding 1.7 posts have proved unsuccessful- the associated risks are considerable. The difficulty in recruiting and retaining Learning Disability nurses is a regional issue.
- **Approved Social Workers (ASW)** The Trust remains committed to engaging staff in the Approved Social Work (ASW) Programme. 2 social work managers, have successfully completed the ASW Programme during the reporting year and another social worker is currently part of the 21/22 Programme intake.

Introduction

The COVID-19 reset and rebuild pressures throughout 2021/22 continue to challenge the wider HSC in an unprecedented manner.

Mental Health Services in particular have worked hard to meet the increasing demands relating to Covid-19, demands from existing and new service users, with particular pressures facing acute inpatient and crisis services, and also to needs arising from within its workforce.

Staff have worked creatively to deliver services in new and innovative ways, keeping services available and accessible to those who need them, despite the considerable challenges and risks presented.

Progress has been made in relation to the areas identified in the DSF Action Plan for 2021/22 across all Trusts.

Challenges

Each HSC Trust Mental health services reported service pressures, issues and challenges regarding the areas as identified below.

- **Sustained Covid 19 Pandemic Pressures** - All of the Trusts have experienced pressures related to the Covid Pandemic. Trusts detailed their particular challenges regarding service delivery, workforce and the discharge of statutory functions as a consequence of the pandemic. Each Trust has been working to identify new ways of working that can meet the organisation's key priorities and to develop plans to respond to increasing numbers of ASW assessments required as a result of mental health surge and increasing levels of acuity among patients.
- **The Mental Capacity Act (MCA)** - All of the five Trusts are compliant with phase one implementation however continue to experience challenges in implementation of Phase 2 of the MCA in this reporting period. The Trusts cite service pressures such as lack of capacity of social work staff as well as limited access to medical input as part of the difficulty going forward in successfully implementing MCA.
- **Availability of acute in-patient beds -** Across the region, all Trusts have been experiencing increased and significant demand for beds within mental health inpatient wards. Trusts reported a shortage of acute beds within the reporting

period for patients requiring an admission for assessment under the Mental Health (NI) Order 1986. This presents a significant challenge for ASW's and their colleagues in Adult Mental Health. All Trusts also reported increasing acuity levels, with more patients requiring detention under the Mental Health (NI) Order 1986 and more increasing numbers of continuous observations. The Regional Bed Management Network continues to operate to ensure that all Trusts continue to work collaboratively on a daily basis, via a Daily Huddle, to find ways to improve flow, and make best use of the beds available to them. Supporting this work is the opportunity to strengthen community based services that will help prevent unnecessary admissions and also facilitate timely discharge.

- **ASW Workforce** - All five HSC Trusts reported that the ASW role remains challenging compounded by the fact that it can also be coupled with responsibilities and roles regarding safeguarding and MCA roles. The retention and workload of ASWs continues to be a service pressure during the reporting period regionally and all HSC trusts are actively working implement the new ASW standards and associated action plans.

BHSCT DSF Overview Report

BHSCT Key Issues and Service Pressures

- **Mental Health Admissions to Psychiatric Hospital for Assessment and Treatment** –The Trust report lack of psychiatric hospital beds due to increased demand, this has challenged the completion of formal admissions under the Mental Health (NI) Order (1986), and has led to significant delays in conveying detained patients to hospital from the community, general hospital emergency department or in police custody suites. In-patient bed capacity has also impacted on the ASW service within BHSCT (day rota) and RESW (out of hours) service as the protracted conveyance period causes a number of challenges to the deployment of ASWs across the system.
- **Approved Social Worker (ASW)** The Belfast Trust takes corporate approach to the provision of the ASW resource across Divisions. However, the HSC Trust reports challenges in respect of the ASW day time rota. The lack of qualified ASW staff within the service continues to present challenges in respect of deficits in expertise relating to risk assessment and key legislation i.e. the Mental Health (N. Ireland Order) 1986, Mental Capacity legislation and Human

Rights legislation. The Trust notes a number of factors which impact on the ASW Service these include;

- Lack of beds locally and regionally lead to prolonged waits for individuals to be admitted to hospital. This impacts on the ASW service as ASWs are required to make additional contingency arrangements and/or additional assessments under MHO due to lapses in time for hospital admission.
- Lack of GP availability and requests for ASWs to attend assessments after 5pm presents a significant challenge the ASW service which leads to ASWs working outside of their working hours to facilitate the working patterns of GPs.
- Interface issues with key agencies, particularly with the police service is problematic .This centres around different perceptions as to when police would be involved in conveyance under MHO legislation and the interpretation of the Interagency Conveyance Protocol (revised December 2019). Delays in police assistance can increase risk of harm to the service user and the public.
- Issues with handover of ASW responsibilities between HSCT day rota and RESWS out of hour's service. Lack of ASW capacity within the RESW service often requires ASWs to remain within the individual until considerably out with contracted hours of employment.

BHSCT Risk Issues and Governance

- **Mental Health Admissions to Psychiatric Hospital for Assessment and Treatment** –Lack of psychiatric hospital beds have impacted on the completion of formal in-patient admissions under the Mental Health (NI) Order (1986). This has also impacted on the ASW service due to conveyance issues.

BHSCT Professional / Workforce Issues

- **Adult safeguarding DAPO provision**
  The Trust reports that it currently has a challenge in having a DAPO in situ within each Team. There are currently 15 teams in mental health who do not have a designated DAPO in situ. This is due to a lack of targeted funding for the role as well as limited band 7 social work designated posts within mental health. To mitigate against this deficit the HSC Trust reports that MH Teams have some support from the ASG team, and the Mental Health Adult Safeguarding Team also screen referrals made via police, APGT and external agencies.

BHSCT Service Developments and Innovations

- **Admissions Pathway Quality Improvement Initiative**

Acute Mental Health Inpatient Centre (AMHIC) in response to increasing bed pressures, an initiative lead in partnership by both the Mental Health Divisional Social Worker and Divisional Nurse has been developed to analyse demands and pressures within AMHIC. A prioritisation tool has been created and daily huddle put in place track admissions and discharges. These initiatives are showing some progress in ensuring priority is given according to need.

NHSCT Key Issues and Service Pressures Adult Mental Health

- **Overall bed pressures in Adult mental health units** – The Trust reports that bed occupation is regularly at 100% plus capacity. This has been impacted upon by capacity issues within Dementia, Learning Disability and Children and Young People in-patient provision. A review of the Crisis and Home Treatment function within the Crisis Response Home Treatment Service has been completed. Work is ongoing to review discharge pathways and Facilitated Early Discharge within Home Treatment.
- **Increase in Assessment Requests** There has been an increase in requests for assessments during the reporting period from 227 to 290 however the number of hospital admissions resulting from assessment did not increase significantly.
- **Covid19 Pandemic** has impacted on the discharge of statutory functions however these have been maintained over the course of the pandemic by dedicated Social Work staff.
- **ASW Service**- the Trust reports that the ASW service has been under significant pressure and a number of factors have impacted on the capacity and workload of the ASW service within NHSCT. The factors which are not unique to the NHSCT include;

  - **Lack of in-patient beds** - ASWs are required under MHO legislation to remain with the person until they can be admitted to hospital. ASWs are regularly working until the early hours of the morning and on occasions have had to remain with service users for up to a 48 hour period until a bed can be sourced.
  - The interface with PSNI and NIAS can also lead to significant delays in completing admission to hospital. On occasions the PSNI have refused to attend to situations in which there is potential physical harm to the service user, the ASW or others. Work is ongoing with the local interface group to resolve these issues. Confusion with GPs and the PSNI continues around the interface between MCA and MHO, the ASW service has been contacted to give advice on this. The PSNI remain of the opinion that the powers within MCA relating to the Police have not been implemented. This has been raised via the Dept. of Health with the PSNI.

- **Lack of Specialist Learning Disability In-Patient Provision** The continued inability of Muckamore Abbey Hospital to admit adults with a severe learning

disability has caused particular stresses within the learning disability ASW service. For one admission in August last year the NHSCT, following consultation with RQIA and the Dept. the Trust had to temporarily open a closed ward in Holywell to accommodate one person who could not have been safely supported in an Adult MH bed. This was staffed by community nursing staff, Holywell bank staff and community support staff. This position remained for 6 days and was not in keeping with the requirements of the legislation. It proved difficult to obtain a bed regionally and the Trust had to request RQIA and the Dept. to intervene to resolve the situation. An alternative to these situations would be to take the service user to a place of safety such as an ED department but given the very real pressures on ED departments and the profile of the service users being assessed this is not a viable alternative.

NHSCT Risk Issues and Governance

- **Mental Health Order** the Trust struggles to meet demand for MH inpatient beds as required under the Mental Health Order (NI) 1986

NHSCT Professional / Workforce Issues

- **Recruitment** The Trust has initiated a number of proactive, collaborative approaches to recruitment difficulties, which are already underway and need to be developed further, to ensure an adequate supply of social workers and improve and strengthen the workplace supports and practice for every social worker. The Trust is currently focusing on 4 key areas that are connected to the OSS DoH SW Workforce Review.

NHSCT Service Developments and Innovations

- **Champions** following several Domestic Homicide Reviews the Mental Health Service is proactively reviewing the Inter-Agency Policy to further develop the role of the Mental Health Champions and Domestic Violence Champions across all teams.
- **Addictions Service** will also review the interface with Children's Services and consider cross – programme training on the impact of addiction on families. Addictions Services will also review their initial engagement with referred individuals to include those who are reluctant to engage. The Think Family

Social History tool and the Think Family Risk Assessment is under further development within to improve identification of escalating risk to family members by those who domestically abuse.

- **Approved social work (ASW)**
  There were 7 places offered for ASW training during 2021/2022, to include all programmes of care. There will be an additional 2 candidates who complete the ASW course from last year's cohort.
- An on-going challenge in recent years is the aging workforce. However, recent workforce development has seen an increase in the younger age group with 65% of the ASW workforce now under 50 (35% under 40). The ASW workforce plan 2020-22 continues to identify an increase of staff in these age groups.
- The implications for the ASW role in implementing the Mental Capacity Act (MCA) legislation remain significant. Discussion and collaboration has occurred between HR, senior managers and the relevant unions to discuss workforce issues and the implications of MCA. This continues to be shared widely with ASW practitioners.
- The Trust has 32 active ASW's on 31st March 2022. Of these 12 are part time. 5 ASWs are currently unavailable due to sickness. 8 ASWs have left the rota due to retirement or change in roles. Covid-19 and sickness have continued to impact on the ASW rota.
- **Designated adult protection officer (DAPO)**
  The DAPO continues to oversee safeguarding referrals from the hospital inpatient setting working closely with the adult safeguarding gateway team. Following an RQIA inspection and an increase in the number of adult safeguarding referrals an adult safeguarding action plan has been put in place. An action plan has been developed to include support for staff, service development and training. Review meetings have occurred between Trust managers, RQIA, strategic planning & performance group (SPPG), gateway team and PSNI. An early indicators audit is being implemented in all mental health inpatient units.
- **Resettlement Posts**
  The Trust reports the recruitment of 2 additional Band 6 social work posts to support the discharge of long stay patients transitioning from hospital to the community.

South Eastern Health and Social Care Trust

SEHSCT Key Issues and Service Pressures

COVID 19 The Trust continues to work hard to deliver services, despite the impact of COVID 19 vacancies and timescales for restart of service plans.
There are a greater number of social workers employed in Mental Health Services which supports a healthy position to grow and compliment the ASW service.

- **Bed Pressures** The demand for acute inpatient beds remains significant from a regional perspective. The Trust continues to engage with the Regional Bed Management Network to support this process.
- **Conveyance** Interfaces with PSNI and NIAS can be difficult on occasion. The Trust remains engaged in the review of the Regional protocol for transfer of patients to a place of safety and also remain committed to local engagement with the associated stakeholders.

SEHSCT Risk Issues and Governance

- **Mental Capacity Act (MCA)** The implementation remains a challenge. Concerns are expressed based on an increased need for ASW support. All legacy cases are compliant under MCA

Supervision arrangements the Mental Health programme of care is not compliant with the regional supervision framework. An action plan is being taken forward to promote stability of the workforce via supervisory arrangements and group supervision is being piloted. Peer support groups for the ASW staff have been beneficial.

SEHSCT Professional/Workforce Issues

- **Staff Vacancies** The Trust reports a changing profile within their workplace. This is significant is respect of the ASW Service. The current profile is 32 ASWS, 12 part-time staff, 5 on sick leave and 8 retiring. The Trust continues to mitigate against the impact of all vacant posts in order to deliver safe and effective care. This remains a priority for the South Eastern Trust.
- **MCA Medical Practitioners** There is continued liaison with the Medical Director within the Trust re access to appropriate medical staff for MCA work.

Despite these workforce issues the Trust has taken steps to deliver required statutory functions in respect of MCA.

- **ASW.** The Trust has 32 active ASW'S, 12 of these are part time, five are currently on sick leave and eight have left due to their issues. Covid continues to impact on the overall workforce including ASW. Seven places were offered as expected for ASW training and there will be an additional two candidates to qualify from previous uptake. The implementation of the Mental Capacity Act legislation has placed serious pressure on the ASW workforce.
- **DAPO** Following an RQIA inspection and an increase in adult safeguarding referrals an adult safeguarding action plan has been developed. This plan will include support and training for the workforce and will include an early indicators audit with plans to implement in all mental health inpatient units.

SEHSCT Service Developments and Innovation

Recruitment; There are clear recruitment plans in place with 5.5 social posts in the process of recruitment currently, 4.5 band 7 ASW vacancies and one band 7 team leader vacancy underway.

ASW an ASW workforce and training review has been achieved in line with the new regional ASW standards.

Inspections: following a follow up inspection from RQIA at Slievegrane supported lodging complex, significant improvement has been noted since the first improvement notice was served

Specialist Safeguarding Role, Following on from the RQIA inspection and action plan as previously discussed, there are three key areas of focus, openness and transparency, practice development and supporting staff. Close working with adult safeguarding gateway has been successful and investigations continue to involve PSNI and where necessary patient's representatives are attending Trust reviews as required.

Inpatient Beds Access to inpatient beds for patients with a Learning Disability and who present with Mental Health issues remains problematic. However the Trust has been collaborating with the Northern Trust in order to develop a three bed unit

placed on the Holywell site, Antrim as a bespoke alternative. This unit is due for completion in September.

Southern Health and Social Care Trust

SHSCT Key Issues and Service Pressures

- **COVID 19 -** the Trust reports that the impact of COVID 19 remains significant across the workforce and within the delivery of service.
- **Approved Social Work (ASW) -** the ASW service has experienced the most challenging of years, with very low availability for the MHO rota. For a period of approximately 6 months the service was reduced to 18 ASWs available to cover the rota. This was due to staff isolating, extended sick leave, maternity leave and senior managers no longer having capacity to undertake ASW functions due to workload pressures in the their substantive posts. A risk assessment was undertaken and the risk escalated to the corporate risk register. However, there has been a notable improvement in the past 2 months and the Trust has increased the number of ASWs by 5, through newly qualified ASWs and staff returning from sickness absence and maternity leave. There are now 38 ASWs appointed by the Southern Trust, with 31 currently active on the MHO Rota, four for MCA rota only, one for F5 assessments only, and 2 unavailable due to maternity leave. The appointment of a Bank ASW, one day per week, has also had a very positive impact.
  There is a number of social work staff, from a range of services areas, expressing an interest in commencing the ASW programme this year and we are hopeful all allocated places will be filled.
  ASW / Short Term Detention Authoriser team has experienced vacancies during the reporting period due to numerous career opportunities in other areas. This team will be reconfigured to be incorporated within the Hospital Social Work team going forward. There are currently 3.8 wte ASW/ Short-term Detention Authorisers working across four hospital sites.

SHSCT Risk Issues and Governance

- **Implementation of Mental Capacity ACT (MCA)**
  The Implementation of the Mental Capacity Act Legislation has impacted across the whole HSC Workforce. Concerns remain about the Trust capacity to

meet the demand. Teams are working with higher level of vacancies and less experienced staff, therefore many Social Work staff does not have the required two years' experience to qualify in capacity. There has also been no increased staffing resource to Core teams to deal with this additional statutory responsibility. The increasing numbers of Rule Six requests has affected staffs time to focus on extensions. The limited funding received by the Trust to undertake MCA work will have an ongoing impact on workload capacity.

- **Carers Assessments** The Trust has prioritised MCA work and this has negatively impacted on ability to complete Carers Assessments and annual reviews. The Trust is actively taking steps to revert back to pre-covid levels. The overall uptake of carers Assessments in the Southern Trust have been limited. This is due to staff challenges across the division, impact of additional MCA tasks and the appropriate recording on Paris.
- **Adult Safeguarding**
  The Trust has reported that Adult Safeguarding has has had a significant impact on the service during the DSF review period
- **ASW Service** the ASW service has experienced the most challenging of years, with very low availability for the MHO rota. For a period of approximately 6 months the service was reduced to 18 ASWs available to cover the rota. This was due to staff isolating, extended sick leave, maternity leave and senior managers no longer having capacity to undertake ASW functions due to workload pressures in the their substantive posts. A risk assessment was undertaken and the risk escalated to the corporate risk register. However, there has been a notable improvement in the past 2 months and the Trust has increased the number of ASWs by 5, through newly qualified ASWs and staff returning from sickness absence and maternity leave. There are now 38 ASWs appointed by the Southern Trust, with 31 currently active on the MHO Rota, four for MCA rota only, one for F5 assessments only, and 2 unavailable due to maternity leave. The appointment of a Bank ASW, one day per week, has also had a very positive impact.
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Social Work team going forward. There are currently 3.8 wte ASW/ Short-term Detention Authorisers working across four hospital sites.

SHSCT Professional/Workforce Issues

- **Impact of COVID 19 Pandemic on Staff** Impact of COVID19 on staff remains significant in terms of the challenges in delivery on optimum service.
- **MCA Workforce Challenges**
  Lack of GP input and an insufficient ASW Workforce is a challenge.
  ASW'S face challenges in maintaining the day rota. This has been severely impacted by COVID/Staff Isolation/Long term sick leave and Maternity. A new cohort of ASW'S commenced the rota in March 2022, based on this the issue has been de-escalated from the corporate risk register to the directorate risk register.
- **Support and Recovery**
  Support and Recovery services have experienced a very challenging year and have been impacted by both staff covid-related absence and general recruitment and retention issues.
  In recent months, the service has seen managerial changes, through retirement, promotion and alternative roles. This is in addition to practitioner staff moving to alternative roles in the wider mental health service and GP MDTs, as well as maternity leave vacancies. Recruitment is ongoing and the service has seen new social workers appointed to Support and Recovery teams during the reporting year. Although there are currently no vacant social work posts, the high level of staff changes both at practitioner and management level resulting in vacant caseloads has resulted in increased pressure and poor staff morale on social work colleagues in post. Due to these challenges teams have been reluctant to support student social work placements, as they would prefer that students are offered a stable and conducive learning environment where there is sufficient easement to support them. The majority of ASWs have core social work roles within Support and Recovery services, the additional pressure on our ASW service has resulted in reduced capacity for core workloads in this staff group.

WESTERN HEALTH AND SOCIAL CARE TRUST

WHSCT Key Issues & Service Pressures

Acute inpatient beds – the pressure remains significant in this area and the Trust will provide ongoing assurance that they will continue to engage with the Regional Bed Management Network via their Bed Capacity Co-ordinator.
Increase in referrals - the Adult Mental Health Service has seen a significant increase in Social Work referrals and ASW assessments in 2021/22. There has been an increase in SW referrals from 4440 to 6258 and an increase in ASW assessments form 211 to 260. There has also been an increase in applications to the Mental Health Review Tribunals from 4 in previous reporting period to 13 in current reporting period. This primarily has been related to the impact of Covid

- **Delayed Discharges** - The Trust have continued to experience difficulties in relation to the impact of delayed discharges due to the lack of supported living or rehabilitation units to support these adults.
  Conveyance of patients in need of acute psychiatric care - The conveyance of patients in need of acute psychiatric care has remained at times challenging. An interface meeting has been set up by the Lead Social Worker with PSNI and regional social work service to discuss and map local ASW cases which experienced challenges related to conveyance.
- **Accommodation** - There is a current review of supported living services led by the supported living project senior manager, the review is scoping both statutory and independent sector supported living provision. The completion of the review in 2022 will support with the future direction of supported living services and identify and address areas of unmet need.

WHSCT Risk Issues & Governance

- **MCA** - Completion of Short Term Detention Authorisations (STDAs) in Acute Inpatient settings has been identified as an ongoing issue with lower numbers of authorisations having been achieved than in other Trusts- this is a particular area of focus and we have established an Operations Group to advance this work.

WHSCT Professional/Workforce Issues

The Trust report that the adult mental health social work workforce has been strengthened by the appointment of a social work practice manager in the Northern Sector.

- **Approved Social Workers (ASWs**)Reduction in numbers of ASWs due to OH assessments and maternity leave - required the implementation of a corporate contingency of a trust wide ASW response at times when activity has not been met due to high number of ASW assessment requests. A workshop will be held in June 2022 to explore the challenges in this area.
- **MCA Medical Assessments** Availability of necessary medic resource for MCA continues to be a significant challenge with potential access to regionally available resources being an area of particular interest.

WHSCT Service Developments & Innovations

ASW Service An ASW Senior Manager on call for ASWs Trust wide 9am – 5pm Monday to Friday has been put in place to triage and support ASW activity.
An MCA Operations Group has been developed to support the ASW service.

- **Supported Living** A Trust Assurance Process for Supported Living, and Residential and Nursing homes, has been ongoing throughout 2021-22, to assist with more robust governance arrangements and assurance around patient and client safety for those residing in 24/7 settings.
- **Service User Consultant -** The continued investment in the appointment of a Service User Consultant has proved beneficial to service user engagement and to the sub directorate in understanding the challenges for those wishing to access services. It has included co-produced training within the Recovery College and the appointment of three peer educators.
- **Carers Assessment** A Qi project will support with all carers being offered a carer's assessment at initial point of contact within Adult Mental Health Services, including initial points of contact with crisis home treatment, inpatient adult mental health wards, primary care liaison and addictions services.
- **Medication Errors** A Qi project is ongoing to reduce medication errors within each supported living facility in partnership with staff, service users and pharmacy support. The point of focus is to reduce medication errors to 90% by December 2022 and 100% by April 2023.

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OLDER PEOPLE, PEOPLE WITH PHYSICAL AND/OR SENSORY DISABILITY AND ADULT SAFEGUARDING

Introduction

There are familiar pressures noted in this year's DSF report (increasing complexity of client need, workforce, hospital discharge, increased adult safeguarding referral numbers, access to domiciliary care and the care home sector) plus a range of new challenges in terms of how we 'live with Covid' and re-build HSC capacity.

Covid-19 has required continued agility from the HSC system. Service continuity and contingency plans were deployed by Trusts to ensure that people, particularly those with the most critical level needs, continued to receive the services they required.

Covid-19 further amplified existing pressures within the care home, domiciliary care and hospital sectors. Trusts responded well to these challenges, with learning from earlier Covid-19 surges usefully deployed to deal with increasing demand and workforce pressures.

A number of Trust pressures, relevant across Trusts and all adult programmes of care to varying degrees, can be identified in this year's report:

- The care home sector (workforce and market stability)
- Access to domiciliary care (workforce recruitment and retention issues)
- Recruitment/ retention of the social care workforce at all grades
- Access to annual reviews
- Hospital discharge pressures
- Support for carers
- Data validation issues.
- Increasing numbers of adult safeguarding referrals

These are discussed later in the report.

Workforce

The HSC system is highly dependent on access to a suitably trained and skilled workforce. All Trusts report some level of recruitment and retention difficulties across their social work/ social care workforce.

Recruitment and retention of domiciliary care workers remains a key pressure, but in addition, staff have been faced with multiple and competing challenges as they endeavour to carry out Approved Social Work, Mental Capacity Act, carer assessment and other professional roles.

More senior and team manager grades (typically Band 7) remain difficult to recruit.

Statistics/Information

Data accuracy remains a problem across the reporting process despite ongoing Trust efforts to improve systems and accuracy. There is some indication that improvements in this area have been made.

However, the engagement process between Trusts and SPPG often highlights the disparity between Trust assurances of compliance with their statutory duties and the evidencing of this via data submitted. This issue arose again this year in terms of carer assessments and also Adult Safeguarding activity.

Domiciliary Care

The impact of Covid-19 continues to be felt across the domiciliary care sector. Staff sickness, recruitment/ retention of staff are reported as one of the main pressures in this area. Rolling recruitment strategies are in place to try to attract more staff into domiciliary care work within the statutory and independent sectors. Some Trusts have under Agenda for Change terms and conditions uplifted the Trust Home Care worker from Band 2 to a Band 3 to recognise the important work domiciliary staff undertaken and to encourage retention of staff.

The demand for domiciliary care continues to grow and exceeds service capacity. Trusts are reporting higher levels of complexity of need and increased frailty. Service users are more reluctant to go into care homes and this is having repercussions for

domiciliary care. Each of the Trusts have plans in place to review and address those at highest risk on the unmet needs list.

Trusts actions in this area have included increased focus upon domiciliary care recruitment drives; retention of the existing workforce; re-organisation of current resources; promotion of Direct Payment s and SDS responses. The provision of £23m new regional funding late in 21-22 helped stabilise the service but did not create the expected new capacity.

The SPPG has requested Trusts to develop action plans outlining specific steps for addressing domiciliary care waiting lists and these will be discussed at upcoming review meetings.

Trusts are reporting that they are promoting the uptake of Direct Payments as an alternative to a domiciliary care packages, however due to staffing pressures in the Social Work and Social Care sector a decrease in direct payments is noted with service users also reporting difficulties in sourcing personal assistants. SPPG will also keep this issue under review with Trusts.

Hospital Social Work

This is not a specific programme of care return but there are commonalities across Trusts in terms of the issues raised:

Discharge pressures are a focus for acute hospital social work with reports highlighting issues re the availability of domiciliary care and difficulties with discharging someone with dementia, delirium, confusion and those with enhanced care requirements into a care home. The SHSCT references the negative impact on length of stay by the lack of care home beds for those under 65 years.

The utilisation of transition care home beds whilst awaiting a domiciliary care package is highlighted by the SEHSCT and NHSCT and is a practice that is occurring across the region. The impact of Covid-19 on discharge is highlighted particularly by the NHSCT in terms of staffing, domiciliary care availability and care homes discharges due to isolation requirements and the associated staffing needs.

Current vacancies or difficulties recruiting to higher band posts within acute hospital social work is referenced by the BHSCT, SEHSCT and the WHSCT and is perhaps symbolic of widely acknowledged pressures within acute hospitals.

BHSCT had to implement its Business Continuity and Surge Plans twice in the reporting period. These issues will be picked up in follow-up meetings with the Trust.

Care Homes

Staff from across all HSC Trust areas have worked closely with care home sector staff to respond to the Covid-19 pandemic.

The pandemic has resulted in increased capacity in the sector i.e. vacancies in care homes, but there remain challenges in accessing placements in a timely manner, specifically after 5pm and at weekends and for people with complex physical and cognitive needs, including delirium/ dementia. Trusts have undertaken to explore 'block' bed purchasing arrangements as an option to address this.

Regional funding guarantees ensured service stability, but can only be a short term solution. The SPPG recognises that market stability issues exist, with some recent home closures during the reporting period. SPPG continues to monitor the market and bed capacity across the region, now via a new weekly data report from Trusts.

Trusts have noted the suspension of regular care reviews as the pandemic progressed, these have been re-instated and Trusts are working to achieving a minimum standard of an annual review for each client.

Carers

Covid-19 has impacted significantly upon carers across all Trusts and programmes of care; anxieties about infection, the suspension of care packages, restrictions on visits to care homes and access to short breaks and day-care.

Trusts are working to a re-build and re-mobilisation agenda that will see these services re-established to at least pre-Covid levels.

While the feedback from carers has, for the most part, been positive and recognises the efforts by Trusts to continue to provide services in the face of a pandemic, many carers are anxious to have services (domiciliary, day care and short-breaks) restored as soon as possible. In this year's DSF meetings, Trusts noted their activities around a safe and phased re-opening of services such as day-care as they move towards re-mobilisation.

The roll out of the Carers Conversation Wheel within Western, Southern, Northern and South Eastern Trusts is credited as providing a platform for identifying support needs more effectively.

In this year's report, the majority of Trusts, notably SHSCT, reported challenges in accurate reporting of carer assessment activity. Given this is a statutory obligation it is an area where specific focus on improvement is being required from Trusts by HSCB, especially in light of the adoption of the Carers' Conversation Wheel.

Services for People with Complex Needs

Challenges in this area typically refer to Acquired Brain Injury (ABI) and other complex physical disability needs. Issues are primarily related to developing bespoke care packages or identifying accommodation solutions (with support). However, accommodation options for people with complex needs can be limited and for those with highly complex needs, 'out of area placements' or supported placements in the care home sector are often the only option.

The requirement for services for people with more complex needs (ABI, dementia, delirium) challenges hospital services where patients who are medically fit for discharge are unable to access care packages or appropriate placements in the community. This is recognised by SPPH as a regional DSF action plan issue. Work has also been undertaken to scope this issue from a hospital discharge perspective.

Dementia

Only 2 of the Trusts (BHSCT and SHSCT) reference memory/dementia services in their DSF report.

SHSCT has successfully effected the transition of new referrals for those under age 65 years from Psychiatry of Old Age (POA) to the Memory Service, completing an action from the 21/22 DSF action plan.

The plan to implement the regional dementia care pathway published in 2018 in the prototype sites has not been realised. Work within the ICPs to progress the business cases was hampered by the unavailability of key stakeholders as a result of the pandemic response. Although the ICPs have concluded the business cases, the final business case has not been progressed due to the absence of identified funding.

In the WHSCT memory assessment service, staffing levels and recruitment remains a challenge in relation to medical, psychology, nursing and social work staffing. As a consequence there are breaches in new and review waiting lists. Covid related pressures have continued to impact upon this service area.

As of 31st March 2022, waiting lists for memory assessment exist in all Trusts with 57% of all waits greater than 9 weeks. In SEHSCT, which has the highest numbers of waits greater than 9 weeks, this issue has been placed on the corporate risk register.

The pandemic has had a negative impact on the waiting lists due to the necessity to downturn the number of clinics to conform with social distancing and IPC requirements. The majority of Trusts commenced waiting list initiatives during the reporting period, temporarily funding additional memory clinic sessions.

In SEHSCT, substantive staffing levels in one dementia assessment ward remains inadequate and has been added to the Trust Risk Register. SEHSCT acquired additional staffing via Covid rebuild funding: two Band 6 Mental Health Practitioners and two Band 3 Social Care Workers were appointed to support the work of the wider multi-disciplinary team.

Analysis of Individual Trust Reports

Key issues/ Service pressures

Domiciliary care remains an ongoing service pressure for the Trust. In March 2022 there were 873 clients requiring 6,106.25 care hours. SPPG has expressed its concern to the Trust that unmet need has significantly increased from the 31 March 2021 position (278 service users awaiting care packages equating to 1588.75 hours). This is a decline in performance despite recent significant regional investment and an area that SPPG will continue to follow-up with the Trust.

The Trust is seeking to address pressures through a number of measures including structural changes, modernisation of homecare and a domiciliary care action plan. In addition, a pilot is ongoing in West Belfast to increase utilisation of Direct Payments.

The significant backlog in relation to the completion of statutory annual reviews has been highlighted in the Executive Director of Social Work (EDSW) Summary. From a starting position within the reporting year of 5,500 face to face reviews requiring completion, to the end of year position of 2,239 reviews outstanding, SPPG notes that the Trust has made some progress. However, over 2,000 reviews outstanding is a failure to meet delegated directed statutory functions and is a concern that SPPG has sought to address by the development of an action plan with key milestones and deliverables.

The Trust has outlined mitigating factors to include: ongoing contact with the Key-Worker; escalation prioritised based on service user needs/risk and increased staffing. .

SPPG has concerns regarding service pressures within Acute Hospital Social Work.

The Trust has acknowledged that change will not be effected until senior managers are in post which is not expected until September 2022. It has been agreed with the Trust that a separate meeting would be held with SPPG to address issue of case closures, outside of the DSF process.

Remobilisation of day care activity to pre-Covid levels is a priority for the Trust. The report notes activity of approximately 37.6% of the previous daily activity. Measures taken by the Trust to address this issue include working with key stakeholders to

review and complete risk assessments; use of PPE, review of vaccination status of staff and service users; regular testing and booster vaccinations for those who are eligible. The SPPG recognises the comparatively low level of daily activity within this programme of care and has stressed to the Trust the need for ongoing focus in this area.

Risk and Governance

The BHSCT DSF report references a number of unallocated cases for Community Social Work. There were 425 unallocated cases, primarily linked to transfers to a new key worker from staff who have left the service or been promoted within it. Whilst SPPG accepted the measures in place to address which included tracking and monitoring cases (unallocated cases assessed as being low level) it has been stressed that this position is unacceptable and the Trust must accelerate steps to address.

Professional and Workforce issues

Across the programme there is recognition of the impact of Covid-19 on staffing levels. The Trust reports within the programme relatively low rates of vacancy but recognises challenges with staff turnover.

SPPG notes that Business Continuity Plans have been implemented in Acute Hospital Social Work within the reporting period and Service Contingency and Business Continuity Plans are currently in place for the Care Review and Support Team (CREST). These workforce pressures have had a negative impact on the required frequency of professional social work supervision, in which the Trust reports 70% compliance across the programme. SPPG notes the concepts outlined by the programme which should affect a positive change. Progress on these will be followed up at mid-point DSF review meetings.

SEHSCT

Key issues/ Service Pressures

The Trust has experienced challenges meeting the requirement to complete annual reviews. In this reporting period their compliance was 22%. An action plan has been put in place to address the backlog and to address standardisation of the review process as per the recommendation from the BSO internal audit – care management. This will be kept under by SPPG at future review meetings.

Domiciliary Care continues to be a key pressure for the Service Area which has seen a significant increase in demand and increased levels of unmet need. This is attributed to the impact of Covid-19 and with the emergence of higher levels of complexity and increased frailty of service users in need of domiciliary care packages.

The Service Area has been proactive in trying to recruit statutory domiciliary care staff via a rolling recruitment programme. Furthermore, an agenda for change review concluded that domiciliary care workers banding will be uplifted from Band 2 to Band 3. It is anticipated this will assist resolve in-house recruitment issues.

The Trust has continued to be proactive in progressing the domiciliary care reform agenda. Digitalisation has been introduced into some sectors with full implementation expected by May 2022. This achievement will improve transparency, efficiency and timely staff communications. It is also anticipated that a family/carer portal will improve service user/carer experience.

Risk and Governance

The BSO internal audit of care management 21/22 was concluded in this reporting period with a final report issued in December 2021. This audit focused on the care management process and was conducted across 4 programmes of care including older people. 7 recommendations have been identified for this Service Area and an action plan has been agreed to provide assurance in the care management process. It is expected that these improvements will be implemented and further audited in June and October 2022.

The Service Area repots RQIA have completed 13 inspections - including unannounced and announced in this reporting period. Whilst good practice has been identified and some areas have received no areas of improvements, overall the Service Area has received 23 areas of improvement across a range of their regulated services and facilities with one unit still awaiting their final report.

Professional and workforce issues

The Service Area reports significant challenges in recruiting staff have impacted on its ability to fulfil aspects of the delegated statutory functions.

The Service Area reports a significant number of vacant posts in this reporting period: 23.2 WTE band 2 care work posts, 7.79 WTE band 3 posts, 2 WTE band 5 posts and 31.8 WTE band 5/6 social work posts.

Recruitment to senior manager Band 8a and Band 7 team lead posts continues to prove challenging with hospital, community and Adult Protection teams all experiencing band 7 team leader/designated adult protection officers (DAPO) vacancies.

SHSCT

Key Issues and Service Pressures

Domiciliary Care

The Trust continues to experience staff shortages and an increase in demand for domiciliary care packages. Unmet need figures for end of year continue to be high.

The Trust has continued with its rolling recruitment for Trust domiciliary Care Workers and going into 2022/2023 plans to review its in-house model of domiciliary care. SPPG will seek updates from the Trust on this work and the impact upon unmet need figures.

Hospital Discharges: Complex Delays

The Trust is continuing to report problems with hospital discharges and complex delays. They are continuing to work on more robust systems to improve timely discharge and working closer with care homes to reduce delayed transfers to care and to ensure that bed vacancies are utilised to full capacity. SPPG will continue to monitor this at DSF review meetings

Remobilisation of Day Care services

The Trust report they are not achieving full capacity in their day care attendance numbers. This is largely due to restrictions around social distancing guidance. The Trust is aware that there is a DOH plan to get service user attendance back to pre-pandemic levels and will work towards this. This will continue to be monitored by SPPG.

Risk & Governance

Outstanding Annual Reviews

Trust figures up to middle of February 2022 indicate a substantial number of outstanding care reviews, particularly for service users in receipt of domiciliary care packages. The Trust has put this on their plan for 2022-23 with actions to include improved recruitment and retention. SPPG will request a more detailed plan of action from the Trust to address this breach of DSF duties.

Professional & Workforce Issues

The Trust reports 15% vacancies across social work and social care in the ICTs for older people. The challenges have included Covid-19 related absences. The Trust Management team have moved to a position of replacing temporary vacancies with permanent staff to stabilise teams, improve staff morale and ensure longer term retention of staff. Recruitment is ongoing.

A new service development, the 'Access & Information Team' has dealt with over 1,500 referrals that otherwise would have been managed by the ICT social workers. The success of this model is indicated by a timely response to referrals, early intervention and prevention. Whilst this project has only been funded on a temporary basis, SPPG would identify the value of its learning to date.

Key Issues and Service Pressures

Domiciliary Care

The demand for domiciliary care this year has continued to increase. The Trust continues to implement the 'fair access' eligibility criteria and has an assurance framework in place to review its unmet needs lists regularly. Despite this, full package of care waits have increased. The Trust has given SPPG a commitment to continue to promote Direct Payments as an alternative to a statutory domiciliary package of care. Piloting an area of the Trust to test and review the impact of this may be an option for the Trust. This will continue to be re-visited at DSF meetings going forward.

Day Care

SPPG notes the Trust report a decrease in number of adults in receipt of centre based day care. The Trust has indicated that due to current guidance in relation to social distancing and the layout of some Trust day centres they cannot at this stage return to pre-pandemic capacity yet. The Trust is aware that there is a DOH plan to get service user attendance back to pre-pandemic levels. This will continue to be monitored by SPPG and the DOH.

Carers Assessments & Direct Payments

DSF report highlights a decrease in both, citing staff shortages and fewer numbers of available personal assistants available. As this is a delegated statutory function the Trust need to provide a clear and proactive approach going forward and SPPG will seek an update on this at future meetings.

Risk & Governance

Care Reviews & Care Management Standards

Reference is made to an 87% reduction in annual care reviews from last year reporting period, 31/3/21. The Trust has indicated this is due to Covid absence, general absence, staff vacancies and an increase in referral rates. SPPG have asked

the Trust for an update on their action plan to address this reduction and this will be reviewed throughout the year at DSF meetings.

SPPG have noted that an internal audit of care management was described as offering 'limited assurance' to the Trust. SPPG would suggest that the Trust not only put in place actions to improve on this but that an audit is completed in six months time to ensure compliance with care management standards.

Professional & Workforce Issues

The Trust Executive Director's summary report outlines that Social Work staff shortages are having a significant impact on the Trusts ability to deliver its statutory functions.

The issue of retention of staff has begun in part to be addressed by the Trust with the implementation of a Trust wide Social Work Transfer Scheme. The Trust has placed an increased focus on retaining experienced Social Workers. SPPG will engage with the Trust on this issue in future DSF meetings to ascertain measured benefits of this.

WHSCT

Key issues/ challenges

Carer Assessments

The Trust has not completed the projections of demand for carer assessments across all programmes of care which had been identified as an action within the 2021/22 action plan. The Trust cites the pandemic as the reason this work not being completed. The Trust will be asked by SPPG to addressed this as a matter of priority.

For the previous reporting period, 321 carer assessments were offered with 150 carer assessments completed and 171 carer assessments declined. The Trust has not provided any explanation why this number of carer assessments was declined in the report, this will be addressed with the Trust and an analysis requested and steps required.

Domiciliary Care Unmet Need

At March 2022, there were 270 full packages outstanding and 132 partial packages outstanding. This is unsatisfactory and the SPPG will seek an action plan from the Trust to address.

Memory Assessment

Adequate staffing levels and recruitment remains a challenge in relation to medical, psychology, nursing and social work staffing. As a consequence there are significant breaches in new and review waiting lists. Memory assessment work was stood down in November 2021 because of staff shortages with assessments recommencing February 2022 in the Northern sector only. SPPG will keep this issue under review.

Annual Reviews

The report makes no reference to outstanding annual reviews in care homes and domiciliary care which has been an issue in the last reporting period for all Trusts. SPPG will seek an update on this from the Trust and actions planned/ taken.

Professional and Workforce Issues

The Trust reports a number of social work vacancies in the Service Area. This includes a number of vacancies at Band 7 and above. The Head of Discharge and Hospital Social Work post (8B) is currently vacant and is in the process of recruitment.

There are a number of community social work vacancies at Band 7 due to sickness and maternity leave. Recruitment delays to these vacancies have been exacerbated by local and regional recruitment challenges in relation to the social work workforce. The Trust plans to fill these posts via the Temporary Internal Promotion (TIP) process. The length of time to recruit and appoint to all grades via the BSO regional service has been escalated within the Trust.

Adult Safeguarding and Protection

Introduction

Adult Safeguarding (ASG) continues to provide critical services regionally. Trusts are in the process of transitioning from Covid-19 operational models and in the main report a significant increase in Adult Safeguarding referrals, stretching existing capacity.

Regional ASG issues

As Trusts return to pre-Covid-19 service levels, there will be an increase in face to face contacts. With the exception of the SHSCT, all Trusts reported significant increase in referrals in the reporting year. SHSCT link the drop in referrals to a 10% reduction in available DAPOs in ICTs. The Trust has indicated they have completed internal audits around this issue

SPPG will drill down on this issue with the Trust and expects the Trust to put in place a process to provide assurance that these issues are being addressed, measured and reviewed on a regular basis.

The BHSCT noted ongoing issues with inappropriate referrals; referrals to the Adult Protection Gateway Team (APGT) by Adult Community and Older Peoples Service rose from a starting position of 21% to 45%. The Trust has taken active measures to address this issue including ongoing liaison with the PSNI regarding referral pathways and training with care homes. Increasing referral numbers will be closely monitored by SPPG to ensure any increasing demand is appropriately resourced by the Trust and capacity is available.

Trusts responded to the Covid -19 challenges in a variety of ways, employing a range of technologies to maintain service provision. Technology assisted contact will continue to play a part going forward, but it will require attention and professional judgement to determine the appropriate and effective use of such remote contact.

SET Adult Protection Gateway Team: The Service Area is the Trust's single point of entry for all adult safeguarding queries and referrals. The Team has had a 13% increase in the number of referrals (828) received into its duty system. 65% of these referrals (540) met the adult protection threshold for investigation, which is an increase of 16% compared to the previous reporting period. The Service Area notes that a rise in domestic abuse referrals post Covid-19 lockdowns, an increased awareness of the Team and workforce issues within the independent sectors have all contributed to this rise in referrals.

Staff vacancies and sickness have had a significant impact on the Team's ability to respond to this increase in demand. Despite this, no service user has been left without a robust interim protection plan and cases have been referred under Joint Protocol when appropriate to do so. However, the Service Area notes that final inspection reports are outstanding and an action plan has been put in place to ensure the outstanding reports are completed.

Data Validation

Difficulties with data reporting continue in this period. It is difficult to be always confident that data presented is accurate.

Returns were simplified this year, but accuracy issues persist. In some instances Trusts information was limited and reported in a variety of formats, making it difficult to draw comparisons and identify trends.

Improving consistent and accurate data process and recording must be a priority for Trusts in identifying and responding to ASG and developing best practice for the future. This issue will be followed up in future meetings with the Trust.

Workforce Pressures

All Trusts report critical challenges with the retention and recruitment to key posts in all adult service areas. This presents a specific risk in terms of timely and appropriate ASG responses. Trusts have provided assurances that these issues are being kept

under review and workforce issues closely monitored. SPPG will continue to seek updates and assurances around this.

Training & Development

Trusts report challenges to retaining appropriately trained staff. The social care workforce adapted online training to increase training access and efficiency. Technology has also been used effectively to provide supervision and staff support huddles. This has likely contributed to full compliance with supervision in most areas, a key to supporting and developing ASG practice.

Joint Protocol – Policies & Procedures

During this reporting period most Trusts reported increasing numbers of Police led Single Agency investigations. This reportedly had an effect on the skill and competence of the ASG workforce. Staff shortage and PSNI operational priorities were offered as reasons for this. The Trust response has been to deploy a rota system in Trusts and place an emphasis on recruiting and retaining Investigating Officer and DAPOs. Developing and maintaining Joint Protocol investigative skills is critical to effective ASG and these issues should be addressed at local Trust/ PSNI fora. SPPG will seek further updates on this issue.

Trust Issues by Exception

Southern Trust noted a reduction in ASG referrals in the reporting period. This is in contrast to the other Trusts. Part of the rationale provided suggests inexperience in the workforce. The Trust plans to focus on 'awareness raising' across the Service Area. The decline in referrals could be a cause of concern if, as suggested, it is a result of poor levels of ASG awareness in the workforce. A refresh of ASG awareness training should be prioritised and SPPG will seek further updates on this.

Belfast Trust has continued to manage the demands emanating from Muckamore Abbey Hospital. ASG referrals have increased alongside other workforce pressures.

SEHSCT Trust, the RQIA inspection of Ward 27 and improvement actions are still in progress. The Trust reports it is successfully managing issues as they arise.

In the Western Trust, Lakeview Hospital faces challenges in its delivery of safe and effective services. The Trust is still working to improve quality of care, address ASG concerns and respond to RQIA inspection recommendations.

Regional Key Issues and Service Pressures

As in previous years, a number of recurring challenges remain across the region to varying degrees. Limited resources continue to remain at the root of some of these issues. Key themes include:

Complexity of cases: All Trusts note the growing complexity of cases in PSD as well as the volume in cases.

Service Users increasingly voice their choice to remain living at home and thereby require Trusts to provide bespoke packages of care. To ensure the safety and welfare of these service users, Trusts require suitably skilled and experienced staff deemed competent to carry out the tasks associated with the service users' health care requirements.

There are limited numbers of care homes able to meet the need of PSD service users and if places are available there is significant increase in charges to the PSD Service Area.

These complex cases may also have a detrimental impact on hospital discharges for patients who are deemed medically fit for discharge but are unable to access an appropriate and safe care package/placement in the community due to the issues outlined above.

PSD Service Areas note the increase in referrals for people with alcohol related brain injury. These service users also require complex care packages and frequently additional 1-1 supervision to mitigate against any challenging behaviours.

Absence of accommodation options: All Trusts continue to highlight the lack of designated living options for people under 65 years of age with a physical, sensory or neurological condition. There are gaps of accommodation both locally and regionally which extends to supported living and social housing sector options as well as residential and nursing home options.

Lack of provision is due to the levels of complexity of service users care needs, challenging behaviours and service users wanting to reside at home which requires adapted accommodation and intensive care support. All Trusts continue to report the extensive enhanced funding needed to meet the costs of these placements.

Lack of capacity within domiciliary provisions: Whilst this has been reported previously, there are increasing pressures to secure domiciliary care packages across all the Trusts. Inability to access domiciliary care carries significant cost and emotional distress as well as service user decline in their health and wellbeing. Furthermore, the lack of capacity has a direct impact and pressure on other Trust services such as re-ablement, carer support and hospital discharges.

Day care provision: Some Trusts have indicated that due to current guidance in relation to social distancing and the layout of some day care facilities they are unable to return to pre-pandemic capacity. However, Trusts report that alternative arrangements have been put in place to support service users; such as outreach opportunities with some users citing this as their preferred option for future support. All Trusts have day care remobilisation plans in place which are being closely monitored by SPPG.

Regional Risk Issues/Governance

Trusts report varying risk and governance issues across the PSD Service Area with a few consistent themes impacting on all.

One common theme is challenges within the workforce and lack of appropriate staffing which impacts on all aspects of service delivery. This is outlined in more detail below.

Another common theme for some PSD Service Areas relates to compliance with inspections and audits. Overall performance has been satisfactory and Trusts have action plans in place to ensure any recommendations / requirements are implemented within agreed timescales. SPPG will monitor this during the next reporting period.

Regional Professional/Workforce Issues

In respect to the risk and governance challenge noted above, PSD has historically had a steady and reliable workforce. However, in this reporting period, all Trusts with the exception of WHSCT note challenges with vacancies and recruitment. Trusts report that they are experiencing vacancies across all levels of PSD including social workers, DAPO's, ASWs and team managers. In addition, they experience challenges in accessing appropriately skilled care workers and health care assistants to support service users live independently at home. The challenge in recruiting staff has impacted on Trusts' ability to fulfil aspects of the delegated statutory functions.

Analysis of Individual Trust Reports:

BHSCT

Key Issues and Regional Service Pressures

Complexity of cases and lack of accommodation options: In relation to the complexity of referrals, the PSD Service Area reports unmet need in the number and availability of specialised services and placements for service users living with an alcohol related brain injury, both locally and regionally. The impact on discharge and the increase of 1:1 requests from the care home setting is also highlighted. Measures to address this include the PSD Service Area undertaking a population needs analysis.

Lack of capacity within domiciliary provisions: Domiciliary care remains an ongoing service pressure within the programme with 92 individuals waiting for a package of care equating to 811 hours of unmet need.

The Trust plans to develop and implement a social care strategy in the next reporting period to address these issues and SPPG can review progress in the DSF meetings scheduled throughout the year.

Re-mobilisation of day care BHSCT remain at approximately half of the previous daily activity, for this programme of care. The SPPG recognises the comparatively low level of daily activity and the need for ongoing focus in this area.

Risk Issues/Governance

Annual care reviews also feature as a key issue and pressure for PSD although SPPG would recognise the progress made in the reporting year.

From a starting position of 283 outstanding reviews the programme is now down to a total of 106. Actions taken to address have included: triage, risk stratification and the support of line management in assessing the risk. The Trust advice they aim to be fully compliant in annual care reviews by the end of July 2022.

Professional/Workforce Issues

The PSD Service Area has reported changes at managerial level within this reporting period with the departure of a Service Manager, an Interim Service Manager and an Assistant Service Manager. Three Band 7 Senior Social Work posts are also being actively recruited. The Service Area reports funded staffing levels of suitably qualified practitioners in place to meet their delegated statutory requirements in the: Designated Adult Protection Officer (DAPO); Investigating Officers (IO) and Approved Social Worker roles. It also notes staffing in their core teams to have remained stable, with a low turnover of staff at practitioner level. SPPG is reassured by this in light of the fact that there has been an increase in the number and complexity of referrals in the reporting year.

SHSCT

Key Issues and Regional Service Pressures

Complexity of cases: PSD Service Area indicates that the number of complex cases within the community continues to rise. This increased service demand includes complexities such as tracheostomy care, enteral feeding and bowel management. This pressure is linked to service users choosing to remain at home to receive nursing care.

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PSD Service Area reports that approximately 50% of all individuals referred to the service have an addiction issue which creates complex case management issues. Action plan to address this concern involves physical disability staff receiving training to uplift knowledge and understanding of addiction alongside collaborative working with colleagues in the Trust addiction service.

Lack of accommodation options: Lack of capacity within residential care for adults aged under 65 with physical disability often results in service users being inappropriately placed in nursing care, when residential care would meet their needs.

An exercise completed between April to June 2021 found that 6 service users were placed in nursing homes when residential facilities would have appropriately met their needs. SPPG notes that the Trust has not identified an action plan for this key issue and will progress this with them in subsequent DSF reporting meetings.

Lack of capacity within domiciliary provisions: This continues to be a key pressure across the Trust's adult services including PSD. An increase in demand along with lack of availability from both Trust and private agencies to fulfil demand, has led to service users assessed needs not being met. With regards the recruitment of domiciliary care workers, the Trust has an action plan in place and is reviewing the In-house model as part of the work plan for the next reporting period. SPPG can review progress in the DSF meetings scheduled throughout the year. Furthermore, cases are kept under regular review, and Direct Payments are offered as an option however families report difficulty in recruiting care workers.

Risk Issues/Governance

The PSD Service Area reports the RQIA have completed 4 inspections during the reporting period, with no recommendations noted. The Service Area continues to progress the recommendations of audits including the BSO Care Management Processes.

Professional/Workforce Issues

In addition to the challenges in meeting statutory functions with the reported staffing shortages outlined below, PSD Service Area highlights areas of particular risk in relation to staffing. The service lost two experienced Designated Adult Protection Officers (DAPO) in the reporting period, and have faced difficulties in filling Band 7 social work vacancies. By way of action planning for these risks, a DAPO rotational model has been implemented, along with various strategies to support and mentor less experienced DAPOs.

WHSCT

Key Issues and Regional Service Pressures

There has been a significant doubling of referrals to social work across the PSD Service Area within the reporting period. SPPG will engage with the Trust to better understand the reasons for this.

Complexity of cases: The Service Area notes significant escalating costs in relation to complex case management both in the community and with enhanced care arrangements in independent nursing homes. The need for suitably skilled, trained staff to meet the complex needs of individuals who require support with a health care task in the community as part of their support plan is increasing

The PSD Service Area previously reported that it is absorbing all adult referrals under 65 years who do not meet the criteria for learning disability or mental health services, with an increase in referrals for service users living with addiction and where there are clear welfare concerns. This issue is cited again and notes there is pressure placed on PSD to accept the cases to avoid delays in hospital discharge.

Subsequently, this increase in referrals is creating resource issues in terms of staff capacity and a significant overspend in the independent homes budget. PSD are not commissioned or resourced to provide this service which requires significant resources in terms of social work time spent managing the risks and challenges associated with these individuals including supporting families. SPPG is seeking assurances from the Trust that the service being delivered is robust and safe.

Lack of accommodation options: Gaps exist in supported living, residential and nursing homes as well as within the social housing sector. Enhanced rates for nursing home placements related to high levels of complexity, including bariatric care and challenging behaviours, is placing significant pressure on the Independent Homes budget, in addition to the escalating costs of top up fees.

Risk Issues/Governance

An RQIA inspection of a day centre noted areas of improvement in relation to out-dated documentation and the physical environment. There was also training needs identified regarding adult safeguarding and dysphagia for support staff and transport

staff. Although there was evidence that the care provided by staff was compassionate and person-centred, work has commenced with service leads to ensure appropriate training is provided and documentation is updated.

The Trust has not completed the projections of demand for carer assessments across all Adult Service Areas, however the PSD Service Area is currently progressing a quality improvement project with an aim to improve the uptake of carers assessments by 10%. Current outcomes indicate a 20% and learning is being shared across the Trust.

Professional/Workforce Issues

Recruitment and retention of social work staff has remained challenging for all areas in WHSCT. With particularly reference to the PSD Service Area, challenges to recruit suitably skilled, trained staff to meet the complex needs of individuals who require support with a health care task in the community as part of their support plan is increasing.

NHSCT

Key Issues and Regional Service Pressures

Lack of accommodation options: The PSD Service Area continues to experience problems securing appropriate placements from hospital for people with acquired brain injury and challenging behaviours. The Trust has processes in place to deal with this on a case by case basis. To mitigate against this, the Trust have increased their numbers of purchased 'contingency beds' since December 2021. SPPG will continue to explore this issue at future DSF meetings to clarify what plan the Trust has in place to provide appropriate placements for people with complex disabilities.

Day care provision: SPPG notes there is a decrease in number of adults known to the PSD Service Area in receipt of centred based day care. The Trust have indicated that due to current guidance in relation to social distancing and the layout of some Trust day centres they cannot at this stage return to pre-pandemic capacity yet. The Trust is aware and engaged with the DOH remobilisation plan to return service user attendance back to pre-pandemic levels. This will continue to be monitored by SPPG during the next reporting period.

Carers Assessments: The DSF report highlights a decrease in carers assessments offered and completed. Reasons cited include staff shortages and fewer numbers of available personal assistants. As this is a delegated statutory function the Trust need to provide a clear and proactive approach to addressing this going forward.

Risk Issues/Governance

The DSF report provides limited detail on risk issues and governance pertaining specifically to the PSD Service Area and SPPG will seek compliance in this regard during the scheduled DSF meetings during the next reporting period.

Professional/Workforce Issues

The Trust Executive Director's summary report outlines that social work staff shortages are having a significant impact on the Trusts ability to deliver its statutory functions. The Trust is focusing on some key areas connected to the social work workforce review. Two of the areas involve regional pieces of work on manageable/normative caseloads and safe staffing levels. SPPG will review the progress on this at scheduled DSF meetings during the next reporting period.

SEHSCT

Key Issues and Regional Service Pressures

Complexity of cases: The PSD Service Area reports an increasing issue of clinical governance for young service users with complex clinical needs who wish to remain living at home but are dependent on others to meet their care and nursing needs either through an agency or direct payment for carers.

In addition the Service Area is finding it challenging to meet the financial demands that these packages of care require, especially those service users who rely on 24/7 direct payment provisions to live at home.

Lack of accommodation options: As previously reported PSD note that remains a significant challenge in the provision of supported living services for people with physical disability or a brain injury and as a consequence this has resulted in high cost out of jurisdiction placements.

Lack of capacity within domiciliary provisions: The PSD Service Area notes that hospital discharges have been delayed due to the lack of domiciliary provision across the system and in particular rural areas. This has resulted in an increase in self-directed support and direct payments to ensure the safe discharge of patients. However, as noted above the increasing complexity of service users' carers needs impacts on the ability of domiciliary care being able to source adequately trained and skilled staff who are able to safely manage the risks and needs of these service users.

Day care provision: The impact that Covid-19 has placed on day care attendance continues in this reporting period. The Service Area has utilised other options to ensure service user need is met and as such has led to an increase in the uptake of direct payments. PSD is currently remobilised to 90% but some challenges with transport and staffing persist. The additional 10% return will be completed at a pace with service user's individual needs. SPPG will continue to closely monitor this.

Risk Issues/Governance

Under the assurance framework and in line with the recommendations from the Commissioner for Older People in Northern Ireland (COPNI) report, the Trust has restructured adult disability services at senior level. The restructure has put in place a mechanism within adult disability to link with the independent sector, across teams and other directorates and as such now has a dedicated Band 8B to oversee the PSD community teams.

In this reporting period PSD has experienced a 37% increase in adult safeguarding referrals. SPPG will monitor how the Trust will develop capacity to manage this increase during the DSF scheduled meetings. In addition, the Service Area notes that adult protection investigations across Trust boundaries can be challenging. PSD note that effective communication between Trusts ensures good working practices and information sharing in regard to safeguarding issues.

Professional/Workforce Issues

PSD report that services have been impacted by social work and staff absence and vacancy. The Trust has ensured contingency arrangements are in place to fulfil statutory functions and to safeguard service users.

CONCLUSION

As outlined in the introductory section of this report, despite the challenges experienced by the Health and Social Care Trusts in terms of the impact of Covid, recovery and rebuild of services and the workforce pressures, the SCCD/SPPG has determined that each Trust has submitted a satisfactory report and have achieved reasonable compliance in their Delegated Statutory Functions for the period 2021-2022.

Both the Regional Action Plan and the Local Action Plans outline the areas which are required to be taken forward during 2022/23. The improved process around the Action Plans will enable the SCCD/SPPG to closely monitor progress and ensure that the key issues outlined in this report are addressed appropriately. This will in turn ensure our services continue to meet the needs of the population in a safe and effective manner.

The SCCD/SPPG will continue to work on the development of an outcomes framework, the focus of which is to enrich the information we gather currently by placing the voice of those with lived experience at the centre of the Directed Delegated Statutory Function reporting process.

Brendan Whittle
Director of Social Care and Children
& Executive Director of Social Work
SCCD/SPPG

MAHI - STM - 097 - 5583

Directed Statutory Functions

Statistical Report

Directorate of Social Care and Children

Strategic Planning and Performance Group

Department of Health

Department of Health
An Roinn Sláinte
Mánystrie O Poustie
www.health-ni.gov.uk

1 April 2021 – 31st March 2022

HSC Health and Social Care

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Adults Section

Factfile

Introduction

THE SCHEME FOR THE DISCHARGE OF SOCIAL CARE AND CHILDREN'S FUNCTIONS

The scheme sets out the arrangements between the Department of Health (DoH) and the Health and Social Care Trusts (HSCTs/Trusts) for the discharge under The Health and Personal Social Services (Northern Ireland) Order 1991 of Social Care and Children's Functions (SCCF) functions by the Trust on behalf of the Department. The Scheme describes the fundamental principles, values and accountability relationships

On a six monthly basis, Trusts report to the HSCB on those statutory functions which have been delegated by the DoH to Trusts. These updates incorporate reporting on the Corporate Parenting responsibilities of the Trusts as set out in the DHSSPSNI Circular (OSS) 03 / 2022.

This report provides a statistical update using information extracted from the five delegated statutory functions reports.

Additionally the report incorporates context information on population, projections deprivation and the social worker workforce across N. Ireland.

The childcare data flow used to inform this report has replaced the data flows which were used by legacy HSC Boards. This flow of data is now used for monitoring of the Circular on Corporate Parenting, monitoring of Delegated Statutory Functions, monitoring of Safeguarding (including sharing data with SBNI) and is shared with DHSSPSNI for use in published national childcare statistics.

MAHI - STM - 097 - 5587

Population – N Ireland

The N Ireland Statistics and Research Agency have published the 2020 Mid-Year Estimates. These are currently the most up to date population statistics available.

Total population in N Ireland of 1,895,510

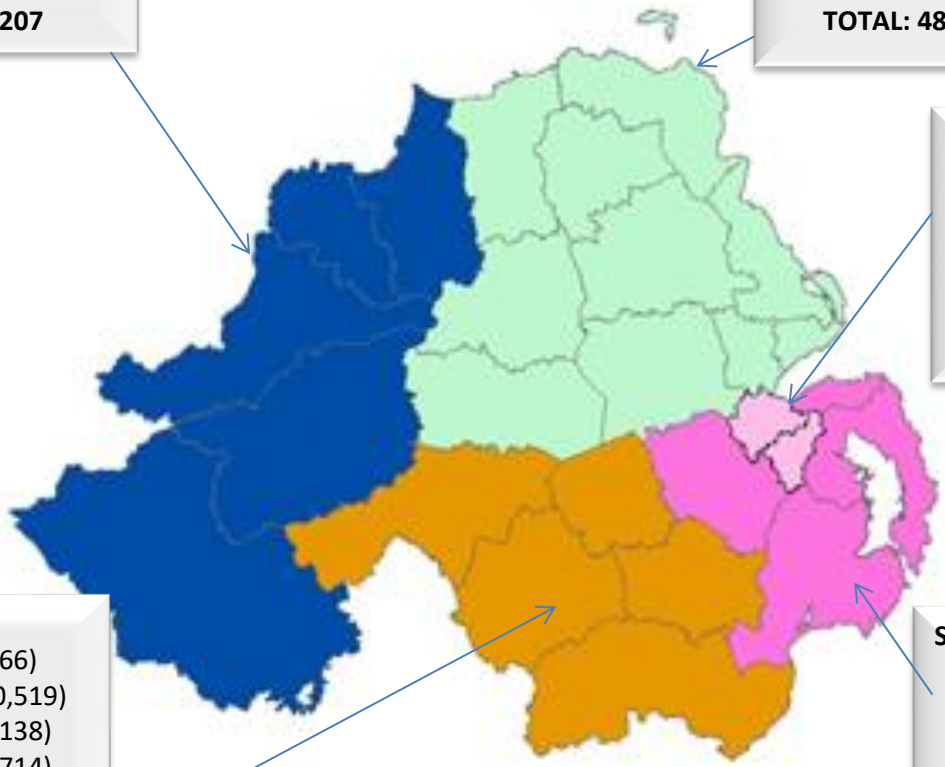
- Children Aged 0-17 years – 441,108 **23%** of the population of NI are children and young people.
- Adults Aged 18-64 years – 1,134,453 **60%** of the population of NI are adults.
- Older People Aged 65+ years – 319,949 **17%** of the population of NI are older people aged 65+

WHSCT
- **0-17 (**73,142)
- **18-64** (180,356)
- **65-74** (28,230)
- **75-84** (15,959)
- **85+** (5,520)

TOTAL: 303,207

NHSCT
- **0-17** (109,282)
- **18-64** (284,898)
- **65-74** (46,152)
- **75-84** (29,331)
- **85+** (10,531)

TOTAL: 480,194



BHSCT
- **0-17 (**77,506)
- **18-64** (225,884)
- **65-74** (28,210)
- **75-84** (19,428)
- **85+** (8,202)

TOTAL: 359,230

SHSCT
- **0-17** (99,466)
- **18-64** (230,519)
- **65-74** (32,138)
- **75-84** (19,714)
- **85+** (6,851)

TOTAL: 388,688

SEHSCT
- **0-17 (**81,712)
- **18-64** (212,796)
- **65-74** (38,025)
- **75-84** (23,274)
- **85+** (8,384)

TOTAL: 364,191

The Northern Trust has the highest population across the five Trusts at 25.3%. The Southern Trust has the second highest population with 20.4%. This is slightly higher than the South Eastern Trust at 19.2%. Belfast Trust had 19% of the NI Population while Western Trust has 16%.

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Population of Children/Young People By Trust

2020 MYEs

Age	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total	%
<1	4,192	5,292	3,810	5,039	3,615	**21,948**	**5%**
1-4	17,564	22,889	17,141	22,235	15,959	**95,788**	**22%**
5-11	31,650	44,449	33,363	40,681	29,733	**179,876**	**41%**
12-15	16,348	25,131	18,791	21,764	16,170	**98,204**	**22%**
16+	7,752	11,521	8,607	9,747	7,665	**45,292**	**10%**
TOTAL	**77,506**	**109,282**	**81,712**	**99,466**	**73,142**	**441,108**	**100%**
%	17.6%	24.8%	18.5%	22.6%	16.6%	100%	

Geographical Coverage (Square kilometres)

Trust	Sq Kms
BHSCT	200
NHSCT	4355.7
SEHSCT	1551.2
SHSCT	3187.6
WHSCT	4840.9
NI	**14135.4**

Western Trust has the largest geography with 4,840 sq kilometres followed by Northern Trust at 4355.7. Belfast Trust has the smallest geography at 200 sq kilometres.

Population Projections – Children Aged 0-17

Information supplied by NISRA also highlights that the populations are projected to change.

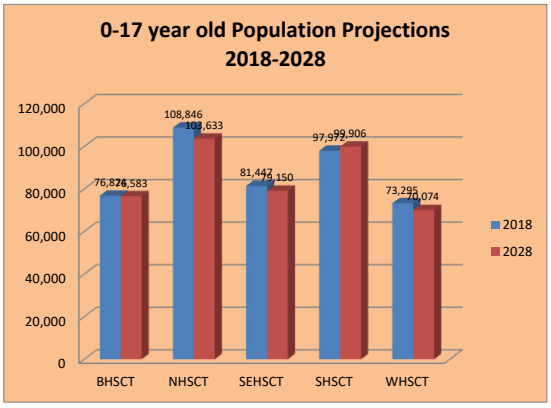
2018 Population Projections

	2018	2028	% Change 2018 to 2028	2043	% Change 2018 to 2043
BHSCT	76,824	76,583	-0.3%	70,274	-8.5%
NHSCT	108,846	103,633	-4.8%	92,758	-14.8%
SEHSCT	81,447	79,150	-2.8%	73,449	-9.8%
SHSCT	97,972	99,906	2.0%	98,154	0.2%
WHSCT	73,295	70,074	-4.4%	61,638	-15.9%
NI	**438,384**	**429,346**	**-2.1%**	**396,273**	**-9.6%**

The total number of children in N Ireland is projected to decrease by 2.1% between 2018 and 2028.

Northern Trust will decrease by 4.8% and Western Trust by 4.4%. South Eastern Trust is projected to decrease by 2.8% while Southern Trust will increase by 2.0%.

The Belfast Trust is projected to decrease by 0.3% over the same period.



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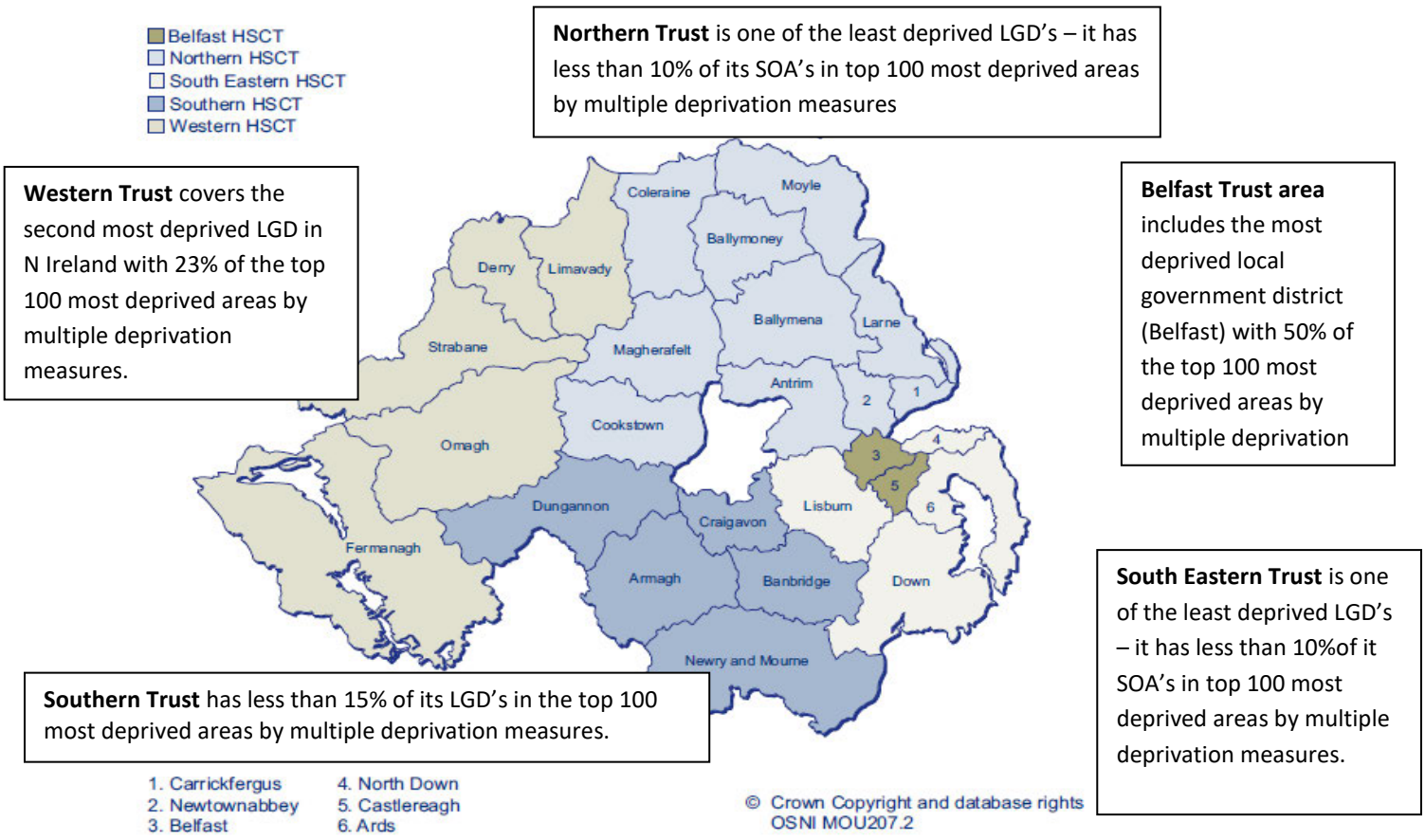
Deprivation - N Ireland (2010)

In 2017, NISRA updated the NI Multiple Deprivation Measure (NIMDM). The NIMDM outputs results at a number of geographies including local government district. The measures provide a mechanism for ranking the 890 Super Output areas (SOAs) in Northern Ireland from the most deprived (rank 1) to the least deprived (rank 890).

The Multiple Deprivation Measure (MDM) combines the 7 deprivation domains to rank areas based on multiple types of deprivation. Since the last deprivation figures were released in 20210, the number of Councils has been reduced from 26 to 11; this has resulted in some Council areas being located across a number of Trust localities.



Northern Trust is one of the least deprived LGD's – it has less than 10% of its SOA's in top 100 most deprived areas by multiple deprivation measures

Western Trust covers the second most deprived LGD in N Ireland with 23% of the top 100 most deprived areas by multiple deprivation measures.

Belfast Trust area includes the most deprived local government district (Belfast) with 50% of the top 100 most deprived areas by multiple deprivation

Southern Trust has less than 15% of its LGD's in the top 100 most deprived areas by multiple deprivation measures.

South Eastern Trust is one of the least deprived LGD's – it has less than 10%of it SOA's in top 100 most deprived areas by multiple deprivation measures.

Where are the 100 most are deprived SOAs according to the Multiple Deprivation Measure?

- 50 are in Belfast (Belfast Trust) accounting for 29% of its 174 SOAs; the highest proportion of all Local Government Districts (LGDs).
- None of the 67 SOAs in Lisburn & Castlereagh (South Eastern Trust) are among the 100 most deprived SOAs.
- 5 of the 100 most deprived SOAs are classified as rural East, located in Derry City & Strabane (Western Trust), is the most deprived SOA according to the MDM
- 5 of the 10 most deprived SOAs are in Belfast (Belfast Trust) with the other 5 in Derry City & Strabane(Western Trust)

Social Work Posts Summary

4,772 social workers employed at 31/12/21

Social Work Posts (31.12.21)

- At the 31st December 2021 there were a total of **4,772** social worker posts across the five HSC Trusts.
- The workforce included **4,492** (94%) **permanent** posts and a further **280** (6%) **temporary** posts.
- Within the permanent workforce there were a total of **4,067** social workers and **425** social work managers.

Permanent Posts
4,492 (94%)

+

Temporary Posts
280 (6%)

Social Work Posts By AfC Bands *(see table 1 below)*

Table 1: **All Social Work Posts By Band**

AfC Banding	No of Posts	%
Band 5 AYE	223	4.7%
Band 6	2645	55.4%
Band7	1465	30.7%
Band 8a	319	6.7%
Band 8b	85	1.8%
Band 8c and above	35	0.7%
Total	**4772**	**100.0%**

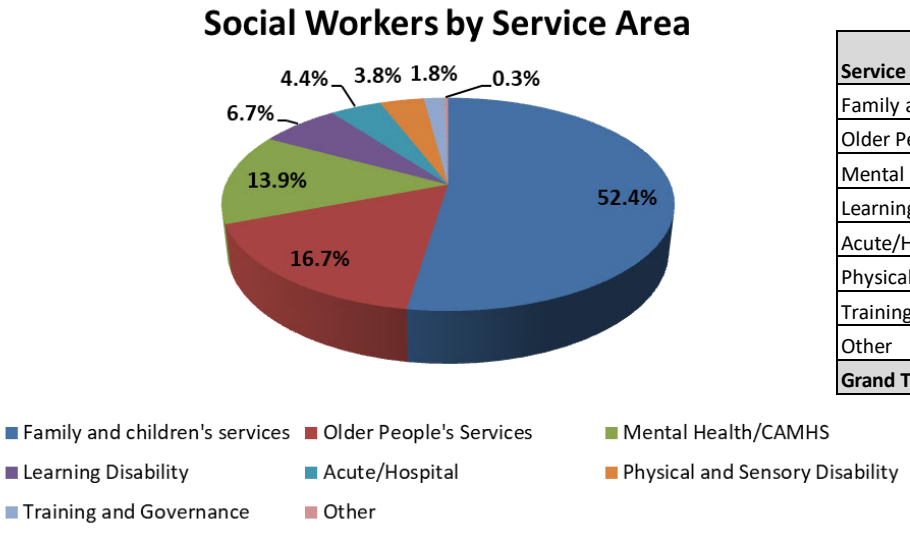
Teams (Bands 5-7)
4,333 (91%)

+

Management (Band 8) and above 439 (9%)

Social Workers by Service Area

More than half of social workers work within children's services followed by mental health and older people's services.



Service Area	No of Staff	%
Family and children's services	2502	52.4%
Older People's Services	797	16.7%
Mental Health/CAMHS	662	13.9%
Learning Disability	322	6.7%
Acute/Hospital	210	4.4%
Physical and Sensory Disability	180	3.8%
Training and Governance	85	1.8%
Other	14	0.3%
Grand Total	**4772**	**100.0%**

MAHI - STM - 097 - 5591

Fact File – Children and Young People

Population:

- N Ireland:- **1,895,510**
- **Children** -441,108 (23%), **Adults** – 1,134,453 (60%), **Older People** – 319,949 (17%)

Children In Need:

- 24,545 Children In Need across N Ireland.
- Of the Children in Need 4,601 were known to be disabled.
- 34,969 children were referred for assessment of need during the year.

Child Protection:

- 2,346 children were on the Child Protection Register.
- 2,051 were added to the Register while 1,963 were removed from the Register during the year.
- 85% of Parents involved in the child protection process agreed with the social worker about 'what we are concerned about'[2].
- 92% of parents felt the case conference focused on the needs of the children [1].

16+ Care Leavers:

- 1,625 children entitled to access care leaver services (includes 505 children aged 16, 17 years and still in care).
- Of those that have left care 26% live in a Tenancy Arrangement, 25% with Former Foster Carers, 17% were at Home with Parents/siblings and 8% had returned to live with Relatives/Friends.
- 72% of those young people that left care were in Education, Training or Employment.

Children In Care:

- 3,624 Children In Care, 83% - Foster Care, 7% - Placed with Family, 7% in Residential Care.
- 899 children were admitted to care during the year. 777 children were discharged from care during the year.

Adoption:

- There were 172 Domestic Applications for Assessment during the year
- There were 4 Inter-country Applications for Assessment during the year.
- 105 children were subject of an Adoption Order (Art 12) during the year.

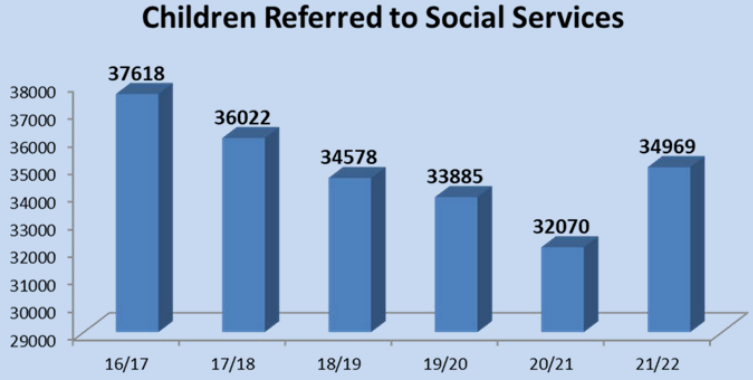
Early Years:

2,288 childminders, 403 playgroups, 323 day nurseries, 221 out of schools and 75 crèches were registered with early year's teams at 31st March 2022.

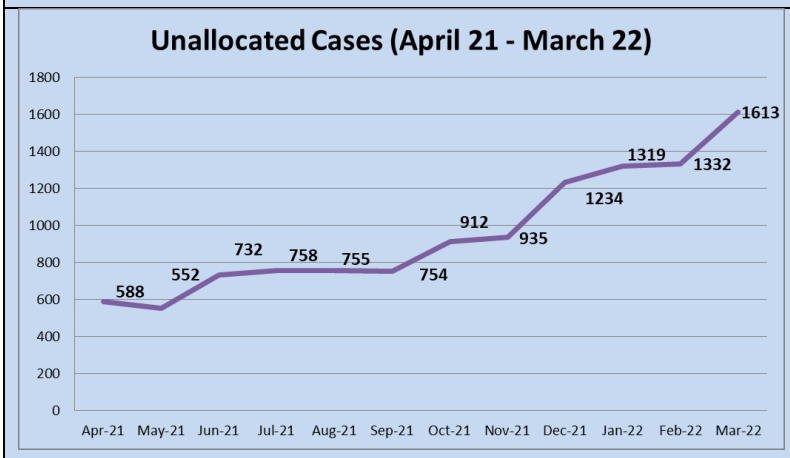
CHILDREN IN NEED

Key Issues

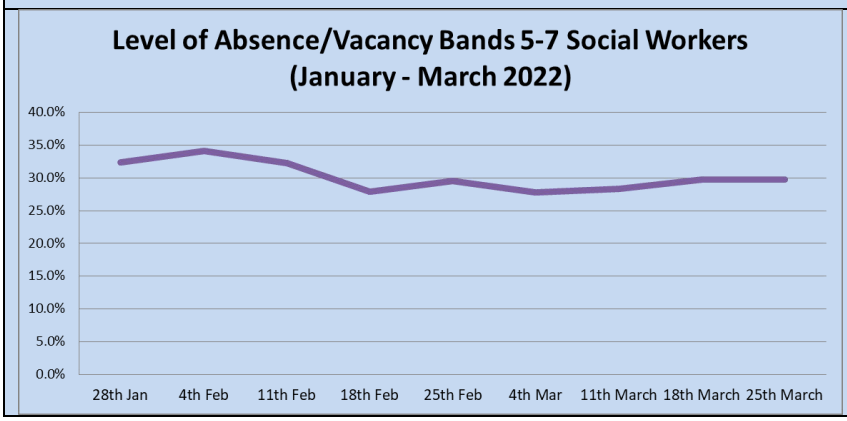
- At 31st March 2022, 24,545 children in Northern Ireland were known to Social Services as a child in need;



Some **34,969** children were referred to Social Services during the year. An increase of 9% from the previous year. The largest proportion of these children were referred by the Police (36%).
89% of referrals come from partner agencies and from the community.



The number of unallocated cases has risen significantly this year by **1,025**. To **1,613** The unallocated cases were within the Gateway (354), Family Support (535) and Children's disability services (724).
Belfast Trust had the highest number of unallocated cases at 745 (46% of the total across the region).



During the period January to March 2022 children's services experienced vacancy/absence rates of between 30-35% for social work staff (Bands 5-7). This rate was higher within some specific service areas.

9%	**Increase in the number of children in need referrals from 32,070 during 20/21 to 34,969 during 21/22**
32	**Increase in the number of children in need per 10,000 population aged under 18 years from 524 to 556**

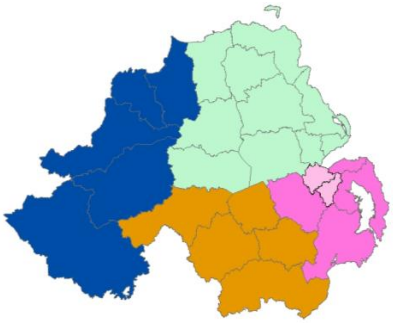
6%		Increase in the number of children in need
1%		Increase in the number of children in need that were recorded as having a disability from 4,545 at Mar 21 to 4,601 at March 22

10.1 Children In Need

MAHI - STM - 097 - 5594

3888

3929



Children In Need Summary (1.4.21 - 31.3.22)

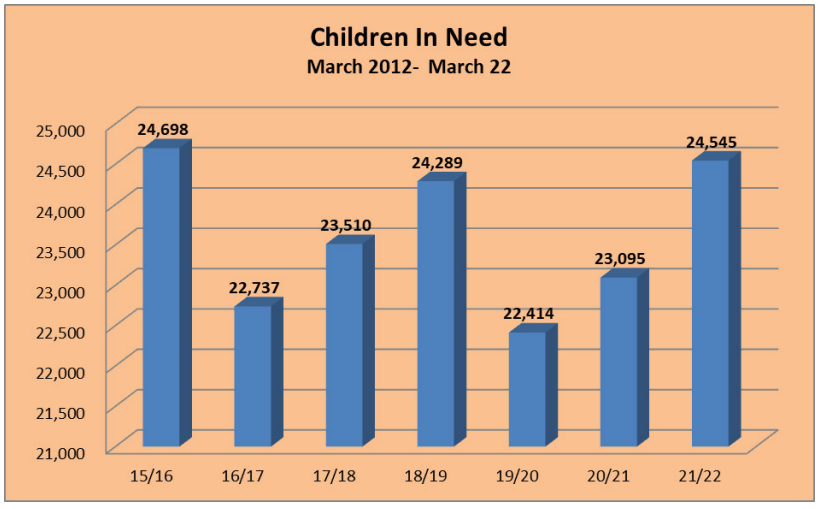
Trust	Children In Need	Rate per 10,000	Children Referred to Social Services	Children with a Disability known to Social Services	Young Carers
BHSCT	3,888	502	7,472	711	85
NHSCT	5,448	499	8,064	985	n/a
SEHSCT	3,929	481	3,654	1,103	48
SHSCT	6,829	687	8,909	1,196	145
WHSCT	4,451	609	6,870	606	80
Total	24,545	556	34,969	4,601	n/a

10.1.1 Number of Children In Need at 31st March 2022 by Age

Trusts notified the HSCB that there were a total of 24,545 Children In Need in their areas at 31st March 2022. This is a snapshot figure at a point in time.

Trust	15/16	16/17	17/18	18/19	19/20	20/21	21/22	% By Trust	% share of Population
BHSCT	5,153	4,262	4,331	4,088	3,546	3,681	3,888	16%	18%
NHSCT	4,986	5,326	5,113	5,191	5,814	4,978	5,448	22%	25%
SEHSCT	4,146	3,837	3,796	3,598	3,785	3,852	3,929	16%	19%
SHSCT	5,264	4,875	4,686	5,277	5,213	5,522	6,829	28%	23%
WHSCT	5,149	4,437	5,584	6,135	4,056	5,062	4,451	18%	17%
N Ireland	**24,698**	**22,737**	**23,510**	**24,289**	**22,414**	**23,095**	**24,545**	**100%**	**100%**

Note the collection has been amended to ensure that the children in need data provided are those children known to Social Services.



SHSCT had the highest reported number at 6,829.

BHSCT had the lowest reported figure at 3,888.

10.1.2 Children In Need By Ethnicity and Religion

Children In Need By Ethnicity at 31.3.22

MAHI - STM - 097 - 5595

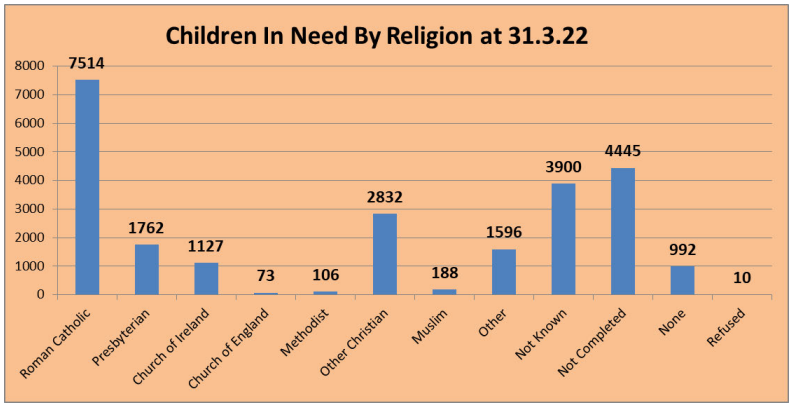
Ethnicity	Total	%
White	17536	71.4%
Chinese	48	0.2%
Irish Traveller	181	0.7%
Roma Traveller	55	0.2%
Indian	26	0.1%
Pakistani	20	0.1%
Black African	144	0.6%
Black Other	90	0.4%
Mixed Ethnic Group	387	1.6%
Any Other Ethnic Group	549	2.2%
Not Stated	5509	22.4%
TOTAL	**24545**	100.0%

Most Children In Need were from a 'White' Ethnic background (71%). This was followed by Any Other Ethnic Group (2%) and Mixed Ethnic Group (1.6%).

22% of Children In Need had 'Not Stated' given for the ethnicity category.

Children In Need By Religion at 31.3.22

Religion	Total	%
Roman Catholic	7514	30.6%
Presbyterian	1762	7.2%
Church of Ireland	1127	4.6%
Church of England	73	0.3%
Methodist	106	0.4%
Other Christian	2832	11.5%
Muslim	188	0.8%
Other	1596	6.5%
Not Known	3900	15.9%
Not Completed	4445	18.1%
None	992	4.0%
Refused	10	0.04%
TOTAL	**24545**	**100.0%**



The religion with the highest number of Children In Need was Roman Catholic at 31%, followed by 'Other Christian' at 12%.

The religion was Unknown for 34% of Children In Need (i.e. Not Known or Not completed).

10.1.4 Number of Children who have been referred for an Assessment of Need April 2021 – March 2022

Trust	Referrals for a Six Month Period													
	April-Sept 15	Oct-March 16	April-Sept 16	Oct-March 17	April-Sept 17	Oct-March 18	April-Sept 18	Oct-March 19	April-Sept 19	Oct-March 20	April-Sept 20	Oct-Mar 21	April-Sept 21	Oct-Mar 22
BHSCT	3424	3944	4812	4830	4456	4817	4233	3619	3400	3371	3497	3422	3751	3,721
NHSCT	4259	4365	5103	4614	4263	4115	4085	3295	4411	3914	3409	3716	4036	4,028
SEHSCT	2951	2585	2659	2841	2628	2910	2503	2415	2081	2140	1335	1949	1892	1,762
SHSCT	3247	2971	2986	3066	2868	3493	3626	3884	3628	4043	3742	4513	4350	4,559
WHSCT	3005	3373	3271	3436	3270	3202	3524	3394	3467	3430	3068	3419	3817	3053
Total	**16886**	**17238**	**18831**	**18787**	**17485**	**18537**	**17971**	**16607**	**16987**	**16898**	**15051**	**17019**	**17846**	**17,123**

A total of 34,969 children were referred to social services for an Assessment of Need during the year. SHSCT had the highest number of referrals 8,909 during the period, and SEHSCT had the lowest 3,654.

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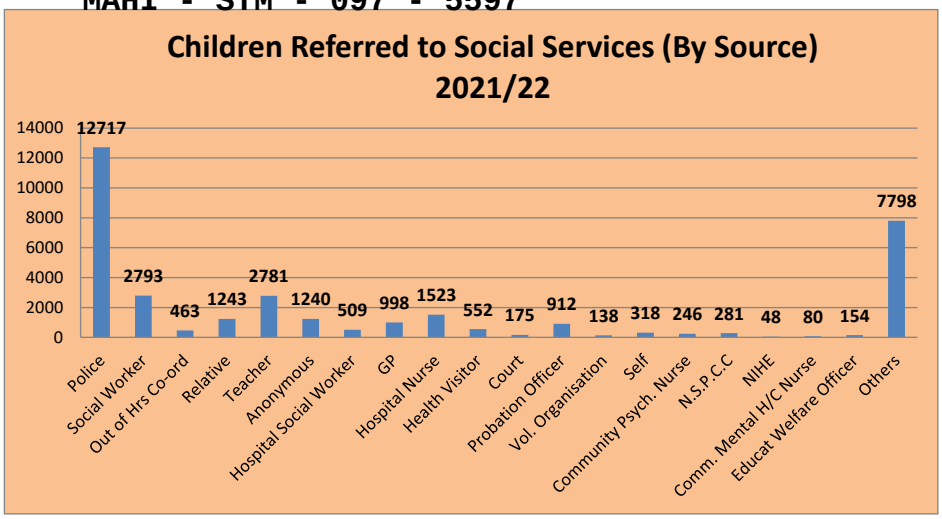
Note: A child could be referred in the first six month period and again in the second six month period.

The Police referred the highest number of children at 12,717.

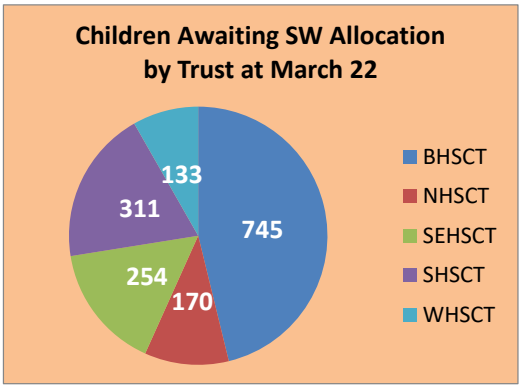
Note: the number of referrals is a cumulative figure i.e. all referrals over the 12 month period



10.1.5 Number of Children currently awaiting Social Worker Allocation (unallocated cases including disability as at 31st March 22)

Trust	Number of Children awaiting SW Allocation at												% by Trust (Mar 22)
	Mar-11	Mar-12	Mar 13	Mar 14	Mar 15	Mar 16	Mar-17	Mar-18	Mar-19	Mar-20	Mar-21	Mar-22	
BHSCT	97	93	24	45	45	104	72	120	189	221	116	745	46%
NHSCT	267	79	91	82	82	37	19	27	44	41	16	170	11%
SEHSCT	105	86	5	71	150	179	105	272	151	206	287	254	16%
SHSCT	178	43	50	44	27	44	44	38	71	122	120	311	19%
WHSCT	61	53	66	105	95	15	41	103	162	214	76	133	8%
Total	**708**	**354**	**236**	**347**	**399**	**379**	**281**	**560**	**617**	**804**	**615**	**1613**	**100%**

At 31st March 2022, there were 1,613 children awaiting Social Worker Allocation. This represented an increase of 1,025 cases from April 2021. BHSCT had the highest number of children awaiting Social Worker Allocation with 745 at 31st March 22, followed by SHSCT at 311. WHSCT had the lowest at 133.



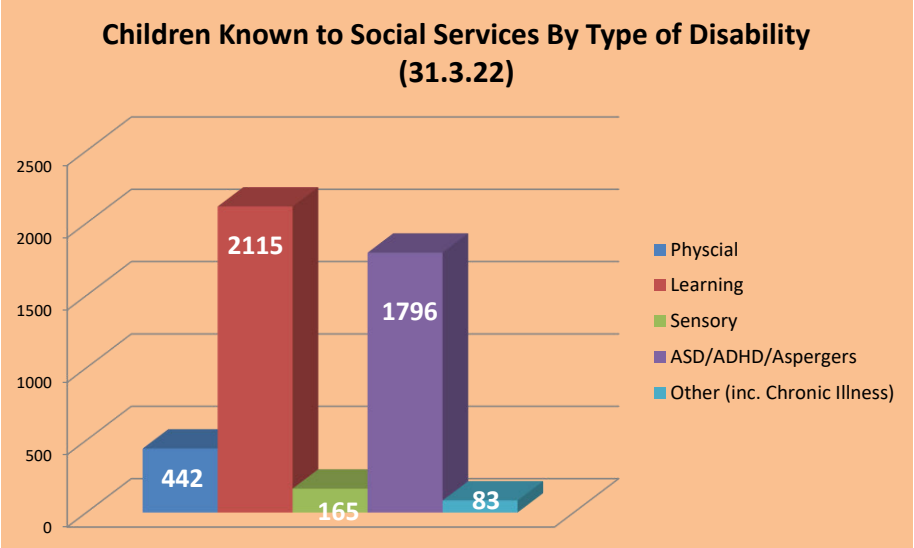
10.1.6 Number Children In Need who are disabled (by type of disability) and known to Social Services

Disability Type	0-4	5 - 11	12-15	16+	Total	%
Physical	86	193	109	54	**442**	**9.6%**
Sensory	30	74	43	18	**165**	**3.6%**
Learning	97	998	689	331	**2115**	**46.0%**
Autism (ASD/ADHD/Aspergers)	51	906	631	208	**1796**	**39.0%**
Other (undefined) inc. Chronic Illness	18	35	21	9	**83**	**1.8%**
TOTAL (With Disability)	**282**	**2206**	**1493**	**620**	**4601**	**100.0%**

Of the 24,545 Children In Need and ***known to Social Services*** a total of 4,601 children had a disability.

The children with a Disability figures represents 1% of the overall population of children aged 0-17 years in N Ireland.

The figures above include all children known to Social Services including those children known to disability teams. Most children had a learning disability (2,115) followed by children with ASD/ADHD/Aspergers (1,796).



Children with a Disability By Trust (31.3.22)

Trust	Physcial	Learning	Sensory	ASD/ADHD /Aspergers	Other (inc. Chronic Illness)	Total	% By Trust
BHSCT	89	397	13	196	16	**711**	**15.5%**
NHSCT	99	495	25	299	67	**985**	**21.4%**
SEHSCT	89	625	62	327	0	**1103**	**24.0%**
SHSCT	78	266	65	787	0	**1196**	**26.0%**
WHSCT	87	332	0	187	0	**606**	**13.2%**
Total	**442**	**2115**	**165**	**1796**	**83**	**4601**	**100.0%**

SHSCT had the highest number of children with a disability and known to Social Services while Western Trust had the lowest. Northern and South Eastern Trusts had the highest number of children with a learning disability.

10.1.7 Number of Disabled Children, known to the Trust, who leave school during the year and have a transition plan in place at 31.3.22

Type of Disability	Total	No with Transition Plans in Place
Physical Disability	74	64
Sensory Impairment	4	3
Learning Disability	300	274
Autism(ASD/ADHD/Aspergers)	42	17
Other Inc. Chronic illness	2	17
Total	**422**	**375**

Trusts reported that 375 of the 422 children with a disability aged 16+ that left school during the year had a transition plan in place.

10.1.10 Number of Children In Need who are Young Carers

Trust	31.3.15	31.3.16	31.3.17	31.3.18	31.3.19	31.3.20	31.3.21	31.3.22
BHSCT	105	66	123	134	146	115	147	85
NHSCT	153	149	158	148	148	109	n/a	n/a
SEHSCT	53	32	48	63	100	77	69	48
SHSCT	136	109	104	139	169	163	163	145
WHSCT	100	105	89	89	63	59	70	80
Total	**547**	**461**	**522**	**573**	**626**	**523**	**n/a**	**n/a**

10.1.11 Homeless Young People Aged 16-17 years at 31.3.22

MAHI - STM - 097 - 5600

Trust	No. Presented	No. Placed In Temporary Accommodation
BHSCT	4	0
NHSCT	8	5
SEHSCT	8	1
SHSCT	20	0
WHSCT	6	4
Total	**46**	**10**

A total of 46 young people presented as homeless during the year; 10 were placed in temporary accommodation.

TO BE UPDATED

10.1.12 Number of Sponsored Daycare Places By Age and Trust (31.3.22)

Sponsored Daycare for Children (Aged 0-4 years)

Daycare	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total
Day Nursery	309	20	51	45	27	**452**
Playgroup	0	0	1	22	2	**25**
Childminder	0	32	26	5	5	**68**
Out of School Hours Club	0	4	0	0	0	**4**
Other (Creche, 2YOP, Summer scheme)	0	0	0	0	0	**0**
Total	**309**	**56**	**78**	**72**	**34**	**549**

Belfast Trust had the highest use of sponsored day care places with day nursery places being the highest used sector.

Childminders were the second highest used sector for this age group.

Sponsored Daycare for Children (Aged 5-12 Years)

Daycare	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total
Day Nursery	0	4	0	7	2	**13**
Playgroup	0	0	0	0	0	**0**
Childminder	0	10	6	3	0	**19**
Out of School Hours Club	44	15	5	24	6	**94**
Other (Creche, 2YOP, summer scheme)	0	0	0	0	0	**0**
Total	**44**	**29**	**11**	**34**	**8**	**126**

Out of School Hours Clubs was the sector most frequently used for those children aged 5-12 years; childminders was used second most frequently.

Belfast Trust made most use of sponsored places purchased in the out of school sector

10.1.13 Trust Usage of Family Centre Places (01/10/21 – 31/3/22)

BHSCT Family Centre Places

BHSCT						
Name of Centre	Stat/Vol	No of Referrals by Primary Reason for Intervention		Completed During Period		On Waiting List At Period end
		Primary Reason	Number of Referrals	Average Wait from referral to Start of Intervention (Weeks)	Average length of Intervention (Weeks)	
Beersbridge Family Centre	Statutory	Family Support	6	12	8	9
		Child Protection	28	12	15	8
		Looked After	13	12	14	6
Windsor Avenue Family Resource Centre	Statutory	Family Support	15	3	10	0
		Child Protection	18	2	12	0
		Looked After	11	8	12	0
Whiterock FRTW	Vol	Family Support	0	0	0	0
		Child Protection	16	10	13	3
		Looked After	8	6	12	4

Average waits ranged from 12 weeks at Beersbridge to 2 weeks at Windsor Avenue.

NHSCT Family Centre Places

NHSCT						
Name of Centre	Stat/Vol	No of Referrals by Primary Reason for Intervention		Completed During Period		On Waiting List At Period end
		Primary Reason	Number of Referrals	Average Wait from referral to Start of Intervention (Weeks)	Average length of Intervention (Weeks)	
Newtownabbey Family Centre(including Antrim FC)	Statutory	Family Support	0	0	0	0
		Child Protection	14	2	13	2
		Looked After	4	0	10	0
Causeway/Mid Ulster Family Centre	Statutory	Family Support	0	0	0	0
		Child Protection	28	1	10	0
		Looked After	14	2	6	1

Average waits ranged from 1 week to 2 weeks at both Family Centres.

SEHSCT Family Centre Places

MAHI - STM - 097 - 5602

Name of Centre	Stat/Vol	No of Referrals by Primary Reason for Intervention		Completed During Period		On Waiting List At Period end
		Primary Reason	Number of Referrals	Average Wait from referral to Start of Intervention (Weeks)	Average length of Intervention (Weeks)	
SEHSCT						
Knocknashinna Family Centre	Stat	Family Support	1	6-8 weeks	12 -14 weeks	1
		Child Protection	7	6-8 weeks	12 -14 weeks	4
		Looked After	7	6-8 weeks	12 -14 weeks	2
Colin Family Centre	Stat	Family Support	4	6-8 weeks	6-8 weeks	2
		Child Protection	12	6-8 weeks	12 -14 weeks	7
		Looked After	11	6-8 weeks	12 -14 weeks	6
Simpson	Vol	Family Support	4	6-8 weeks	8 - 10 weeks	1
		Child Protection	5	6-8 weeks	12 -14 weeks	0
		Looked After	12	6-8 weeks	12 -14 weeks	3
SET Connects	Stat	Family Support	0	0	0	0
		Child Protection	0	0	0	0
		Looked After	51	2 weeks	184 weeks	4

Average waits ranged from 2 weeks at SET Connects to 6-8 weeks at Colin, Simpson and Knocknashinna Family Centres.

SHSCT Family Centre Places

Name of Centre	Stat/Vol	No of Referrals by Primary Reason for Intervention		Completed During Period		On Waiting List At Period end
		Primary Reason	Number of Referrals	Average Wait from referral to Start of Intervention (Weeks)	Average length of Intervention (Weeks)	
SHSCT						
Newry Family Resource Centre	Voluntary	Family Support	0	0	0	0
		Child Protection	28	3	11	0
		Looked After	6	2	10	0
Armagh & Dungannon Family Centre	Voluntary	Family Support	5	3	8-12 weeks	0
		Child Protection	23	3-4 weeks	8-12 weeks	1
		Looked After	9	3-4 weeks	8-12 weeks	0

Average waits ranged from 2 weeks at Newry to 3-4 weeks at Armagh & Dungannon.

WHSCT Family Centre Places

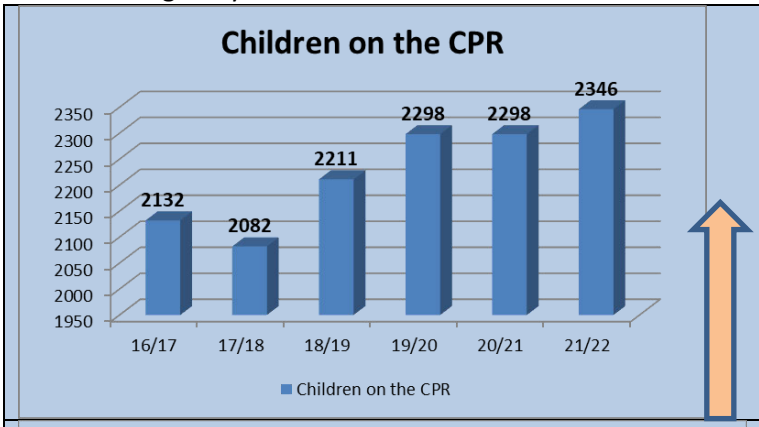
MAHI - STM - 097 - 5603

Name of Centre	Stat/Vol	No of Referrals by Primary Reason for Intervention		Completed During Period		On Waiting List At Period end
		Primary Reason	Number of Referrals	Average Wait from referral to Start of Intervention (Weeks)	Average length of Intervention (Weeks)	
WHSCT						
Erne Family Centre	Statutory	Family	1	9 weeks	0	1
		Child	10	6 weeks	8 weeks	5
		Looked After	7	9 weeks	8 weeks	6
Creggan Day Centre	Statutory	Family	6	2 weeks	24 weeks	4
		Child	9	3 weeks	24 weeks	2
		Looked After	3	7 weeks	24 weeks	4
Clooney Family Centre & Derryview Site	Voluntary	Family	8	6 weeks	4 weeks	4
		Child	0	0 weeks	0	0
		Looked After	1	15 weeks	0	1
Riverside Family Centre	Statutory	Family	8	1 week	11 weeks	0
		Child	19	1 week	12 weeks	10
		Looked After	4	0	12 weeks	1
Shantallow Family Centre	Statutory	Family	5	2 weeks	12 weeks	4
		Child	12	2 weeks	16 weeks	2
		Looked After	7	2 weeks	16 weeks	4
Strabane Family Centre 2A Melmount Road. Strabane	Voluntary	Family	4	4 weeks	12 weeks	1
		Child	10	4 weeks	14 weeks	1
		Looked After	3	4 weeks	14 weeks	0
The Dry Arch Children's Centres	Voluntary	Family	9	2 weeks	12-26 weeks	0
		Child	6	2 weeks	12-26 weeks	0
		Looked After	6	2 weeks	12-26 weeks	0

Average waits ranged from 2 weeks at Shantallow and Clooney Family Centres to 15 weeks at Dry Arch Centre.

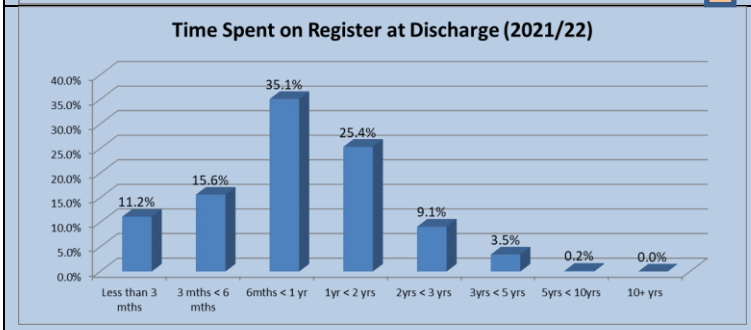
Key Issues

- At 31st March 2022, 2,346 children were listed on the Child Protection Register;
- Neglect at 29% was the highest single category for children on the Register followed by Physical abuse at 25%.
- Neglect and Physical Abuse was highest multiple category at 19%.
- 16% of children were on the Register for Emotional Abuse while for 6% of children the Registration was for Sexual Abuse.
- A total of 1,552 child protection referrals were received by HSC Trusts during the year.
- There were 2,051 new registrations to the Child Protection Register and 1,963 de- registrations during the year.

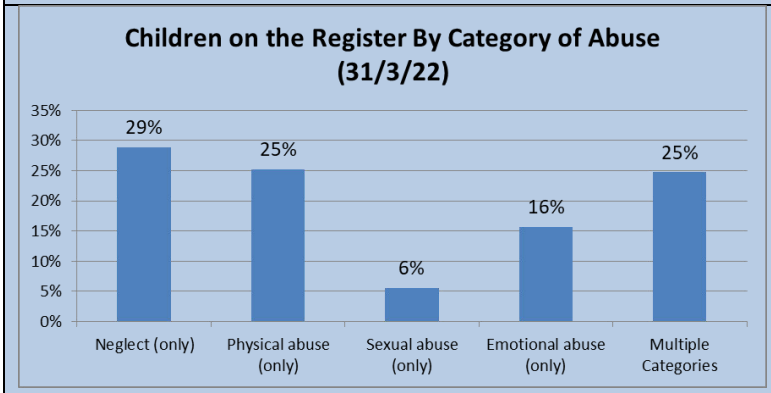


The number of children on the Child Protection Register (CPR) has been increasing.

Data at page 22 indicates that the Western HSC Trust has the highest rate per 10,000 followed by the Southern HSC Trust.



Most children spend between 6 months and 1 year on the Child protection register. (35.1%)
Almost 30% of children were on the register for less than 6 months.
12.6% of children were on the Register for 2-5 years with 0.2% on the Register for more than 5 years.



29% of children were on the CPR due to Neglect with a further 25% due to physical abuse.
16% of children were on the Register due to emotional abuse with 6% registered due to sexual abuse.
25% of children were added to the register for more that one of the categories listed above.

Outcomes **During the year 2021/22 as part of work to develop Outcomes Based Accountability measures:-** **Parents and family were asked for their views and experience of the child protection process.** 	**92%** of parents felt the case conference focused on the needs of the children. **81%** of parents felt the family were listened to at case conference. **87%** of parents who agreed that their social worker has spent time with the children and has listened to what they say about the problems and what should happen **87%** of parents indicate that their social worker has spent time with and listened to their children

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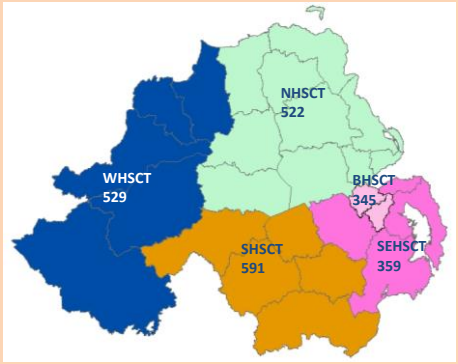
Delegated Statutory Functions – Child Protection

10.2 Children (NI) Order 1995



Child Protection Summary April 2021 - March 2022

Trust	On CPR	No. of Registrations	No. of Re-Registrations	No of De-Registrations
Belfast Trust	345	300	40	287
Northern Trust	522	498	117	465
South Eastern Trust	359	313	71	290
Southern Trust	591	513	89	528
Western Trust	529	427	60	393
NI	**2346**	**2051**	**377**	**1963**

10.2.1 Number of children on the Child Protection Register as at 31.3.22

Children on the Child Protection Register By Age and Gender

	< 1 Year	1 to 4	5 to 11	12 to 15	16+	TOTAL	%
Male	123	307	439	236	68	**1173**	50.0%
Female	104	316	420	262	71	**1173**	50.0%
TOTAL	**227**	**623**	**859**	**498**	**139**	**2346**	100.0%
% By Age Group	**9.7%**	**26.6%**	**36.6%**	**21.2%**	**5.9%**	**100.0%**	

At the end of March 2022, there were a total of 2,346 children on the Child Protection Register. The highest age category was primary-school ages (5-11 years) with 859 (37%). Males and Females were evenly split (50%) on the Register.

Children on the Child Protection Register By Trust at 31.3.22

Trust	CPR	% of NI CPR	% of NI 0-17 yr olds	0-17yr olds	Rate per 10,000 (0-17 yr olds)
Belfast Trust	345	14.7%	17.6%	77,506	44.5
Northern Trust	522	22.3%	24.8%	109,282	47.8
South Eastern Trust	359	15.3%	18.5%	81,712	43.9
Southern Trust	591	25.2%	22.5%	99,466	59.4
Western Trust	529	22.5%	16.6%	73,142	72.3
NI	**2346**	**100%**	**100%**	**441,108**	**53.2**

Southern and Western Trusts had the highest number of children on the Register (591 and 529) and Western Trust had the highest rate at 72.3 per 10,000 0-17 year olds. Belfast Trust had the lowest number at 345. South Eastern Trust had the lowest rate at 44.

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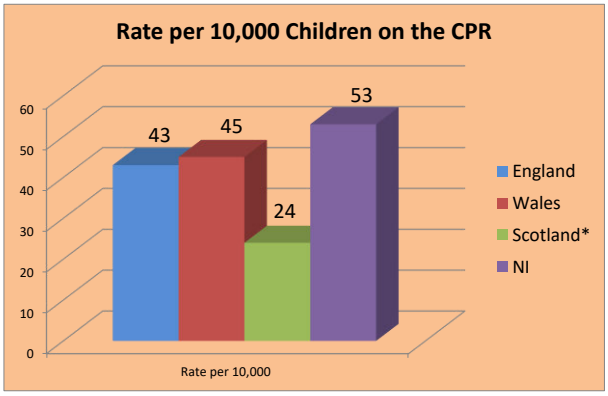
Rate per 10,000 of Children on the Register (UK Countries)



Region	No. on CPR/CPP	Pop of Children 2018 MYE	Rate per 10,000
England	51,510	11,591,701	43
Wales	2,820	629,609	45
Scotland*	2,433	911,282	24
NI	2,346	441,108	53

* Scotland's figure is based on a population of 0-15 year olds

NI had the highest rate per 10,000 children on the Child Protection Register at 53. This was followed closely by Wales which had a rate of 45.

N Ireland's number of children on the Register and rate per 10,000 has fallen from March 11. At March 2011 the number of children on the Register was 2,401 and the rate per 10,000 was 55.6.

There are regional variations in the Rate per 10,000 across the five Trusts as is the case across the rest of the UK.

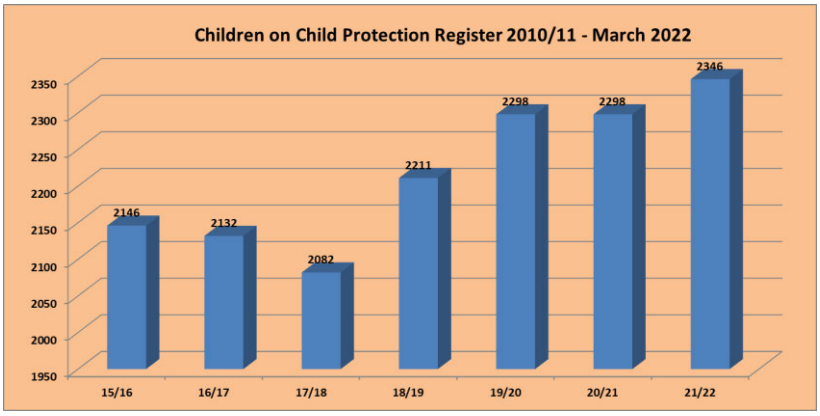
Note: *NI figure at 31.3.22, Wales at March 19, England and Scotland at March 2020.*

Trend of Children on the Child Protection Register (2010/11 – March 2022)

Trust	15/16	16/17	17/18	18/19	19/20	20/21	21/22	% By Trust	% share of Population 0-
Belfast Trust	383	347	317	334	251	335	345	15%	18%
Northern Trust	521	459	467	468	522	492	522	22%	25%
South Eastern Trust	431	388	333	366	373	350	359	15%	19%
Southern Trust	521	579	557	550	555	603	591	25%	23%
Western Trust	290	359	408	493	597	518	529	23%	17%
Total	**2146**	**2132**	**2082**	**2211**	**2298**	**2298**	**2346**	100%	100%

During the year, four Trusts had an increase in the number of children on the Register.

From March 2016 to March 2022 the number of children on the Register has risen from 2146 to 2,346. This represents a increase of 200 children (9%).



10.2.2/3 Number of children on the Child Protection Register with a Disability at 31.3.22

At 31st March 2022, there were 90 children on the Child Protection Register with a disability. Most of these children (76%) had a learning disability.

- Belfast Trust had 35 children with a disability on the Register.
- Northern Trust had 7 children with a disability on the Register.
- South Eastern Trust had 17 children with a disability on the Register.
- Southern Trust had 29 children with a disability on the Register.
- Western Trust had 2 children with a disability on the Register.

Work to improve this data collection will be undertaken as part of the UNOCINI implementation.

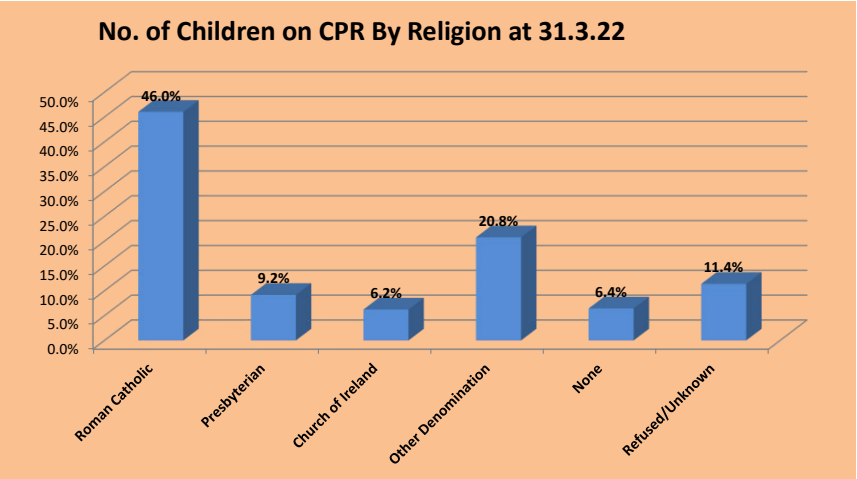
10.2.4 Religion of Children on the Child Protection Register at 31.3.22

Religion	No. on CPR	% on CPR	% Census 2011
Roman Catholic	1080	46.0%	45%
Presbyterian	215	9.2%	16%
Church of Ireland	146	6.2%	12%
Other Denomination	487	20.8%	9%
None	151	6.4%	11%
Refused/Unknown	267	11.4%	7%
Total	**2346**	**100%**	**100%**

At 31st March 2022, 46% of children on the Register were Roman Catholic while 9% were Presbyterian. 6% were from a Church of Ireland background.

The religion of 11% of children on the Register was unknown.

The figures indicate that children from a Presbyterian and Church of Ireland background have a representation less than that of the wider population. As the religion of 11% of children on the Register is not known it is not possible to make accurate comparisons.



10.2.5 Ethnicity of Children on the Child Protection Register at 31.3.22

At 31st March 2022, 88% of children on the Register were of a 'White' ethnic background.

At 31st March 2022, 8% were of an 'Other' ethnic background.

Children on the Register by Category of Abuse

Category of Abuse	No of Children	%
Neglect (only)	677	28.9%
Physical abuse (only)	592	25.2%
Sexual abuse (only)	130	5.5%
Emotional abuse (only)	367	15.6%
Multiple Categories Recorded		
Neglect , physical abuse & sexual abuse	26	1.1%
Neglect & physical abuse	452	19.3%
Neglect & sexual abuse	54	2.3%
Physical & sexual abuse	48	2.0%
Emotional Abuse (Main) and Other categories	0	0.0%
Total	**2346**	**100.0%**

Neglect was the highest category at 29% followed by Physical abuse at 25%.

Neglect and Physical Abuse was the highest multiple category at 19%.

10.2.6 - 10.2.8 Number of Registrations during April 2021 - March 2022

Trust	No. of Re-Registrations (Apr 21-Mar 22)	Re-Registrations as a % of Registrations (Apr 21-Mar 22)	No. of Registrations (2015/16)	No. of Registrations (2016/17)	No. of Registrations (2017/18)	No. of Registrations (2018/19)	No. of Registrations (2019/20)	No. of Registrations (2020/21)	No. of Registrations (2021/22)	% By Trust
Belfast Trust	40	13.3%	291	316	302	260	254	258	300	15%
Northern Trust	117	23.5%	498	490	459	448	497	517	498	24%
South Eastern Trust	71	22.7%	440	417	318	391	325	367	313	15%
Southern Trust	89	17.3%	567	585	502	555	518	587	513	25%
Western Trust	60	14.1%	244	331	340	338	446	336	427	21%
Total	**377**	**18.4%**	**2040**	**2139**	**1921**	**1992**	**2040**	**2065**	**2051**	**100%**

There were a total of 2,051 Registrations to the Child Protection Register during the year April 2021 – March 2022.

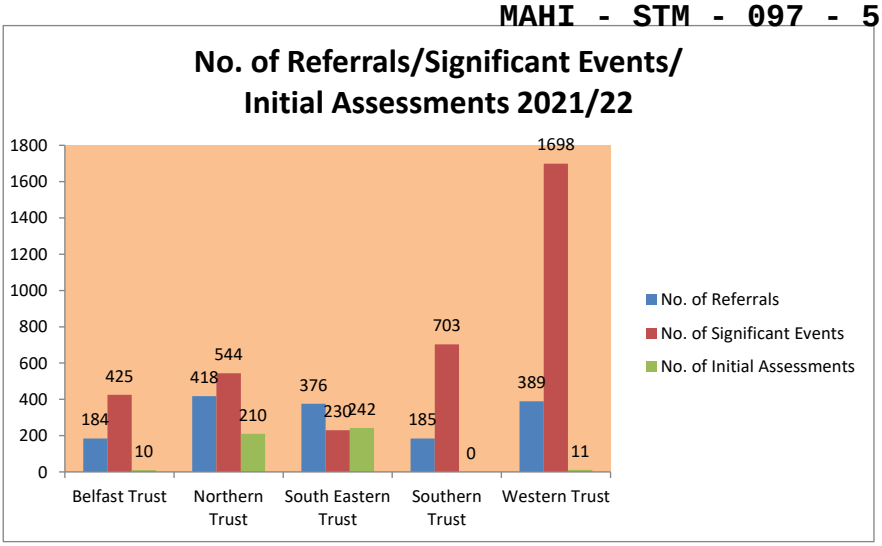
The Southern Trust had the highest number at 513, a total of 25% of all Registrations during the reporting period.

There were a total of 377 Re-registrations during the year. These are children registered during the year but who had also been on the Register as some stage in the past. Northern Trust had the highest rate of Re-registrations at 24%.

Child Protection Referrals/Significant Events/Initial Assessments (by Trust) April 2021 to March 2022

Trust	No. of Referrals	No. of Significant Events	No. of Initial Assessments
Belfast Trust	184	425	10
Northern Trust	418	544	210
South Eastern Trust	376	230	242
Southern Trust	185	703	0
Western Trust	389	1698	11
Total	**1552**	**3600**	**473**

The method of counting child protection referrals was changed during the Covid period. As a result, these figures will not be entirely comparable with previous years.



Northern Trust had the highest number of referrals at 418 while Western Trust had the highest number of significant events at 1,698. South Eastern Trust had the highest number of initial assessments at 242.

10.2.7 Number of De-registrations 1/4/21 – 31/3/22

Trust	No of De-Registrations (April 21-Mar 22)	No of De-Registrations (2015/16)	No of De-Registrations (2016/17)	No of De-Registrations (2017/18)	No of De-Registrations (2018/19)	No of De-Registrations (2019/20)	No of De-Registrations (2020/21)	No of De-Registrations (2021/22)	% By Trust
Belfast Trust	287	289	352	335	251	331	175	287	**15%**
Northern Trust	465	483	555	446	450	439	564	465	**24%**
South Eastern Trust	290	387	459	368	359	330	384	290	**15%**
Southern Trust	528	450	543	509	566	511	541	528	**27%**
Western Trust	393	252	260	288	256	334	431	393	**20%**
Total	**1963**	**1861**	**2169**	**1946**	**1882**	**1945**	**2095**	**1963**	**100%**

There were a total of 1,963 de-registrations from the Child Protection Register during the year April 2021 – March 2022. Southern Trust had the highest number at 528, 27% of total de-registrations.

Length of Time on the Register for those children who were <u>De-registered</u> during April 2021 – March 2022

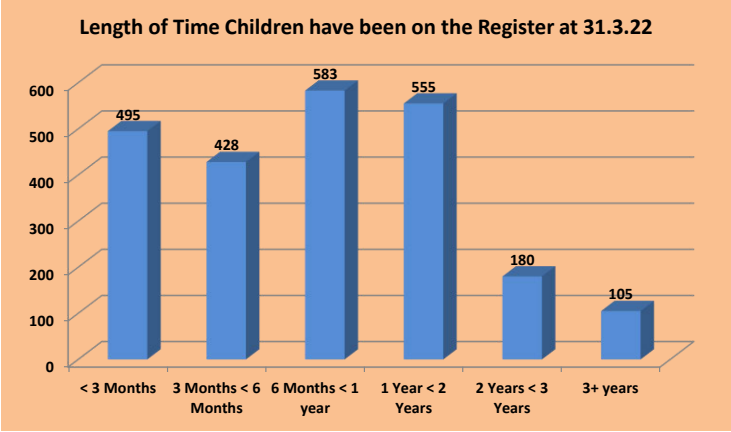
Length of Time on Register at Discharge	No of Children	%
Less than 3 mths	219	11.2%
3 mths < 6 mths	307	15.6%
6mths < 1 yr	689	35.1%
1yr < 2 yrs	498	25.4%
2yrs < 3 yrs	179	9.1%
3yrs < 5 yrs	68	3.5%
5yrs < 10yrs	3	0.2%
10+ yrs	0	0.0%
TOTAL	**1963**	**100.0%**

For those children De-registered during the year, 62% had been on the Register for less than 1 year.

Three children had been on the Register for > 5 years.

10.2.10 For children on the Register at 31.3.22, length of time they have spent on the Register

Trust	< 3 Months	3 Months < 6 Months	6 Months < 1 year	1 Year < 2 Years	2 Years < 3 Years	3+ years	Total	%
Belfast Trust	68	51	94	86	35	11	**345**	**14.7%**
Northern Trust	122	98	133	123	29	17	**522**	**22.3%**
South Eastern Trust	76	68	83	95	30	7	**359**	**15.3%**
Southern Trust	116	114	143	145	44	29	**591**	**25.2%**
Western Trust	113	97	130	106	42	41	**529**	**22.5%**
Total	**495**	**428**	**583**	**555**	**180**	**105**	**2346**	**100.0%**
%	**21.1%**	**18.2%**	**24.9%**	**23.7%**	**7.7%**	**4.5%**	**100.0%**	



64% of children had been on the Register for less than 1 year.

24% of children had been on the Register for 1-2 years while 8% had been on the Register for 2-3 years.

5% of children had been on the Register for 3+ years.

Families Feel Empowered and Valued and has made Positive changes (Extract from views of Families)

OBA Scorecard

80% of Parents Felt involved in plans about what to do. [2]

81% of parents felt the family were listened to at case conference [1]

77% The Safety Plan and trajectory has helped the family make positive changes [1]

85% of Parents Agreed with the worker about 'what we are concerned about' [2]

87% of parents who agreed that their social worker has spent time with the children and has listened to what they say about the problems and what should happen. [2]

[1] Source - HSC Pilot Survey – case conferences, 21/22
[2] Source:– Signs of Safety Parents survey, 21/22

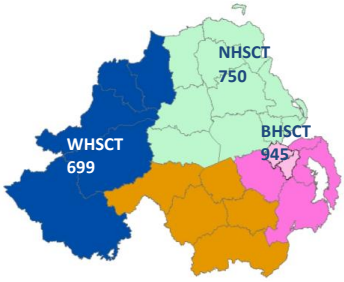
Key issues

3%	↑	Increase in the number of children in care (from 3530 - March 21 to 3,624 - March 22)
1%	↓	Decrease in the proportion of looked after children in care for less than three years from 1801 in March 21, to 1,779 in March 22
2%	↑	Increase in the proportion of looked after children in foster care placements from 81% - March 21 to 83% - March 22

- At March 2022, 3,624 children and young people were in care in Northern Ireland. This was the highest number recorded since the introduction of the Children (Northern Ireland) Order 1995;
- 899 children were admitted and 777 were discharged.
- The number of children admitted has been higher that the number discharged over the past 10 years.
- Some 22% of the children in care had been looked after for less than a year, with 32% looked after for five years or longer;
- More than four fifths of the children in care were in foster care placements (83%), 7% placed with parents, 6.7% in residential care and 4% in other placements. This was similar to previous years;
- 8,205 Looked After Reviews held during the year 87% within timescale and 1084 (13%) outside timescales.
- 198, (5%) of all Looked after children were without an allocated Social worker at 31/3/22.
- 91 looked after children were deemed to be in an Inappropriate Placement given their assessed needs at 31/3/22.
- The number of children awaiting assessment or treatment with CAMHS increased from 38 at 31.3.21 to 127 at 31.3.22.
- The number of children with one or more placement move increased from 453 to 566 between the six month period (Oct-Mar 21 and Oct to Mar 22).

MAHI - STM - 097 - 5613

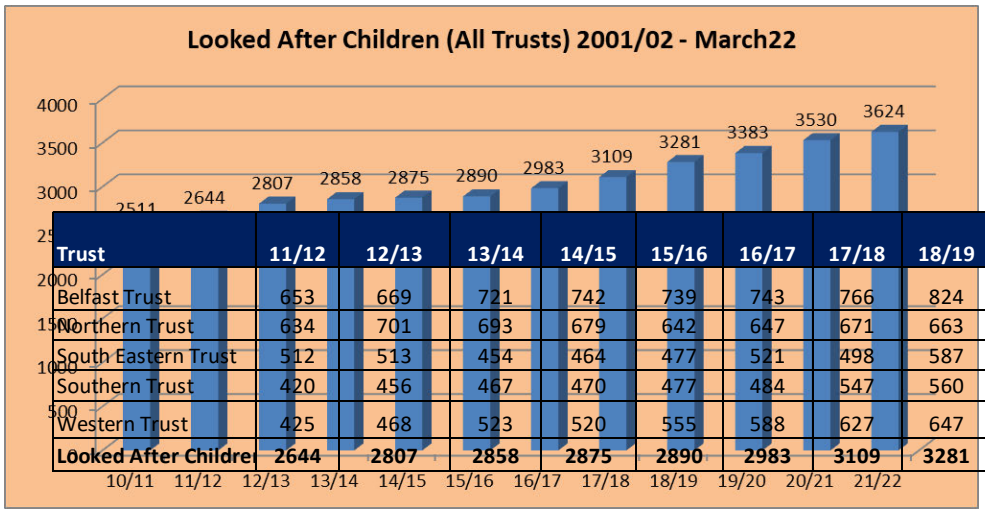
Delegated Statutory Functions – Looked After Children



Summary of Looked After Children at 31.3.22

Trust	Looked After Children	No. of LAC on CPR	Residential Care	Foster Care	At Home	Other	Admissions	Discharges
ildren 2010/11 - March 2022								
SHSCT	589	26	36	476	57	20	151	153
WHSCT	699	82	48	573	47	31	164	136
Total	3624	256	241	3000	248	135	899	777
	3624		6.7%	82.8%	6.8%	3.7%	899	777

Trust	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22
Looked After Children	2511	2644	2807	2858	2875	2890	2983	3109	3281	3383	3530	3624

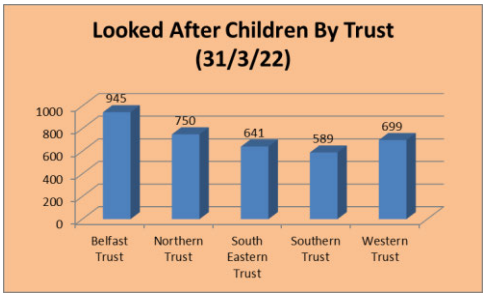


Looked After Children by Trend By Trust 2001 – March 2022

Trust	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	Rate per 10,000
Belfast Trust	653	669	721	742	739	743	766	824	866	875	945	**122**
Northern Trust	634	701	693	679	642	647	671	663	674	737	750	**69**
South Eastern Trust	512	513	454	464	477	521	498	587	630	639	641	**78**
Southern Trust	420	456	467	470	477	484	547	560	562	591	589	**59**
Western Trust	425	468	523	520	555	588	627	647	651	688	699	**96**
Looked After Childre	**2644**	**2807**	**2858**	**2875**	**2890**	**2983**	**3109**	**3281**	**3383**	**3530**	**3624**	**82**

2022

Belfast and Western Trusts have the highest rates of Looked After children at 122 and 96 respectively.



Number of Looked After Children by Age and Gender at 31st March 2022

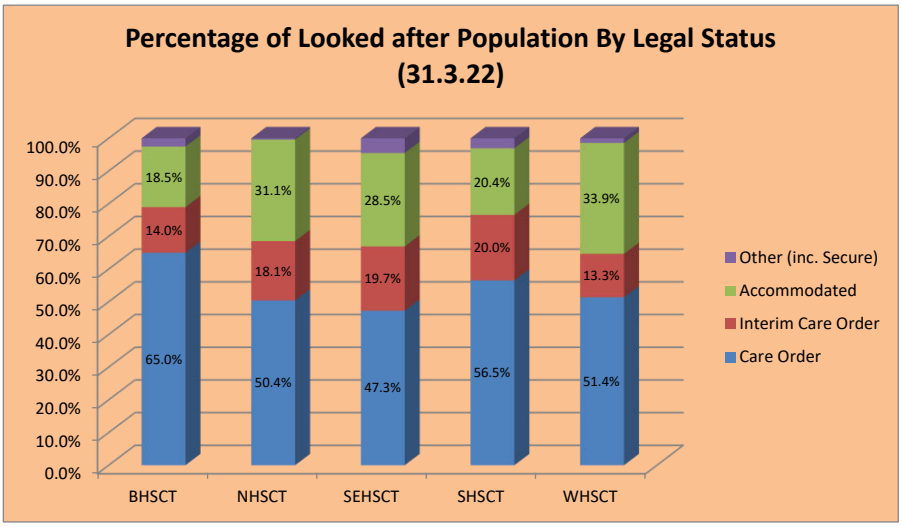
Trust	Age(Years)												
	<1		1-4		5-11		12-15		16+		Total		
	M	F	M	F	M	F	M	F	M	F	M	F	All
BHSCT	19	16	101	96	197	155	123	101	65	72	**505**	**440**	**945**
NHSCT	15	13	71	76	146	121	98	78	80	52	**410**	**340**	**750**
SEHSCT	9	11	71	60	118	107	84	74	54	53	**336**	**305**	**641**
SHSCT	13	6	77	47	101	102	66	80	51	46	**308**	**281**	**589**
WHSCT	8	7	52	61	138	114	110	85	79	45	**387**	**312**	**699**
Total	**64**	**53**	**372**	**340**	**700**	**599**	**481**	**418**	**329**	**268**	**1946**	**1678**	**3624**

At 31st March 2022, there were 3,624 children Looked After across the five Trusts. Belfast Trust had the highest number at 945 followed by Northern Trust at 750. There were more males (54%) looked after than females (46%). Most Looked After Children were in the 5-11 age-group with 1,299 children (36%). This was followed by 12-15 years with 899 children (25%) and 0-4 with 829 children (23%), and 16+ with 597 children (16%).

10.3.1 Current Legal Status for all Looked After Children at 31.3.22 (excluding any who are Looked after on that day only by virtue of a short-break arrangement)

Trust	Care Order	Interim Care Order	Accommodated	Other (inc. Secure)	Total
BHSCT	614	132	175	24	**945**
NHSCT	378	136	233	3	**750**
SEHSCT	303	126	183	29	**641**
SHSCT	333	118	120	18	**589**
WHSCT	359	93	237	10	**699**
Total	**1987**	**605**	**948**	**84**	**3624**
%	**54.8%**	**16.7%**	**26.2%**	**2.3%**	**100.0%**

55% of all children were Looked After under a Care Order.
This was followed by 948 children who were Accommodated (26%).
Belfast Trust had the highest percentage of Looked After population on a Care Order at 65%.

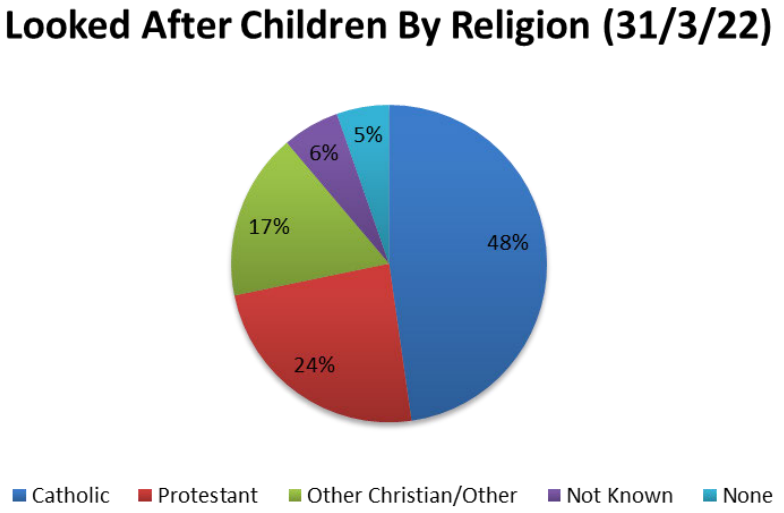


10.3.2 Religion and Ethnicity of Looked After Children 30.9.21

MAHI - STM - 097 - 5615

Trust	Protestant	%	Roman Catholic	%	Other Christian/ Other	%	Not Known/ Not Completed	%	None	%	Total
BHSCT	246	26.0%	436	46.1%	174	18.4%	56	5.9%	33	3.5%	**945**
NHSCT	207	27.6%	149	19.9%	253	33.7%	99	13.2%	42	5.6%	**750**
SEHSCT	215	33.5%	228	35.6%	95	14.8%	31	4.8%	72	11.2%	**641**
SHSCT	102	17.3%	363	61.6%	72	12.2%	21	3.6%	31	5.3%	**589**
WHSCT	101	14.4%	554	79.3%	24	3.4%	4	0.6%	16	2.3%	**699**
Total	**871**	**24.0%**	**1730**	**47.7%**	**618**	**17.1%**	**211**	5.8%	**194**	**5.4%**	**3624**

48% of children Looked After were Roman Catholic. This was followed by Looked After Children who were Protestant at 24%. South Eastern Trust had the highest proportion of children who were Protestant while Western Trust had the highest proportion of children who were Roman Catholic.



45% of all children in the wider population are Roman Catholic - this has increased to 48% within the Looked after population.

30% of the wider population of children are Protestant while 24% of the Looked After population are of the same religion.

(Note: based on Census 2011).

Ethnicity of Looked After Children at 31.3.22

Ethnicity	No. Looked After	%
White	3293	90.9%
Black	69	1.9%
Other	198	5.5%
Not Known/Not Completed	64	1.8%
Total	**3624**	**100.0%**

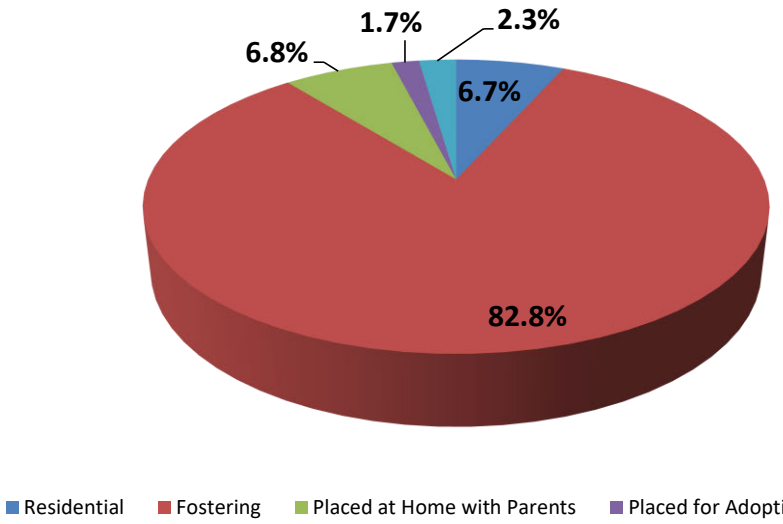
91% of the Looked After population were white. The 2011 Census gave the ethnicity of the population of N Ireland 97.5% white.

2% of the Looked After population were from a 'black' ethnic background.

10.3.3 Number of Looked After Children By Type of Placement at 31st March 2022

Trust	Residential (Statutory/ Voluntary/ Secure)	FOSTERING			Placed at Home with Parents	Other	Total
		Stranger	Kinship	Independent Providers			
BHSCT	61	251	424	141	53	15	**945**
NHSCT	35	193	399	50	45	28	**750**
SEHSCT	61	176	229	88	46	41	**641**
SHSCT	36	263	209	4	57	20	**589**
WHSCT	48	193	365	15	47	31	**699**
Total	**241**	**1076**	**1626**	**298**	**248**	**135**	**3624**
%	**6.7%**	**29.7%**	**44.9%**	**8.2%**	**6.8%**	**3.7%**	**100.0%**

Placement of Looked After Children (31/3/22)



Most Looked After Children (82.8%) were placed with foster carers.

This was followed by those placed at home with parents (6.8%) and those children placed in residential care (6.7%).

Trend of Placement Type

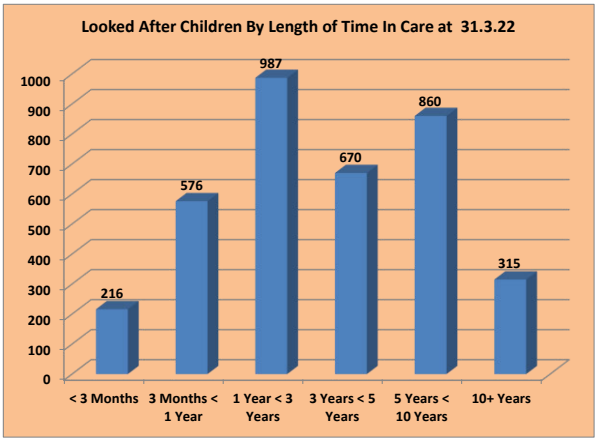
Placement	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22
Residential	6.7%	5.8%	5.5%	5.3%	6.2%	6.4%	5.6%	6.7%
Fostering	76.0%	76.5%	78.2%	78.8%	78.8%	78.7%	80.9%	82.8%
Placed at Home with Parents	11.8%	13.5%	12.2%	11.7%	11.2%	10.3%	9.0%	6.8%
Placed for Adoption	0.9%	1.3%	0.9%	0.8%	1.2%	1.9%	1.8%	1.7%
Other	4.5%	2.9%	3.2%	3.2%	2.6%	2.7%	2.6%	2.3%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

The percentage of children in fostering placement continues to increase from 76.5%(2015/16) to 82.8% in 2021/22. The number of Looked After Children placed at home with parents has significantly decreased from 13.5% in 2015/16 to 6.8% in March 2022.

10.3.4 Age Bands and Length of Time Looked After for all Looked After Children at 31st March 2022

MAR1 - STM - 097 - 5617

- **792** children (22%) were Looked After for less than a year.
- **987** children (27%) were Looked After for 1<3 years.
- **670** children (18%) were Looked After for 3<5 years.
- **860** children (24%) were Looked After for 5<10 years.
- **315** children (9%) were Looked After for more than 10 years.



10.3.5 Number of Disabled Children provided with Short Breaks during the period (April 2021 – March 2022)

Short Breaks	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total
Number of Children	95	223	114	106	122	**660**
No. of Episodes/Events	793	1729	434	1038	372	**4366**
Number of Overnight Stays	1225	2590	818	1504	942	**7079**

A total of 660 children were provided with 7,079 overnight stays for short break purposes.

10.3.6 Number of Children Accommodated for three months or more in a Hospital (31.3.22)

There were 6 children accommodated for three months or more in a hospital at 31.3.22. This had reduced from 8 children accommodated at 31.3.21

10.3.7 Number of Children Accommodated for three months or more in an adult setting: Residential Care Home, Nursing Home, Private Hospital) during April 2021– March 2022.

During the year, two children were placed in adult facilities for more than 3 months. An increase from no children placed during 2020/21.

10.3.8 Residential Care facilities – statutory, voluntary and private which are available to care for Looked After Children at 31.3.22

This section provides information on the numbers of residential beds available for access by Trusts as at the 31st March 2022.

BELFAST TRUST
Residential Provision

Name of Residential Unit	Type	No of Beds	No of Beds available to Trust	No of Respite beds
444 Antrim Road	Statutory	4	4	0
North Road	Statutory	6	6	0
Glandore Avenue	Statutory	8	8	0
Fortwilliam Park	Statutory	8	8	0
Osbourne House	Statutory	4	4	0
Lyndsay House	Statutory	4	1	1
Willow Lodge	Statutory	2	1	0
Forest Lodge	Statutory	8	6	4
Slemish House ISU	Statutory	8	8	0
Somerton Road	Statutory	5	3	0
Merton	Statutory	2	2	0
Safe Spaces	Private	1	1	0
THREE STEPS	Private	1	1	0
Camphill Community Glencraig	Voluntary	1	1	0
Ashdale	Private	1	1	0
Bachlaw Projects,Aberdeenshire	Private	1	1	0
Aisling House ISU	Statutory	6	6	0
Aran House Glenmona	Statutory	8	8	0
Child 23	Voluntary	1	4	0

Foster Carer Provision

Type of Approval	No. of Carers
Kinship Foster Carer	329
Panel Approved Foster Carer (Stranger)	161
Professional Foster Carers (Fee Paid Carers)	44
TOTAL	**534**

Other Foster Carers	No. of Carers
Independent Provider Foster Carers	100
Carers providing care only to children with a disability and who are not available to provide care for Looked After Children	0

At 31st March 2022, Belfast Trust had access to 12 statutory residential children's facilities and 534 foster carers to provide placements for Looked After Children. In addition BHSCT had access to beds in regional, shared residential facilities and in short break facilities.

NORTHERN TRUST
Residential Provision

MAHI - STM - 097 - 5619

Name of Residential Unit	Type	No of Beds	No of Beds available to Trust	No of Respite beds
Ardrath	Statutory	6	6	0
Seaport View	Statutory	6	6	0
Barn Court	Statutory	6	6	0
Spring Meadows	Statutory	6	6	0
The Willows	Statutory	6	6	0
Mount Street Mews	Voluntary	3	3	0
Grove Road	Voluntary	2	2	0
Tafelta Rise	Voluntary	4	4	0

Foster Carers Provision

Type of Approval	No. of Carers
Kinship Foster Carer	307
Panel Approved Foster Carers (Stranger)	195
Professional Foster Carers (Fee Paid Carers)	114
TOTAL	**616**

Other Foster Carers	No. of Carers
Independent Provider Foster Carers	33
Carers providing care only to children with a disability and who are not available to provide care for Looked After Children	7

At 31st March 2022, Northern Trust had access to 6 statutory children's homes and 616 foster carers.
In addition NHSCT had access to beds in regional residential facilities and in short break facilities to provide placements for Looked After Children.

SOUTH EASTERN TRUST

Residential Provision

Name of Residential Unit	Type	No of Beds	No of Beds available to Trust	No of Respite beds
William Street Assessment Unit	Statutory	8	8	0
Marmion Childrens Home	Statutory	8	8	0
Flaxfield Childrens Home	Statutory	8	8	0
Cuan Court Childrens Home	Statutory	8	8	0
Oaklands specialist children's home	Statutory	6	6	0
Ashgrove specialist children's home	Statutory	6	6	0
BCM Supported Accomodation	Voluntary	6	6	0
Barnardos Children's Home	Voluntary	4	1	0
Barnardos Supported Accom	Voluntary	2	2	0
MAC Supported Accomodation, Belfast	Voluntary	8	8	0
Beechfield Short Term Care	Private	5	5	0
Lindsay House Short Term Care	Statutory	8	1	0
Lindsay House Short Breaks	Statutory	8	1	1
Greenhill YMCA	Private	2	2	2
Glenmore Cottage	Statutory	4	4	0

Foster Carer Provision

Type of Approval	No. of Carers
Kinship Foster Carer	138
Panel Approved Foster Carer (Stranger)	185
Professional Foster Carers (Fee Paid Carers)	22
TOTAL	**345**

Other Foster Carers	No. of Carers
Independent Provider Foster Carers	63
Carers providing care only to children with a disability and who are not available to provide care for Looked After Children	0

At 31st March2022, South Eastern Trust had access to 9 statutory children's homes and 345 foster carers to provide placements for Looked After Children.

In addition SEHSCT had access to beds in regional residential/shared facilities and in short break facilities.

SOUTHERN TRUST

MAHI - STM - 097 - 5621

Residential Provision

Name of Residential Unit	Type	No of Beds	No of Beds available to Trust	No of Respite beds
Cedar Grove	Statutory	5	5	0
Woodside	Statutory	5	5	0
Edenvilla	Statutory	5	5	0
Cherrygrove	Statutory	5	5	0
Bocombra	Statutory	5	5	0
Carrickore	Statutory	0	0	5
Oaklands	Statutory	0	0	4
Willowgrove (New)	Voluntary	0	0	2

Foster Carers Provision

Type of Approval	No. of Carers
Kinship Foster Carer	191
Panel Approved Foster Carer (Stranger)	280
Professional Foster Carers (Fee Paid Carers)	24
TOTAL	**495**

Other Foster Carers	No. of Carers
Independent Provider Foster Carers	4
Carers providing care only to children with a disability and who are not available to provide care for Looked After Children	17

At 31st March 2022, Southern Trust had access to 7 statutory children's homes and 495 fostercarers to provide placements for Looked After Children.

In addition SHSCT had access to beds in regional residential facilities and in short break facilities.

WESTERN TRUST

Residential Provision

Name of Residential Unit	Type	No of Beds	No of Beds available to Trust	No of Respite beds
84 Chapel Road	Statutory	4	4	0
Upper Galliagh Road	Statutory	6	6	0
Scroggy Road	Statutory	6	6	0
106, Irish Street	Statutory	6	6	0
Woodlands	Statutory	6	6	0
Beechlea	Statutory	6	6	0
Rosebud Cottage	Statutory	4	4	4
Avalon	Statutory	8	8	8

Foster Carers Provision

Type of Approval	No. of Carers
Kinship Foster Carer	379
Panel Approved Foster Carer (Stranger)	219
Professional Foster Carers (Fee Paid Carers)	16
TOTAL	**614**

Other Foster Carers	No. of Carers
Independent Provider Foster Carers	18
Carers providing care only to children with a disability and who are not available to provide care for Looked After Children	22

At 31st March 2022, Western Trust had access to 8 statutory children's homes and 614 foster carers to provide placements for Looked After Children.

In addition WHSCT had access to beds in regional residential facilities and in short break facilities.

10.3.9 Number of Looked After Children who have had 2 or more Placement Moves (1.10.21- 31.3.22)

Trust	Number of Looked After Children with Placement Moves			
	Once	Twice	Three +	Total
BHSCT	139	16	24	**179**
NHSCT	51	29	90	**170**
SEHSCT	48	7	3	**58**
SHSCT	117	10	8	**135**
WHSCT	17	5	2	**24**
Total	**372**	**67**	**127**	**566**

This data relates to those Looked After Children who experienced placement moves (for any reason including short breaks) during the period.

22% of children who experienced a move had 3+ moves within the period.

This figure has increased from the six month period October – March 2021 when 453 children had one or more placement move.

Note: From March 17, the data provided in the table above reflects the number of moves during a six month period.

10.3.10 Number of Looked After Children awaiting Assessment or Treatment with Child and Adolescent Mental Health Services at 31st March 2022

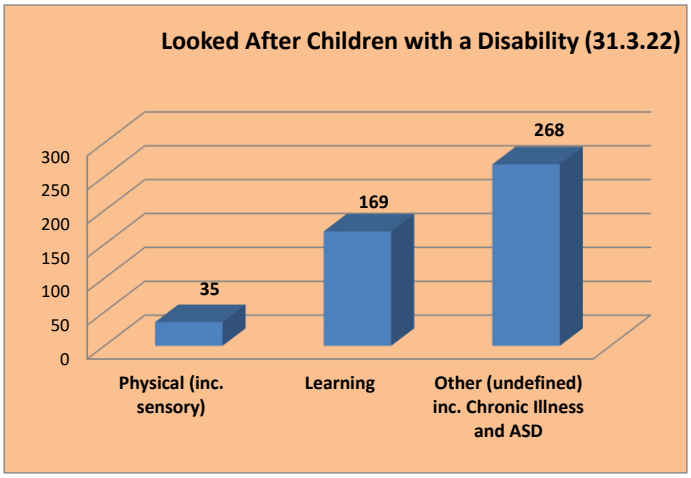
Information provided by Trusts indicates that at 31st March 2022, there were 127 young people waiting for assessment or treatment with Child and Adolescent Mental Health Services. This figure has increased from 38 children waiting at 31/3/21.

10.3.11 Number of Looked After Children who are on the Child Protection Register at 31st March 2022

256 Looked After Children were also on the Child Protection Register.

10.3.12 Number of Looked After Children who are Disabled by major category at 31st March 2022

Trust	Physical (inc. sensory)	Learning	Other (undefined) inc. Chronic Illness and ASD	Total
BHSCT	11	61	117	**189**
NHSCT	9	34	45	**88**
SEHSCT	4	51	73	**128**
SHSCT	7	13	32	**52**
WHSCT	4	10	1	**15**
Total	**35**	**169**	**268**	**472**



472 Looked After Children had a disability at 31st March 2022. This represents 13% of all Looked After Children. The majority of those children who were disabled had Autism/ASD/Aspergers/ADHD (48%).

10.3.13 Number of Looked After Children who have a Statement of Special Educational Need (SEN) at 31st March 2022

Trust	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total
Primary	58	15	48	57	9	**187**
Secondary	63	32	63	48	58	**264**
Special School	63	22	64	11	13	**173**
Total	**184**	**69**	**175**	**116**	**80**	**624**

Trusts reported that there were a total of 624 children with a Statement of Special Educational Need at 31st March 2022. Most children were in secondary school.

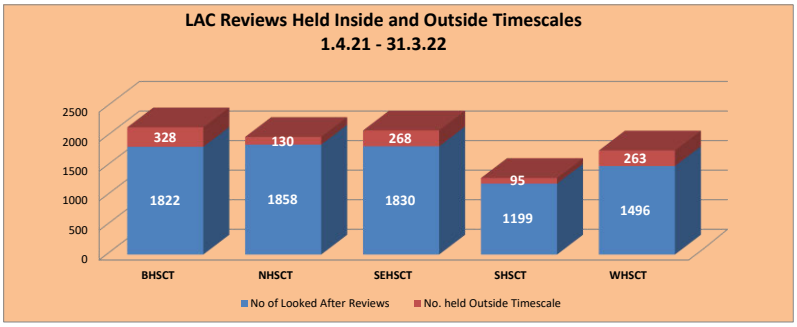
Belfast Trust had the highest number of children with a Statement (SEN).

10.3.14 Number of Looked After Children who during the period were without an Allocated Social Worker (March 2022)

At 31st March 2022, 198 Looked After Children were without an Allocated Social Worker. This figure has increased from 66 at March 2021.

10.3.17 Number of Looked After Children Reviews held during the year (April 21 – March 22)

10.3.18 Number of these Looked After Reviews which were held outside timescale (April 21 – March 22)



Trust	No of Looked After Reviews	No. held Outside Timescale
BHSCT	1822	328
NHSCT	1858	130
SEHSCT	1830	268
SHSCT	1199	95
WHSCT	1496	263
Total	**8205**	**1084**

There were a total of 8,205 Looked After Reviews held during the year.

Northern Trust held the highest number at 1,858 followed by South Eastern Trust with 1,830 while Southern Trust had the lowest number at 1,199.

1084 (13%) of LAC reviews were held outside timescale. This figure has decreased from 1,415 at March 2021.

10.3.21 Number of exemptions to the normal fostering limit made to foster care approvals in order for a child to be placed in an emergency (April 21 – March 22)

There were 54 exemptions to the normal fostering limit during the period- BHSCT had 16, SHSCT had 12 and NHSCT had 11, WHSCT had 8 and SEHSCT had 7. This figure has increased from 29 exemptions at 31/3/22.

10.3.23 Number of Looked After Children deemed to be in an inappropriate placement given their assessed needs at 31st March 2022

Trusts reported that there were 91 children in inappropriate placements at 31.3.22. South Eastern Trust had 37 children in inappropriate placements while Belfast Trust had 35, there were 11 in Northern Trust, 7 in Western Trust, and Southern Trusts had <5. There had been 29 children in inappropriate placements at 31.3.21 an increase of 62 children.

10.3.26 Permanency Panel Recommendations for Looked After Children at 31st March 2022

Trust	Return to Birth family	Return to Kinship Carers outside LAC system(Friend/ Relative/ Family	Adoption	Long-Term Fostering (Including Kinship)	Supported Living/ Independent Living	Other	Total
BHSCT	68	4	54	575	27	60	788
NHSCT	267	1	32	398	15	31	744
SEHSCT	105	43	62	381	15	16	622
SHSCT	92	3	57	309	31	58	550
WHSCT	53	286	25	140	10	78	592
Total	**585**	**337**	**230**	**1803**	**98**	**243**	**3296**
%	17.7%	10.2%	7.0%	54.7%	3.0%	7.4%	100.0%

NOTE: Some children not included as in care for < 9 months.

The highest permanency panel recommendations were for Long-Term Fostering (55%) followed by Return to Birth Family at 18%.

259 children had a permanency plan in place for > 12 months and not yet achieved at 31/3/21. This represents an increase from 250 children at 31/3/21who had a permanency plan in place for > 12 months and not yet achieved.

10.3.29 Number of Looked After Children involved in offending behaviour (are formally cautioned or convicted) April 2021 – March 2022

Trust	Cautioned/ Remanded	Convicted
BHSCT	43	6
NHSCT	33	0
SEHSCT	48	13
SHSCT	13	7
WHSCT	24	<5
Total	**161**	**29**

Cautioned / Convicted	Year Ending			
	31/03/2022	31/03/2021	31/03/2020	31/03/2019
Cautioned	128	82	97	103
Remanded	33	28	32	30
Convicted	29	27	183	50
Total	**190**	**137**	**176**	**232**

The total number of children cautioned/convicted increased from last year 21/22 but is lower than the position at 31/3/19.

10.3.32 Looked After Children Educational Attainment

MAHI - STM - 097 - 5627

Based on information sourced from Children in Care in N Ireland Bulletin, DoH

Key Stage 1 Communication (2014-2018)

Key Stage 1 Communication – 79% of Looked After Children attained Level 2 or above (Sept 18), compared with 87% of the general school population.

Key Stage 1 Trust	30/09/2014 % with Level 2 or above	30/09/2015 % with Level 2 or above	30/09/2016 % with Level 2 or above	30/09/2017* % with Level 2 or above	30/09/2018** % with Level 2 or above
BHSCT	83.3%	57.9%	70.6%	71.4%	
NHSCT	82.4%	73.9%	90.0%	75.0%	
SEHSCT	75.0%	76.5%	75.0%	87.5%	
SHSCT	66.7%	33.3%	66.7%	50.0%	
WHSCT	94.1%	100.0%	85.7%	83.3%	
Total	**81.6%**	**70.3%**	**78.4%**	**77.8%**	**79%**

**Please note that regionally this relates to only 27 children, hence the Trust rates are based on very small numbers.*

***Please note that due to ongoing school industrial action, it has not been possible to present Key Stage attainment results at Trust level for 2017/18.*

Key Stage 1 Using Maths (2014-2018)

Key Stage 1 Using Maths - 79% of Looked After Children attained Level 2 or above (Sept 18), compared with 89% of the general school population.

Key Stage 1 Trust	30/09/2014 % with Level 2 or above	30/09/2015 % with Level 2 or above	30/09/2016 % with Level 2 or above	30/09/2017* % with Level 2 or above	30/09/2018** % with Level 2 or above
BHSCT	83.3%	57.9%	70.6%	57.1%	
NHSCT	94.1%	73.9%	90.0%	75.0%	
SEHSCT	75.0%	88.2%	75.0%	87.5%	
SHSCT	58.3%	33.3%	83.3%	50.0%	
WHSCT	94.1%	100.0%	78.6%	100.0%	
Total	**82.9%**	**73.0%**	**78.4%**	**77.8%**	**79%**

**Please note that regionally this relates to only 27 children, hence the Trust rates are based on very small numbers.*

***Please note that due to ongoing school industrial action, it has not been possible to present Key Stage attainment results at Trust level for 2017/18.*

Key Stage 2 Communication (2014-2018)

Key Stage 2 Communication – 70% of Looked After Children attained Level 4 or above (Sept 17), compared with 80% of the general school population.

Key Stage 2 Trust	30/09/2014 % with Level 4 or above	30/09/2015 % with Level 4 or above	30/09/2016 % with Level 4 or above	30/09/2017 % with Level 4 or above	30/09/2018 % with Level 4 or above**
BHSCT	46.2%	36.8%	43.8%	22.2%	
NHSCT	32.0%	29.6%	42.1%	92.9%	
SEHSCT	9.1%	23.5%	0.0%	100.0%	
SHSCT	44.4%	28.6%	44.4%	100.0%	
WHSCT	66.7%	64.3%	57.1%	60.0%	
Total	**36.8%**	**35.7%**	**44.3%**	**69.7%**	

**Please note that regionally this relates to only 33 children, hence the Trust rates are based on very small numbers.*

***Please note that due to ongoing school industrial action, it has not been possible to present Key Stage 2 attainment results for 2017/18.*

Key Stage 2 Using Maths (2004-2018)

Key Stage 2 Using Maths – 61% of Looked After Children attained Level 4 or above (Sept 17), compared with 80% of the general school population.

Key Stage 2 Trust	30/09/2014 % with Level 4 or above	30/09/2015 % with Level 4 or above	30/09/2016 % with Level 4 or above	30/09/2017 % with Level 4 or above	30/09/2018 % with Level 4 or above**
BHSCT	46.2%	42.1%	43.8%	22.2%	
NHSCT	32.0%	33.3%	47.4%	71.4%	
SEHSCT	16.7%	17.6%	33.3%	100.0%	
SHSCT	33.3%	14.3%	44.4%	100.0%	
WHSCT	44.4%	64.3%	42.9%	60.0%	
Total	**33.8%**	**35.7%**	**44.3%**	**60.6%**	

**Please note that regionally this relates to only 33 children, hence the Trust rates are based on very small numbers.*

***Please note that due to ongoing school industrial action, it has not been possible to present Key Stage 2 attainment results for 2017/18.*

Key Stage 3 English (2014-2018)

Key Stage 3 English – 36% of Looked After Children attained Level 5 or above (Sept 18), compared with 75% of the general school population.

Key Stage 3 Trust	30/09/2014 % with Level 5 or above	30/09/2015 % with Level 5 or above	30/09/2016 % with Level 5 or above	30/09/2017 % with Level 5 or above	30/09/2018 % with Level 5 or above
BHSCT	16.7%	11.8%	38.5%	14.3%	
NHSCT	47.4%	18.5%	22.2%	20.0%	
SEHSCT	12.5%	37.5%	36.4%	50.0%	
SHSCT	37.5%	25.0%	60.0%	25.0%	
WHSCT	38.9%	16.7%	53.8%	71.4%	
Total	**27.3%**	**21.1%**	**40.0%**	**37.0%**	**36%**

**Please note that regionally this relates to only 27 children, hence the Trust rates are based on very small numbers.*

***Please note that due to ongoing school industrial action, it has not been possible to present Key Stage attainment results at Trust level for 2017/18.*

Key Stage 3 Mathematics (2004-2018)

Key Stage 3 Mathematics – 39% of Looked After Children attained Level 5 or above (Sept 18), compared with 78% of the general school population.

Key Stage 3 Trust	30/09/2014 % with Level 5 or above	30/09/2015 % with Level 5 or above	30/09/2016 % with Level 5 or above	30/09/2017 % with Level or above	30/09/2018 % with Level 5 or above
BHSCT	20.0%	11.8%	38.5%	14.3%	
NHSCT	36.8%	25.9%	33.3%	25.0%	
SEHSCT	4.2%	25.0%	27.3%	0.0%	
SHSCT	25.0%	25.0%	40.0%	50.0%	
WHSCT	35.3%	29.4%	53.8%	57.1%	
Total	**22.4%**	**23.6%**	**38.5%**	**30.8%**	**39%**

**Please note that regionally this relates to only 27 children, hence the Trust rates are based on very small numbers.*

***Please note that due to ongoing school industrial action, it has not been possible to present Key Stage attainment results at Trust level for 2017/18.*

GCSE (2004-2018)

GCSE – 90% of Looked After Children achieved 1 or more A*-G (Sept 18)

GCSE Trust	30/09/2014 % 1 or more A* - G	30/09/2015 % 1 or more A* - G	30/09/2016 % 1 or more A* - G	30/09/2017 % 1 or more A* - G	30/09/2018 % 1 or more A* - G
BHSCT	80.0%	42.6%	96.7%	86.3%	94%
NHSCT	65.1%	77.4%	95.4%	96.5%	84%
SEHSCT	72.7%	64.7%	100.0%	93.8%	88%
SHSCT	61.5%	83.8%	100.0%	93.8%	92%
WHSCT	82.6%	72.5%	100.0%	96.0%	95%
Total	**72.6%**	**65.8%**	**98.0%**	**93.5%**	**90%**

GCSE – 76% of Looked After Children achieved 5 or more A*-G (Sept 18)

GCSE Trust	30/09/2014 % 5 or more A* - G	30/09/2015 % 5 or more A* - G	30/09/2016 % 5 or more A* - G	30/09/2017 % 5 or more A* - G	30/09/2018 % 5 or more A* - G
BHSCT	44.0%	24.1%	76.7%	72.7%	81%
NHSCT	51.2%	51.6%	72.7%	72.4%	68%
SEHSCT	54.5%	52.9%	53.3%	56.3%	88%
SHSCT	34.6%	59.5%	81.3%	81.3%	68%
WHSCT	65.2%	55.0%	100.0%	84.0%	85%
Total	**49.1%**	**46.4%**	**76.8%**	**74.1%**	**76%**

GCSE – 54% of Looked After Children achieved 5 or more A*-C (Sept 18), compared with 85% of the general school population

GCSE Trust	30/09/2014 % 5 or more A* - C	30/09/2015 % 5 or more A* - C	30/09/2016 % 5 or more A* - C	30/09/2017 % 5 or more A* - C	30/09/2018 % 5 or more A* - C
BHSCT	24.0%	14.8%	56.7%	59.1%	56%
NHSCT	30.2%	22.6%	50.0%	44.8%	48%
SEHSCT	33.3%	26.5%	33.3%	18.8%	71%
SHSCT	19.2%	35.1%	50.0%	47.1%	52%
WHSCT	43.5%	40.0%	75.0%	60.0%	50%
Total	**29.1%**	**27.0%**	**53.5%**	**47.7%**	**54%**

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10.3.33 Number of Looked After Children suspended or expelled from school during the school years (2008/2018)

Trust	30/09/2008	30/09/2009	30/09/2010	30/09/2011	30/09/2012	30/09/2013	30/09/2014	30/09/2015	30/09/2016	30/09/2017	30/09/2018*
BHSCT	9.3%	6.7%	10.2%	8.8%	11.2%	8.1%	8.2%	8.2%	10.7%	6.4%	7.2%
NHSCT	6.3%	6.1%	8.9%	3.9%	5.7%	5.4%	3.7%	5.1%	6.9%	6.3%	5.5%
SEHSCT	6.0%	10.2%	11.7%	8.0%	10.9%	8.1%	6.9%	6.7%	7.5%	6.4%	6.3%
SHSCT	5.7%	9.1%	9.0%	9.2%	5.9%	5.3%	6.3%	6.8%	8.1%	10.1%	8.4%
WHSCT	9.9%	11.2%	8.9%	6.6%	7.9%	7.5%	3.7%	6.7%	7.9%	8.6%	9.2%
Total	**7.7%**	**8.4%**	**9.7%**	**7.3%**	**8.3%**	**6.9%**	**5.7%**	**6.7%**	**8.4%**	**7.4%**	**7.4%**

** Please note that children with missing values have been excluded from the calculation*

Information sourced from OC 2 returns indicate 7.4% of children in care who had been in care continuously for 1 six month period or more had been suspended or expelled from school during the six month period 6.2% of the children had been suspended only. This has varied over the past six month periods from 5.7% at September 2014 to 9.7% at September 2010.

10.3.34 Number of Looked After Children who have been notified to the Police as having an unauthorised absence or have gone missing from residential or foster care for more than 24 hours (April 2021 – March 2022)

10.3.35 Number of children accommodated by Education and Library Boards for 3 months or more by category at 31st March 2022.

having a total of 56 episodes of absconding in the period of *April 21 – March 22.* Source: Untoward Events Database, HSCB.

There were no children accommodated by Education Authority for 3 months or more at 31.3.22.

10.3.37 Number of young people admitted to Secure Accommodation (April 2021 – March 22)

There were 53 admissions to secure care during the year. The number of children in secure care represents 1% of all Looked After Children. ****This data is sourced from: HSCB Regional Secure Panel***

Trust	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total
Admissions	15	<10	<10	11	12	53
%	**28%**	**-**	**-**	**21%**	**23%**	**100%**

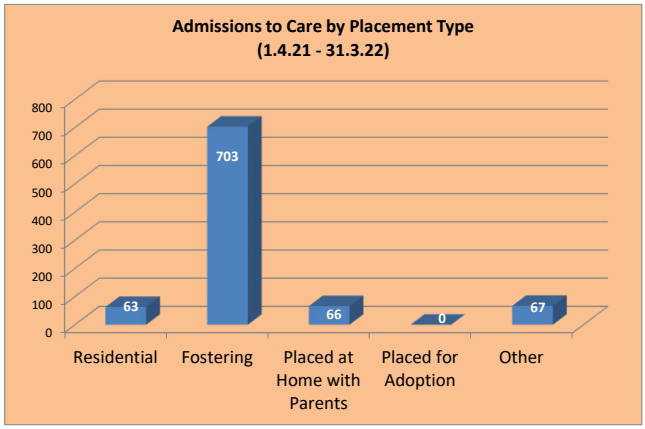
sion to Secure

There were 60 young people designated by the Trust as being in need of Admission to Secure Accommodation during the year

10.3.39 Number of children or young people who became a Looked After Child during April 2021 – March 2022

NI	Residential	Fostering	Placed at Home with Parents	Placed for Adoption	Other	Total
Total	63	703	66	0	67	**899**
%	7.0%	78.2%	7.3%	0.0%	7.5%	100.0%

899 children were admitted to care during the year. Most of these children, 78% were placed in Foster care.



Belfast Trust had the highest number of admissions at 270 followed by Northern Trust at 165. Western Trust had 164 admissions followed by Southern Trust at 151.

South Eastern Trust had 149 admissions to care during year

Children Admitted to Care by Age Group April 2021 - March 2022

Type of Placement	Age Group					Total
	<1	1-4	5-11	12-15	16+	
Residential	0	1	6	26	30	**63**
Fostering	140	168	213	128	54	**703**
Placed at Home with Parents	12	13	29	9	3	**66**
Placed for Adoption	0	0	0	0	0	**0**
Other	11	2	2	12	40	**67**
Total	**163**	**184**	**250**	**175**	**127**	**899**
%	**18.1%**	**20.5%**	**27.8%**	**19.5%**	**14.1%**	**100.0%**

Most admissions during the year were from the pre-school age group (0-4 years). This was followed by primary school aged 5-11 years.

Most children were admitted to fostering (78%) or placed at home with parents (7%).

Trend of Admissions to Care by Age

Age Group	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22
<1	121	173	151	153	156	162	171	165	178	169	163
1-4	187	197	196	198	184	170	160	191	165	207	184
5-11	243	279	251	203	194	224	229	238	238	233	250
12-15	238	230	223	183	187	195	186	185	186	170	175
16+	76	116	89	107	115	108	102	105	129	114	127
Total	**865**	**995**	**910**	**844**	**836**	**859**	**848**	**884**	**896**	**893**	**899**

There were 899 admissions to care during the year.

Trend of Admissions to Care by Trust

Trust	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
BHSCT	216	202	173	231	181	169	141	238	257	195	270
NHSCT	232	312	233	164	157	176	176	131	169	201	165
SEHSCT	151	152	176	176	171	174	156	186	156	138	149
SHSCT	165	195	182	164	178	184	209	171	185	177	151
WHSCT	101	134	146	109	149	156	166	158	129	182	164
Total	**865**	**995**	**910**	**844**	**836**	**859**	**848**	**884**	**896**	**893**	**899**

During the period April 2021 - March 2022, BHSCT had 270 admissions, NHSCT had 165, WHSCT had 164, SHSCT had 151 and SEHSCT had 149.

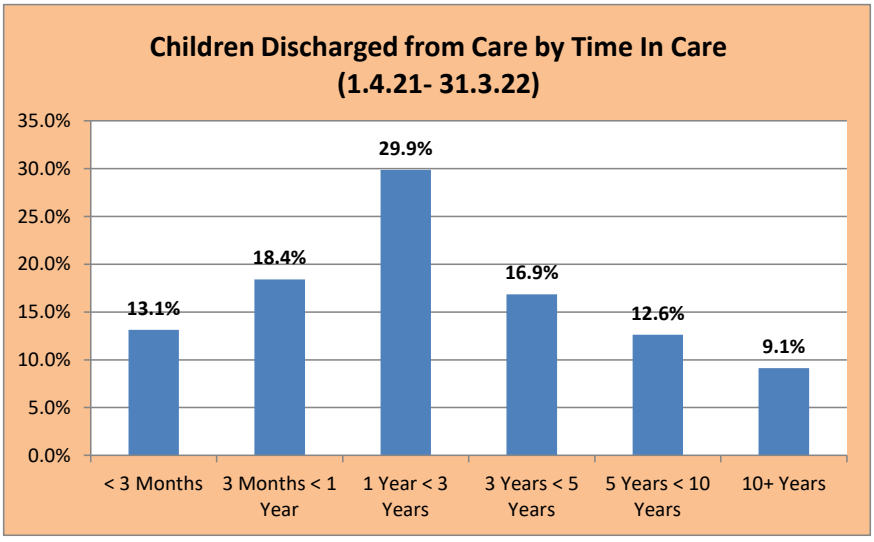
10.3.40 Number of children or young people who became a Looked After Child and Legal Status on Admission (April 2021 – March 2022).

NI	Care Order/ Interim Care Order	Accommodated	Other	Total
BHSCT	41	210	19	**270**
NHSCT	40	120	5	**165**
SEHSCT	34	95	20	**149**
SHSCT	18	97	36	**151**
WHSCT	30	118	16	**164**
Total	**163**	**640**	**96**	**899**
%	**18.1%**	**71.2%**	**10.7%**	**100.0%**

Of the 899 children admitted, 640 (71%) were accommodated. A further 163 (18%) had a Care Order/Interim Care Order.

10.3.41 Number of Children and Young People who Ceased to be Looked After by Length of Time Looked After at Discharge, during April 21 – March 2022.

Trust	< 3 Months	3 Months < 1 Year	1 Year < 3 Years	3 Years < 5 Years	5 Years < 10 Years	10+ Years	Total
BHSCT	33	30	59	33	25	19	**199**
NHSCT	15	31	41	26	22	14	**149**
SEHSCT	8	21	47	26	21	17	**140**
SHSCT	21	25	46	32	16	13	**153**
WHSCT	25	36	39	14	14	8	**136**
Total	**102**	**143**	**232**	**131**	**98**	**71**	**777**
%	13.1%	18.4%	29.9%	16.9%	12.6%	9.1%	100.0%



A total of 777 children were discharged from care during the year. 32% of these children had been in care for less than 1 year. 30% of children had been in care for 1-3 years.

10.3.42 Of all the children and young people reported at 10.3.41, their destination at discharge by age and gender during April 21 - March 2022.

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Trust	Returned to Parents/Family	Other Inc Adopted/ Independent Living)	Total
BHSCT	101	98	**199**
NHSCT	91	58	**149**
SEHSCT	83	57	**140**
SHSCT	97	56	**153**
WHSCT	86	50	**136**
Total	**458**	**319**	**777**
%	58.9%	41.1%	100.0%

Most children discharged from care returned to live with parents/family (59%). 41% moved to other accommodation including independent living.

Trend of Children Discharged from Care

Trust	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
BHSCT	186	193	129	215	185	111	158	155	208	186	199
NHSCT	187	256	212	170	188	179	143	145	141	143	149
SEHSCT	145	141	198	162	161	128	155	93	115	109	140
SHSCT	150	166	173	169	166	176	154	153	170	151	153
WHSCT	77	94	86	109	109	122	122	131	112	137	136
Total	**745**	**850**	**798**	**825**	**809**	**716**	**732**	**677**	**746**	**726**	**777**

The number of annual discharges from care has increased from 677 in 18/19 to 777 in March 2022.

10.3.44 Of all the children and young people reported at 10.3.41, number made subject to a Residence Order and number of Residence Orders in Place (April 21 – March 2022)

Trust	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total
Number made subject of a Residence Order	16	11	18	15	18	**78**
Number of Residence Orders in Place at period end.	187	172	164	101	104	**728**

During the year, 78 children were made subject to a Residence Order and there were 728 Residence Orders in place at 31st March 2022.

16+ (YOUNG PEOPLE ACCESSING CARE LEAVERS SERVICES)

Key Issues

Care Leavers

- At 31.3.22 there were 1,625 young people eligible to access care leaver services from Trusts.
- 533 (33%) of these young people were still in care and aged 16-17 years.

Living Arrangements

Of the 1,092 young people that had exited the care system:

- 26% were in a Tenancy Arrangement
- 25% continue to reside with their Former Foster Carers
- 17% were with Parents/Siblings
- 8% had returned to live with Relatives/Friends

Education, Training and Employment Status

- 72% of young people who had left care were in Education, Training or Employment (Former relevant, Relevant and Qualifying young people).

Additional Needs

- 290(18%) of care leavers had a disability
- 100(6%) of care leavers were young parents
- 273(17%) of care leavers were waiting for or receiving Mental Health Services.

Support to Young People

- The number of young people waiting allocation of a Personal Adviser **reduced** from **202** (31/3/21) to **181** (31/3/22).
- The number of young people without a Pathway Plan **reduced** from **106** (31/3/21) to **82** (31/3/22).
- The number of young people without a completed Needs Assessment **increased** by 1 from **38** at 31/3/21 to **39** at 31/3/22.
-

Cautioned, Remanded, Convicted

- 164 young people were cautioned this year (an **increase** from 133 last year).
- 75 young people were formally remanded (**down** from 79 last year).
- 87 young people were formally convicted (**down** from 94 last year).

Mental Health Concerns

- There were 229 new referrals of young people to mental health services this year (21/22) **up** from 214 in 20/21).

5% increase	↑	**in the number of young people eligible to access care leaver services from Trusts (from 1542 to 1625) from March 21 to March 22.**
21% increase	↑	**in the proportion of young people *eligible* young people that were' accommodated' from (120 to 145) from March 21 to March 22.**
5% decrease	↓	**in the proportion of care leavers that were young parents from 105 to 100**

10.4 Delegated Statutory Functions – Leaving Care

10.4.1 Number of Young People subject to Leaving Care Act by Category, Age and Gender

Category	16	17	18	19	20	21 +	Total
Eligible	**220**	**285**					**505**
Relevant	**13**	**10**					**23**
Former Relevant			**274**	**299**	**271**	**213**	**1057**
Qualifying	**1**	**4**	**14**	**6**	**14**	**1**	**40**
Total	**234**	**299**	**288**	**305**	**285**	**214**	**1625**

There were a total of 1,625 care leavers at 31st March 2022. **505** of these young people were still in care but could access leaving care services. A further **1,120** young people had left care.

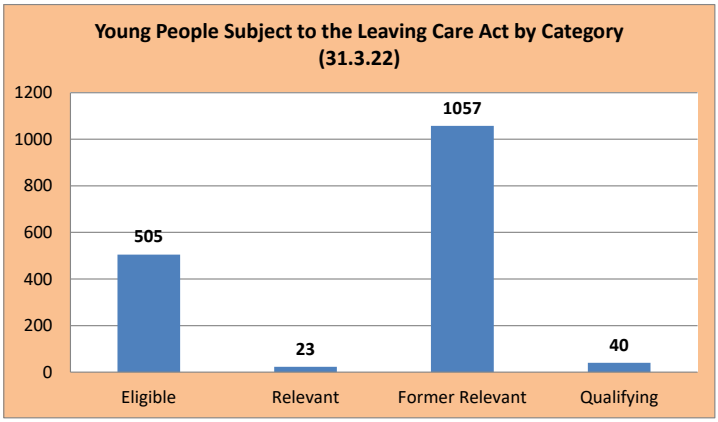
214 young people were aged 21+; many of these young people will be accessing further or higher education. There were 857 male and 768 female care leavers.

Care Leavers Trend 2011 – 2022

Period Ended	Mar-11	Mar-12	Mar-13	Mar-14	Mar-15	Mar-16	Mar-17	Mar-18	Mar-19	Mar-20	Mar-21	Mar-22
Care Leavers	1264	1268	1388	1361	1458	1475	1467	1479	1453	1512	1542	1625

The number of young people accessing leaving care services has been increasing from March 20.

The figure at the end of March 2022 represents an increase of 83 (5%) from March 21.



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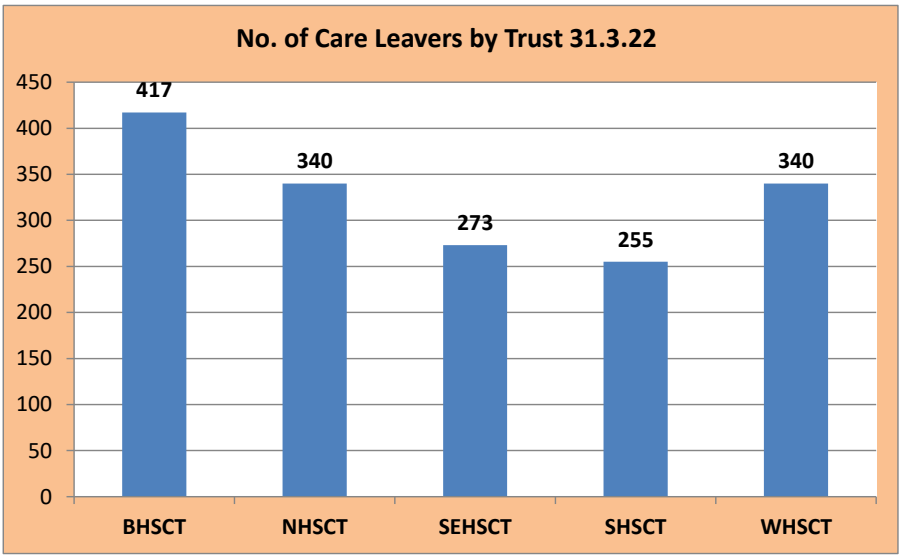
Care Leavers by Trust (31.3.22)

Trust	All Trusts						Total	%
	16	17	18	19	20	21+		
BHSCT	66	69	74	69	70	69	**417**	**25.7%**
NHSCT	34	66	68	65	66	41	**340**	**20.9%**
SEHSCT	59	52	47	42	38	35	**273**	**16.8%**
SHSCT	30	54	45	50	52	24	**255**	**15.7%**
WHSCT	45	58	54	79	59	45	**340**	**20.9%**
Total	**234**	**299**	**288**	**305**	**285**	**214**	**1625**	**100.0%**
%	**14.4%**	**18.4%**	**17.7%**	**18.8%**	**17.5%**	**13.2%**	**100.0%**	

Belfast Trust had the highest percentage at 26%. 21% of all care leavers were within Northern Trust area. Southern Trust has the lowest number at just below 16%.



Belfast Trust had the highest number of care leavers at 417 followed by Northern and Western Trusts with 340. Southern Trust had the lowest number at 255.

533 young people were aged <18 years while 214 young people were aged 21+ years.

10.4.2 Of those Eligible young people reported at 10.4.1 give the Children Order Legal Status at 31.3.22

Legal Status	16	17	Total	%
Accommodated (Article 21)	38	107	**145**	29%
Care Order (Art 50 or 59)	163	173	**336**	67%
Other	19	5	**24**	5%
Total	**220**	**285**	**505**	**100%**

Most 'Eligible' young people (67%) had a care order while a further 29% of young people were Accommodated. Eligible young people are those young people who are still in care and can access leaving care services.

10.4.5/10.4.6 Social Worker/Personal Adviser Arrangements

- 247 young people had a Named Social Worker Only
- 946 young people had a Social Worker and a Personal Adviser
- 421 young people had a Personal Adviser Only
- 181 young people were Awaiting Allocation of a Personal Adviser ***(down from 202 in 20/21***).
- 7 young people were Awaiting Allocation of a Social Worker***(up from 2 last year).***

10.4.6 Number of Young People without a Personal Adviser/Pathway Plan at 31.3.22

There were 82 young people without a Pathway Plan at 31.3.22. ***This figure had fallen from 106 waiting at 31/3/22.***

Category	Number without a Pathway Plan
Eligible	12
Relevant	3
Former Relevant	67
Qualifying	0
Total	**82**

Note: Qualifying young people do not have entitlement to a personal adviser but it is acknowledged that some Trusts may provide support to a qualifying young person through a social worker or possibly through a personal adviser.

10.4.7 Number of Young People without a Completed Needs Assessment and how long have they been waiting at 31.3.22

Category	Number without a Completed Needs Assessment	Time Waiting			
		<3 Months	3-6 Months	7-12 Months	>1 Year
Eligible	20	9	11	0	0
Relevant	0	0	0	0	0
Former Relevant	19	18	1	0	0
Qualifying	0	0	0	0	0
Total	**39**	**27**	**12**	**0**	**0**

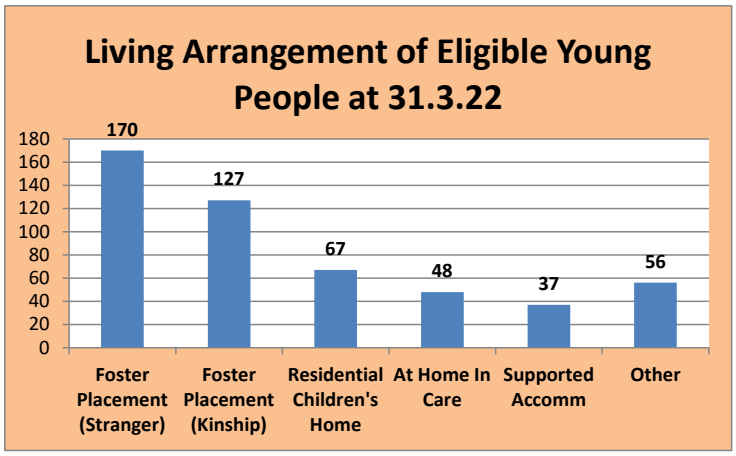
There were **39 young people without a needs assessment** at 31st March 2022. 19 were in the Former Relevant category and 20 were in the Eligible Category; 27 had waited less than 3 months and 12 had waited 3-6 months. **This figure has increased by 1 from 31/3/21.**

10.4.9 Living Arrangements of Care Leavers at 31st March 2022

(a) Eligible Young People

Eligible Placement Type	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	NI	%
Foster Placement (Stranger)	60	19	39	29	23	**170**	**33.7%**
Foster Placement (Kinship)	28	29	16	18	36	**127**	**25.1%**
At Home In Care	14	10	10	9	5	**48**	**9.5%**
Residential Children's Home	13	5	23	9	17	**67**	**13.3%**
Secure Care	<5	<5	<5	<5	0	**5**	**1.0%**
Specialist Residential Placement	<5	0	0	0	<5	<5	**0.4%**
Hospital	0	0	0	0	0	0	**0.0%**
Jointly Commissioned Supported Accommodation Projects	<5	9	12	<5	10	**37**	**7.3%**
Unregulated Placement	9	14	5	12	<5	**44**	**8.7%**
Other	0	<5	0	<5	<5	**5**	**1.0%**
Total	**130**	**89**	**107**	**81**	**98**	**505**	**100.0%**

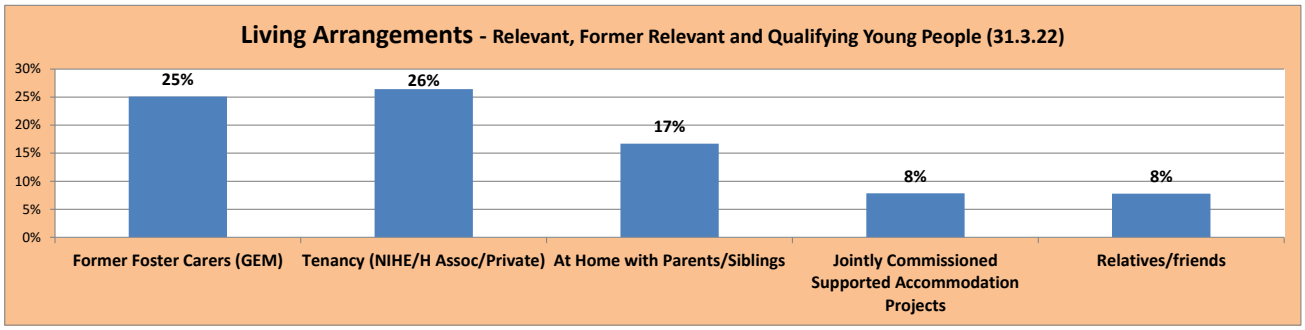
The number of young people in unregulated placements has **increased from 26 at 31/3/21 to 44 at 31/3/22.**



(b-d) Relevant, Former Relevant and Qualifying Young People

Relevant, Former Relevant, Qualifying Living Arrangements	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	NI	%
Former Foster Carers (GEM)	60	75	47	44	55	**281**	**25%**
Tenancy (NIHE/H Assoc/Private)	75	65	60	39	57	**296**	**26%**
At Home with Parents/Siblings	39	48	18	37	45	**187**	**17%**
Jointly Commissioned Supported Accommodation Projects	35	15	11	6	21	**88**	**8%**
Relatives/friends	25	23	18	13	8	**87**	**8%**
Hostel, B+B, Foyer	7	5	<5	6	8	**29**	**3%**
Supported Board and Lodgings	10	<5	0	11	<5	**26**	**2%**
Halls of Residence/Student Accommodation	8	9	6	11	29	**63**	**6%**
Prison	8	<5	<5	<5	10	**26**	**2%**
Other	20	6	<5	<5	7	**37**	**3%**
Total	**287**	**251**	**166**	**174**	**242**	**1120**	**100%**

Most young people were in a Tenancy arrangement (26%) followed by living with Former Foster Carers (25%). 17% of young people were at Home with Parents/Siblings.



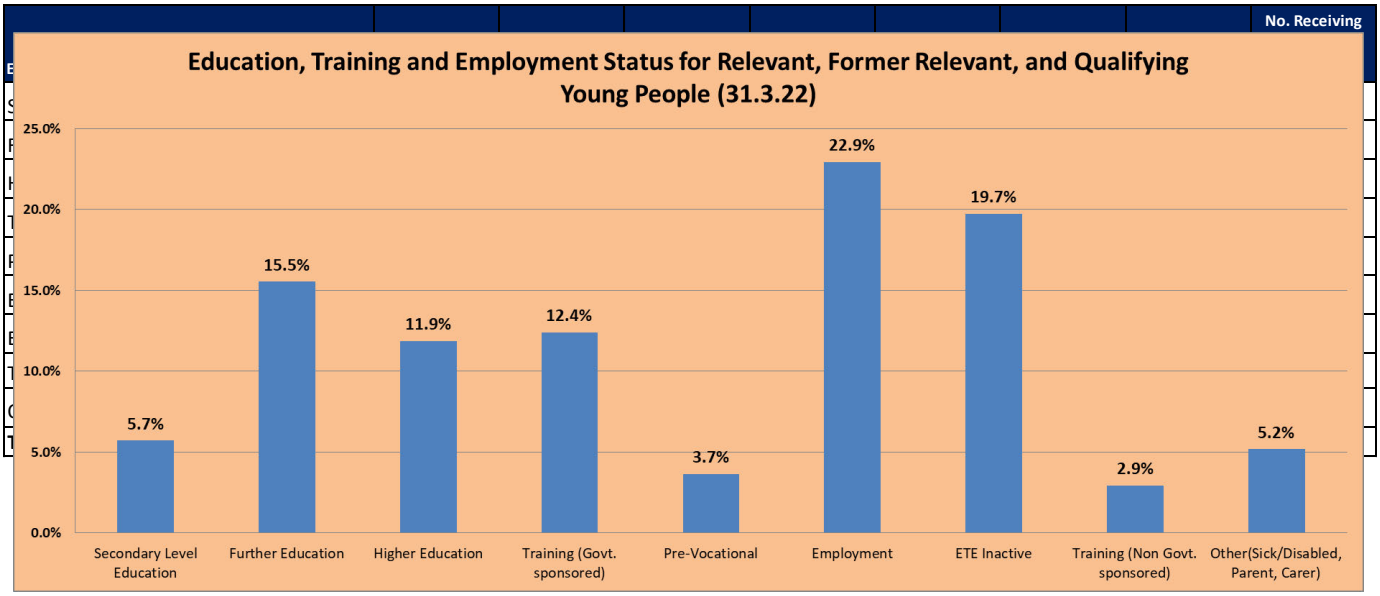
10.4.10 Education, Training and Employment status of care leavers, and how many are being supported financially at 31st March 2022

Eligible Young People

ETE By Trust	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	NI	%	No. Receiving Financial Support
Secondary Level Education	65	34	56	31	45	**231**	46%	111
Further Education	14	10	25	19	9	**77**	15%	47
Training (Govt. sponsored)	13	16	9	7	10	**55**	11%	28
Pre-Vocational	<5	11	8	0	9	**30**	6%	10
Employment	9	9	<5	5	6	**30**	6%	10
ETE Inactive	10	6	5	7	13	**41**	8%	9
Training (Non Govt. sponsored)	13	0	<5	9	5	**29**	6%	21
Other(Sick/Disabled, Parent, Carer)	<5	<5	<5	<5	<5	**12**	2%	<5
Total	**130**	**89**	**107**	**81**	**98**	**505**	**100%**	**239**

A total of 84% of eligible young people were in education, training or employment. 8% of young people were economically inactive while 2% were not in ETE due to sickness, caring arrangements. 47% of eligible young people were receiving financial support. *Note: Non-government sponsored training is now categorised as NETE. This has reduced the number of young people categorised at in ETE.*

ETE for Relevant, Former Relevant and Qualifying Young People (31.3.22)



A total of 72% of relevant, former relevant and qualifying young people were involved in education, training or employment. Note: Non-government sponsored training is now categorised as NETE. This has reduced the number of young people categorised at in ETE.

20% of young people were ETE inactive while a further 5% were not in ETE due to sickness, disability or caring arrangements.

Trend of Percentage of Care Leavers in Education, Training and Employment 2011 – 2022

Category	Mar-11	Mar-12	Mar-13	Mar-14	Mar-15	Mar-16	Mar-17	Mar-18	Mar-19	Mar-20	Mar-21	Mar-22
Eligible	91%	90%	87%	84%	79%	85%	81%	89%	86%	88%	88%	84%
Relevant	76%	72%	80%	73%	80%	59%	69%	76%	63%	91%	96%	91%
Former Relevant	65%	67%	72%	72%	68%	67%	66%	65%	65%	69%	70%	73%
Qualifying	71%	66%	83%	65%	67%	75%	58%	58%	60%	71%	70%	50%

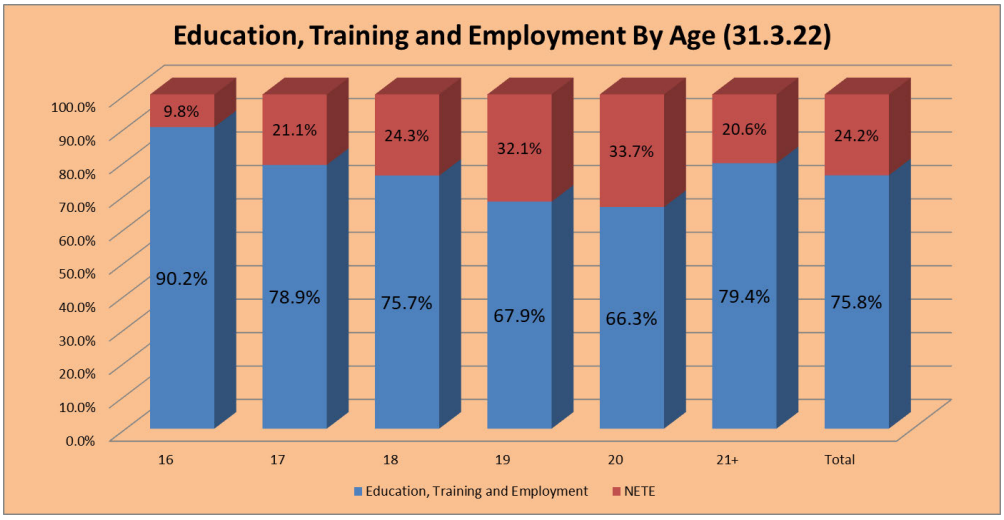
The percentage of eligible care leavers in Education, Training and Employment has remained high.

Education, Training and Employment Status of Care Leavers by Age

ETE Status	16	17	18	19	20	21+	Total
Education, Training and Employment	90.2%	78.9%	75.7%	67.9%	66.3%	79.4%	75.8%
NETE	9.8%	21.1%	24.3%	32.1%	33.7%	20.6%	24.2%

The percentage of young people in Education, Training and Employment at age 16 is 90% and 79% at age 17 years. The percentage gradually falls at age 20 when the figure is 66%. At Age 21+ the percentage in ETE rises again to 79%.

The percentage of care leavers ***not*** in education, training and employment is 34% at age 20 years.



10.4.11 Number of Young people formally cautioned, remanded, convicted (April 21 – March 22)

Category	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total
No of Care Leavers formally cautioned	24	38	26	13	63	**164**
No of Care Leavers formally remanded	21	12	5	11	26	**75**
No of Care Leavers formally convicted	15	17	21	18	16	**87**

164 young people were cautioned this year (up from 133 last year, 75 were formally remanded (up slightly from 79 last year) and 87 were formally convicted (down from 94 last year).

10.4.12 Number of Young People with a Disability at 31.3.22

Type of Disability	Total
Physical (Inc. Sensory)	22
Learning	79
Chronic Illness	7
Autism (ASD/ADHD/Aspergers)	159
Other (Undefined)	23
Total	290

A total of 290 young people had a disability out of a population of 1,625 (18%). The highest category of disability was ASD/ADHD/Aspergers with 159 young people.

10.4.13 Number of Young People who are Parents at 31.3.22

Category	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	NI
Parent	37	25	9	9	20	**100**
Lone Parent	12	13	6	7	<5	-

100 (6%) young people were parents out of a population of 1,625. Within the population of 100 parents, 39 young people were lone parents.

10.4.14 Young People with Mental Health Concerns at 31.3.22

Social workers noted that there were mental health concerns in relation to 273 (17%) young people **down** from 289 in 20/21). There were 229 new referrals of young people to mental health services during the year (21/22) **up** from 214 referrals in 20/21.

Receiving Treatment for Self-Harm

66 young people were receiving treatment for self –harming (**down** from 77 in 20/21). There were an additional 48 new referrals for self -harming during the 21/22 year (**down** from 75 in 20/21).

FOSTERING

Key Issues

Foster Carers

- There were 1,344 Kinship Foster Carers at 31st March 2022. This number has **increased** from 568 at March 2011.
- There were 1,040 Non-kinship Foster Carers at 31st March 2022, **down** from 1,060 at March 2011.
- The number of specialist Foster Carers has **increased** from 101 at March 2011 to 220 at 31st March 2022.

Foster Care Places

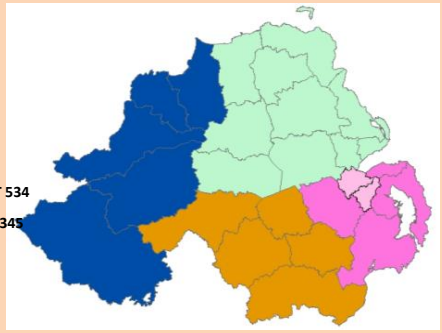
- Kinship Foster Carers provided 1,696 places at 31st March 2022 (up from 1,469 at 31/3/21).
- Non-kinship Foster Carers provided 1,255 places at 31st March 2022 (down from 1,541 at 31/3/21).
- Specialist Foster Carers provided 345 places at 31st March 2022 (up from 329 at 31.3.21).

Vacancies

- There were **210** vacant foster places at 31ST March 2022, 148 with Non-kinship Foster Carers, 45 with Kinship Carers and 17 with Specialist Carers. This represented an increase from **173** vacant places at 31/3/21.

FOSTERING YEAR ENDING 31 MARCH 2022		
19%		increase in the number of Kinship Foster Carers from (1128) at March 2021 to (1344) at March 2022
5%		increase in the number of specialist Foster Carer places from (329) at March 2021 to (345) at March 2022.
21%		increase in the number of vacant foster carer places from (173) at March 2021 to (210) at March 2022.

10.5 Delegated Statutory Functions - Fostering



Summary - Foster Carers and Places 31.3.22		
Trust	Carers	Places
BHSCT	534	724
NHSCT	616	713
SEHSCT	345	358
SHSCT	495	656
WHSCT	614	845
Total	2604	3296

10.5.1 Number of Foster Carers registered with the Trust at period end (31.3.22) and the turnover within the year (April 21 – March 22)

Type of Approval	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	NI	%
Foster Care (kinship) < 12 weeks not yet approved by panel	41	22	10	12	13	98	4%
Foster Care (kinship) >12 wks but not panel approved by 16 wks	29	61	27	11	11	139	5%
Kinship Foster Carers not approved within 12 weeks, but within 16 weeks during the period	13	2	0	6	0	21	1%
Panel Approved kinship carer	246	222	101	162	355	1086	42%
Panel Approved Foster Carer (Non-kinship)	161	195	185	280	219	1040	40%
Specialist Foster Carers (Fee Paid carers)	44	114	22	24	16	220	8%
Total	**534**	**616**	**345**	**495**	**614**	**2604**	100%

No of Carers above that also provide a GEM placement	27	34	17	19	72	**169**
No. of Carers above that are also Prospective adopters dually approved as Foster Carers	14	61	23	56	20	**174**
Of the Prospective Adopters/Dually Approved Carers above, how many are Concurrent Foster/Adoptive Carers	3	44	7	36	17	**107**

A total of **2,604** foster carers were registered with Trusts at 31st March 2022. 1,040 of these carers were Panel Approved Non-Kinship Foster Carers. A further 1,344 were kinship foster carers. There were 220 specialist carers.

Trend of Foster Carers

Number of Carers	Mar-15	Mar-16	Mar-17	Mar-18	Mar-19	Mar-20	Mar-21	Mar-22
Kinship Foster Carers (Field Work Approved)- Stage 1	157	172	175	195	274	341	1128	1344
Kinship Foster Carers (Panel Approved)- Stage 2	549	552	597	634	696	679		
Panel Approved Non Kinship	1023	1004	1009	1044	1083	996	1094	1040
Specialist Foster Carers	203	222	218	216	239	203	206	220
Total	**1932**	**1950**	**1999**	**2089**	**2292**	**2219**	**2428**	**2604**

Northern Trust had the highest number of foster carers at 616 followed by Western Trust at 614. South Eastern Trust had the lowest number of foster carers at 345.

Other Foster Carers

Other Foster Carers	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	NI	%
Independent Provider Foster Carers	100	33	63	4	18	218	82.6%
Carers providing care only to children with a disability and who are not available to provide care for Looked After Children	0	7	0	17	22	46	17.4%
Total	**100**	**40**	**63**	**21**	**40**	**264**	**100.0%**

218 carers were from the Independent sector. The highest numbers of these carers (100) were based in Belfast Trust. 46 foster carers were providing care to children with a disability and not available to provide care for Looked After Children; most of these carers were based in Western Trust (22).

10.5.2 Number of registered places and number of vacant places at 31.3.22

Type of Approval	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	NI	%	Vacant at period end
Foster Care (kinship) < 12 weeks not yet approved by panel	47	35	9	16	0	107	3%	5
Foster Care (kinship) >12 wks but not panel approved by 16 wks	36	73	43	15	0	167	5%	0
Kinship Foster Carers not approved within 12 weeks, but within 16 weeks during the period	18	2	0	6	0	26	1%	0
Panel Approved kinship carer	329	220	130	229	488	1396	42%	40
Panel Approved Foster Carer (Non-kinship)	236	184	154	360	321	1255	38%	148
Specialist Foster Carers (Fee Paid carers)	58	199	22	30	36	345	10%	17
Total	**724**	**713**	**358**	**656**	**845**	**3296**	100%	**210**

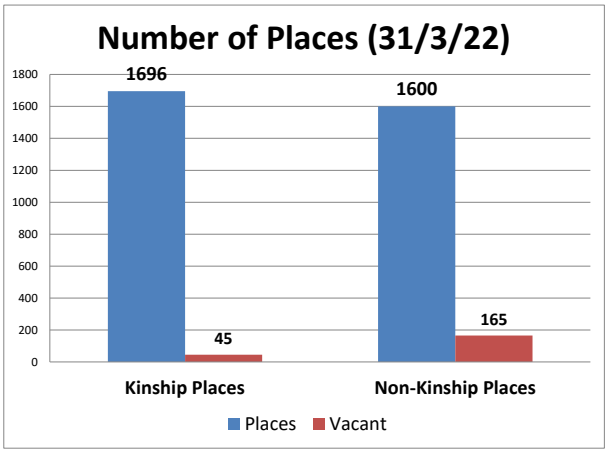
Prospective Adopters dually approved as foster carers	15	65	23	86	34	**223**

At the end of March 2022, there were a total of 3,296 fostering places available. Most were provided by Kinship Foster Carers (1,696). A further 1600 places were provided by non-kinship carers and specialist foster carers. There were an additional 223 places with prospective adopters dually approved as foster carers. 210 (6%) of the total fostering places were vacant at year end.

Vacancies

At 31.3.22 there were 210 foster place vacancies:

- 148 vacancies with Panel Approved Non-kinship
- 45 with kinship carers
- 17 with specialist foster carers



Recruitment Activity

Recruitment Process Activity during the Period (April 21 - March 22)		BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	NI
Numbers receiving information packs	Kinship	0	79	86	55	0	**220**
	Non-Kinship	0	0	100	196	63	**359**
Number of Home Visits	Kinship	0	167	69	55	59	**350**
	Non-Kinship	46	94	49	92	92	**373**
Numbers attending Skills for Foster course	Kinship	0	44	12	1	0	**57**
	Non-Kinship	34	66	32	66	57	**255**
Number of Completed Assessments during the period	Kinship	83	59	16	25	55	**238**
	Non-Kinship	27	53	22	48	23	**173**
Number of these assessments that were already approved as adopters	Kinship	0	2	0	0	0	**2**
	Non-Kinship	0	11	8	17	2	**38**

There were 579 Information Packs Shared, 723 Initial Home Visits, 312 Attended Skills for Foster Courses. 411 Completed Assessments during the year.

40 Assessments involved Foster Carers already approved as adopters at period end 31.3.22.

ADOPTION

Key Issues

Adoptions (Art 12)

- 91 of the children adopted were previously Looked After Children

Application for Adoption Assessment

- 172 domestic applications were received for an adoption assessment during the year.
- 4 inter-country applications for assessment were received during the year.

Waiting for an Adoption Assessment

- 62 domestic applicants were waiting for assessment at 31st March 2022.
  - 60% waiting < 6 months
  - 35% waiting 6-12 months
  - 5% waiting more than 1 year
- 3 inter-country applicants were waiting for assessment at 31st March 2022

Enquiries

- 424 enquiries were made about becoming an adoptive carers during the year.

ADOPTION
YEAR ENDING 31 MARCH 2022

25%

decrease in the number of adoption enquires received during the year from 562 in 20/21 to 424 in 21/22.

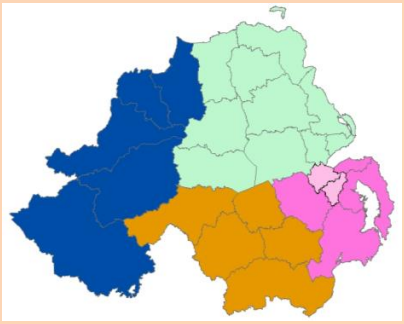
31%		increase in the number of domestic applications received for an adoption assessment during the year from 131 in 20/21 to 172 in 21/22.
39		increase in the number of Looked After adopted from 52 in 20/21 to 91 in 21/22.

MAHI - STM - 097 - 5650

Delegated Statutory Functions - Adoption

Adoption (Intercountry Aspects) Act (NI) 2001

Article 3 (as amended by HPSS Order 1994), Article 11



BHSCT 25

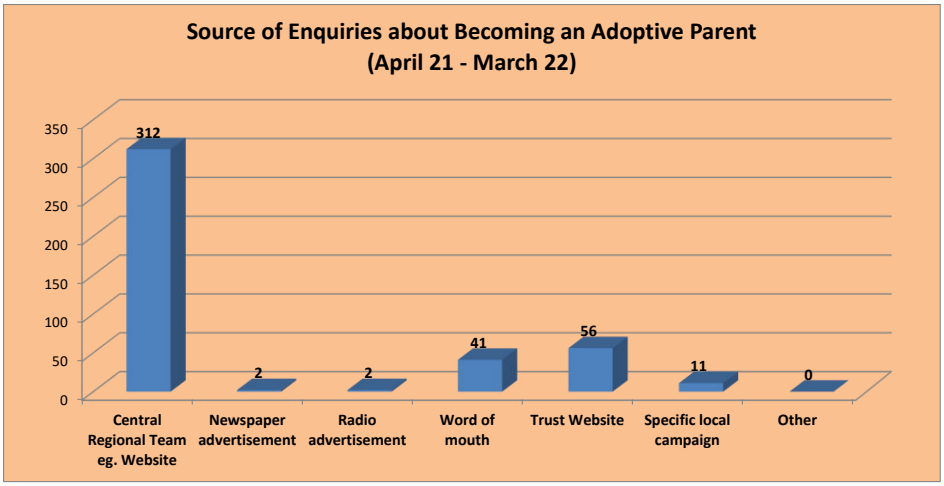
SEHSCT 31

Summary of Adoption Activity April 21 - March 22

Trust	Domestic Applications	Inter-Country Applications	Freeing Orders	Adoption Orders
Belfast Trust	87		21	25
Northern Trust	48		25	14
South Eastern Trust	11		31	31
Southern Trust	19		18	23
Western Trust	7		14	12
Total	172	4	109	105

10.6.1 Number and source of enquiries about becoming Adoptive Carers received by the Trust (1.4.21 – 31.3.22)

Source	Total	%
Central Regional Team eg. Website	312	74%
Newspaper advertisement	2	0%
Radio advertisement	2	0.5%
Word of mouth	41	10%
Trust Website	56	13%
Specific local campaign	11	3%
Other	0	0%
Total	**424**	**100%**



A total of 424 enquiries were made about becoming adoptive carers (domestic and inter-country). Northern Trust received the highest number at 125.

Most enquiries came by the Central Regional Team at 312 or 74%. A further 10% of enquiries came via word of mouth.

There were 562 enquiries during the previous year (21/22)

MAHI - STM - 097 - 5651

10.6.2 Number of Domestic Applications for assessment received by the Trust by civil status (1.4.21 – 31.3.22)

Household type	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total	%
Married Couple	52	33	<5	15	<5	108	**62.8%**
Other (Co-Habiting Couple, Single carer)	35	15	7	<5	<5	64	**37.2%**
Total	**87**	**48**	**-**	**-**	**7**	**172**	**100.0%**

There were a total of 172 domestic applications for assessment; 63% of these from married couples. A further 37% were received from single carers and co-habiting couples. The highest number of applications for assessment were received in the Belfast Trust Area.

10.6.3 Number of Prospective Domestic Adopters awaiting assessment at 31st March 2022

Time waiting	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total	%
Less than 1 month	0	10	<5	<5	0	**14**	**23%**
More than 1 month less than 3 months	0	<5	6	<5	0	**11**	**18%**
More than 3 months less than 6 months	0	8	<5	<5	0	**12**	**19%**
More than 6 months less than 12 months	0	13	0	9	0	**22**	**35%**
1 year or more	0	<5	0	<5	0	**3**	**5%**
Total	**0**	**36**	**11**	**15**	**0**	**62**	**100%**

At 31st March 2022, there were a total of 62 prospective domestic adopters awaiting assessment. NHSCT had the highest number of waiters. 60% percent of all adopters waiting were waiting less than 6 months.

Reason waiting	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total	%
No Social worker available to commence assessment	0	36	11	15	0	**62**	**100%**
Unlikely that any child waiting at this time fits their criteria	0	0	0	0	0	**0**	**0%**
Applicant Not Ready to Proceed	0	0	0	0	0	**0**	**0%**
Other	0	0	0	0	0	**0**	**0%**
Total	**0**	**36**	**11**	**15**	**0**	**62**	**100%**

All waits were due to no social worker available to commence the assessment.

10.6.4 Number of inter-country applications for assessment received by the Trust by civil status

There were 4 inter-country applications for assessment received by the Trusts during the year – up from 1 the previous year.

10.6.5 Number of prospective Inter country adopters awaiting assessment at 31st March 2022

There were 3 prospective inter-country adopters awaiting assessment at 31st March 2022 up from 2 the previous year.

MAHI - STM - 097 - 5652

10.6.6 Outcomes of all assessments completed during April 2021 – 31st March 2022

74 domestic and 1 inter-country assessments were completed during the year.

10.6.7 Number of Looked After Children freed for adoption and not yet placed with their prospective adopters at 31st March 2022 and duration of wait since freeing order was granted

5 children were freed for adoption and awaiting an adoptive family placement at 31st March 2022. This figure has risen from one at March 2021.

10.6.8 Number of children who were made subject of Orders under the Adoption (NI) Order 1987 during the period (1.4.21 – 31.3.22)

Type of Order	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total
Adoption Orders (Art 12)	**25**	**14**	**31**	**23**	**12**	**105**
Previously Looked After Child	25	11	23	22	10	**91**
Adopted by Step Parent						**8**
Inter-country Adoption			<5			<5
Other			5			**5**

Other orders

Freeing Orders (Art 17) with Agreement	0	0	<5	0	0	<5
Freeing Orders (Art 18) without Agreement	21	25	30	18	14	**108**
Court Applications for Freeing Orders Not Granted	10	<5	0	0	0	-

There were 105 children adopted during the year. Ninety-one related to Looked After children.

10.6.10 Number of Households in receipt of an Adoption Allowance at 31st March 2022

No. of Adoption Allowances paid in respect of children at 31.3.22	No. of Allowances	No. of Households
BHSCT	108	89
NHSCT	129	85
SEHSCT	103	84
SHSCT	90	66
WHSCT	91	66
Total	**521**	**390**

There were a total of 521 Adoption Allowances paid in respect of children at 31st March 2022. This equated to 390 households.

Last year at the end of March 2021 there were 534 children in receipt of adoption allowances

10.6.11 Of the number at 10.6.10, number commenced from April 2021 – 31st March 2022.

A total of 48 Adoption allowances commenced during the year an increase from 27 last year.

Key Issues

Early Years Providers and Places

- There were 3,606 early years providers At March 2022 (down from 3,809 at March 21).
- There were 59,213 early years places at March 2022 (down from 59,618 at March 21)

By Sector

- The Day Nursery sector provided a total of 22,440 places. 6,213 of these places were provided to School Aged children.
- 403 Playgroups provided 13,069 places.
- Childminders provided 13,513 places
- 221 Stand-alone out of schools provided 7,044 places.

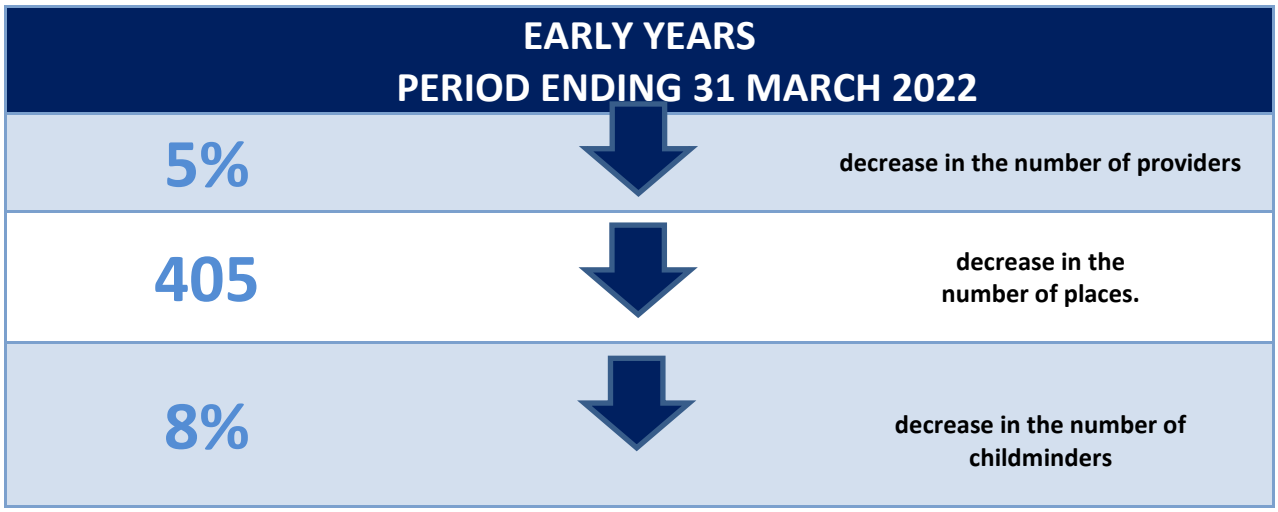
Note: some out of school provision is made available through Day Nurseries.

De-registrations

- 381 were de-registered during the year (21/22). This was an increase on the figure of 326 de-registrations in 20/21.

Inspections

- A total of 2,873 Inspections were carried out during the year.
- There were 422 inspections overdue at 31st March 2022.
- There were 26 applications received but not yet allocated at 31/3/22 with the longest waits between 4-6 months.



MAHI - STM - 097 - 5654

10.7 Delegated Statutory Functions – Early Years

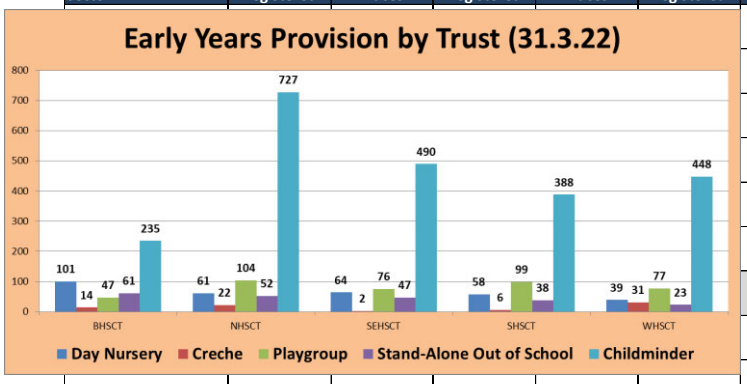
Summary of Early Years Provision at 31.3.22						
Trust	No. of Groups	No. of Places	No. of Childminders	No. of Places	No of Other Providers	No of Othe Places
BHSCT	223	9,353	235	1410	88	516
NHSCT	239	10562	727	4372	64	384
SEHSCT	189	8648	490	2939	72	233
SHSCT	201	8917	388	2303	37	408
WHSCT	170	6299	448	2489	35	380
Total	1022	43779	2288	13513	296	1921

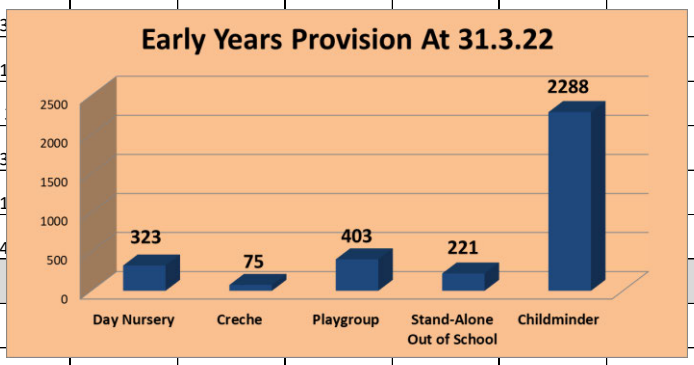
T
roups
Ms
BHSCT
223 Groups
235 CMs

10.7.1 Current Early Years Provision/Places/Registrations and De-registrations

	NI		BHSCT		NHSCT		SEHSCT		SHSCT		WHSCT	
Sector	Services Registered	Places	Services Registered	Places	Services Registered	Places	Services Registered	Places	Services Registered	Places	Services Registered	Places
Two year old Prog.	113	1580	23	300	28	360	11	132	22	408	29	380
Total	**3606**	**59213**	**546**	**11279**	**1030**	**15318**	**751**	**11820**	**626**	**11628**	**653**	**9168**

Out of School services within the Registered Day Nurseries
BHSCT had 56 out of school services within the registered Day Nurseries
SEHSCT had 49 out of school services within the registered Day Nurseries
Groups:- Daynursery, creche, playgroup, out of school
Other:- AHCs, Summer Schemes, 2YOP
NHSCT had 48 out of school services within the registered Day Nurseries
SHSCT had 46 out of school services within the registered Day Nurseries
WHSCT had 23 out of school services within the registered Day Nurseries





At 31st March 2022, there were a total of 3,606 registered early years' providers providing 59,213 places which included 2,288 childminders providing 13,513 places across the five Trusts.

Trend of Early Years Provision

Sector	Mar 11	Mar 12	Mar 13	Mar-14	Mar-15	Mar-16	Mar-17	Mar-18	Mar-19	Mar-20	Mar-21	Mar-22
Day Nursery	314	312	326	334	336	333	337	349	334	333	323	323
Creche	97	86	81	71	76	74	73	78	81	78	75	75
Playgroup	498	504	503	484	463	451	440	437	433	424	412	403
Out of School	248	267	275	241	191	205	199	200	215	220	212	221
Childminder	3826	4076	4068	3837	3427	3188	3098	2871	2714	2613	2488	2288
Approved Home Childcarers						314	230	222	179	161	176	173
Total	**4983**	**5245**	**5253**	**4967**	**4493**	**4565**	**4377**	**4157**	**3956**	**3829**	**3686**	**3483**

Number of Registrations/De-registrations for each sector during the period April 2021 – March 2022

Sector	Registrations and De-registrations over the Period (1.4.21 - 31.3.22)											
	NI		BHSCT		NHSCT		SEHSCT		SHSCT		WHSCT	
	Registrations	De-Registrations	Registrations	De-Registrations	Registrations	De-Registrations	Registrations	De-Registrations	Registrations	De-Registrations	Registrations	De-Registrations
Day Nursery	8	12	0	1	4	3	2	1	2	1	0	6
Out Of School within Day Nursery	0	0	0	0	0	0	0	0	0	0	0	0
Stand-Alone Creche	3	2	0	1	1	0	0	1	0	0	2	0
Stand-Alone Playgroup	9	13	1	1	2	7	4	2	1	2	1	1
Stand-Alone Out of School	16	18	3	3	8	8	2	0	2	1	1	6
Childminder	98	306	3	28	33	112	18	50	15	54	29	62
Approved Home Childcarers	23	26	0	7	7	6	9	3	7	5	0	5
Summer Scheme	2	2	1	2	0	0	1	0	0	0	0	0
Two year old Prog.	2	2	0	0	1	2	0	0	1	0	0	0
Total	**161**	**381**	**8**	**43**	**56**	**138**	**36**	**57**	**28**	**63**	**33**	**80**

There were a total of 98 childminders, 16 stand-Alone Out of schools, 23 approved home child carers, 8 day nurseries, 9 play groups, 3 stand-alone crèches, 2 summer schemes and 2 two year old programmes registered during the year. 306 childminders, 13 play groups, 26 approved home child carers, 18 stand-alone out of schools, 12 Day Nurseries, 2 stand-alone crèches, 2 two year old programmes and 2 summer schemes were de-registered during the year.

10.7.3 Number requiring Inspection during the Year April 2021 – March 2022

Trust	Inspections Carried Out April 21 - March 22	Overdue Inspections 31.3.22
BHSCT	457	42
NHSCT	864	74
SEHSCT	547	98
SHSCT	566	25
WHSCT	439	183
Total	**2873**	**422**

There were 2,873 groups/childminders inspected during the year.

There were 422 overdue inspections at the end of the year.

Overdue Inspections (By Length of Time Overdue)

MAHI - STM - 097 - 5656

Sector	Overdue Inspections	Length of Time Overdue				
		0-3	4-6	7-9	10-12	12+mths
Day Nursery	50	28	17	1	3	1
Creche	6	1	2	2	0	1
Playgroup	36	7	13	0	4	12
Out of School	15	13	0	1	0	1
Childminder	313	199	19	16	23	56
Summer Scheme	0	0	0	0	0	0
Two year old Prog.	2	0	1	1	0	0
Total	**422**	**248**	**52**	**21**	**30**	**71**

There were 422 overdue inspections at 31st March 2022. Most overdue inspections were within the childminder sector with 313 overdue; 56 of these were 12+ months overdue.

1 10.7.4 Number of applications received but not allocated by category at 31st March 2022

Sector	NI	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
Day Nursery	1	1	0	0	0	0
Crèche	0	0	0	0	0	0
Playgroup	0	0	0	0	0	0
Out of School	2	0	1	1	0	0
Childminder	23	0	9	9	0	5
Summer Scheme	0	0	0	0	0	0
Two year old Prog.	0	0	0	0	0	0
Total	**26**	**1**	**10**	**10**	**0**	**5**

There were a total of 26 applications received by Early Years teams but not yet allocated at 31st March 2022.

Most of these applications related to childminders (23). Most unallocated applications were within NHSCT and SEHSCT.

Time Outstanding for Applications not yet Allocated.

Sector	No. of Applications Not Allocated	Length of Time Overdue (if any)				
		Overdue 0-3mths	Overdue 4-6mths	Overdue 7-9mths	Overdue 10-12mths	Overdue 12+ mths
Day Nursery	1	0	1	0	0	0
Creche	0	0	0	0	0	0
Playgroup	0	0	0	0	0	0
Out of School	2	2	0	0	0	0
Childminder	23	11	12	0	0	0
Summer Scheme	0	0	0	0	0	0
Two year old Prog.	0	0	0	0	0	0
Total	**26**	**13**	**13**	**0**	**0**	**0**

13 (50%) of applications had been outstanding for 0-3 months. A further 13 (50%) applications had been outstanding for 4-6 months.

MAHI - STM - 097 - 5657

10.7.5 No. of Current Applications being Assessed (Registrations in Progress) and duration of assessment.

Sector	Number in Progress	Duration of Assessment				
		0-3mths	4-6mths	7-9mths	10-12mths	12+ mths
Day Nursery	0	0	0	0	0	0
Creche	1	0	0	0	0	1
Playgroup	0	0	0	0	0	0
Out of School	2	1	0	0	0	1
Childminder	40	25	3	5	2	5
Summer Scheme	0	0	0	0	0	0
Two year old Prog.	0	0	0	0	0	0
Total	**43**	**26**	**3**	**5**	**2**	**7**

At 31st March 2022 there were a total of 43 applications in progress across the 5 Trusts (40 in respect of childminders and 3 in respect of other providers)

10.9 Separated Children

Separated Children are defined as "children who are outside their country of origin and separated from both parents, or previous/legal customary primary care giver".

Note: Children refers to children/young people aged < 18 years.

- For the year 1st April 2021 – 31st March 2022 there were **66** referrals in respect of separated children.

Adults Section

MAHI - STM - 097 - 5659

Fact File

Population: N Ireland: **1,895,510**

Adults – 1,134,453 (60%), **Older People** – 319,949 (17%) = 77%

1. GENERAL PROVISIONS

- 67,767 adults (excl. Acute) referred for assessment of Social Work/Social Care need
- 63,515 adults in receipt of Social Work/Social Care Services 31st March 2022

1.3 GENERAL PROVISIONS – ACUTE HOSPITAL

- 33,713 adults and children were referred to Acute Hospital Social Workers for assessment during the year
- 33,616 assessments of need were undertaken during the year

2. CHRONICALLY SICK AND DISABLED PERSONS (NI) ACT 1978

- 3,736 adults who are blind
- 3,777 adults who are partially sighted
- 701 adults - deaf with speech, 718 adults - deaf without speech, 13,712 adults - hard of hearing

3. DISABLED PERSONS (NI) ACT 1989

- 10,724 referrals (excl. Acute) to Physical/Learning/Sensory Disability
- 28,244 disabled people known at 31st March 2021

4. HEALTH AND PERSONAL SOCIAL SERVICES (NI) ORDER 1972

- 2,759 TRUST FUNDED adults in residential care
- 6,830 TRUST FUNDED adults in nursing care

5. CARERS AND DIRECT PAYMENTS ACT 2002

- 17,639 adult carers offered individual carers assessments
- 9,949 assessments were completed and 7,557 were declined
- 4,860 adults received direct payments, 680 children received direct payments
- 1,043 carers received direct payment
- 7,629 one off carers grants were made in-year

6. SAFEGUARDING VULNERABLE ADULTS

- 6,897 vulnerable adult referrals year ending 31st March 2022
- Investigations involving regulated facilities/services no longer collected
- 1,860 investigations commenced in the year

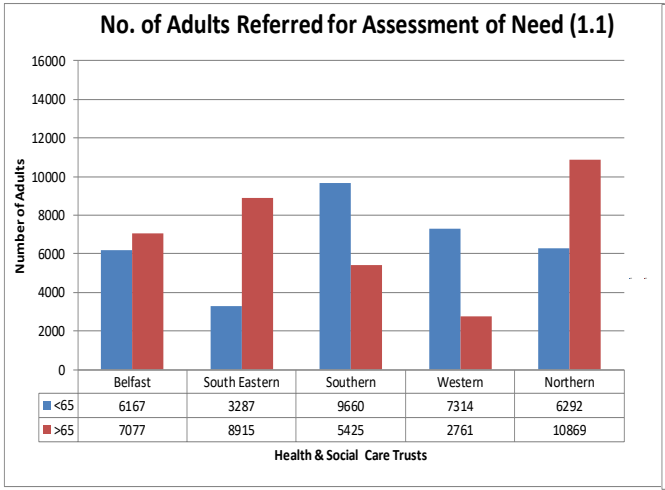
MAHI - STM - 097 - 5660

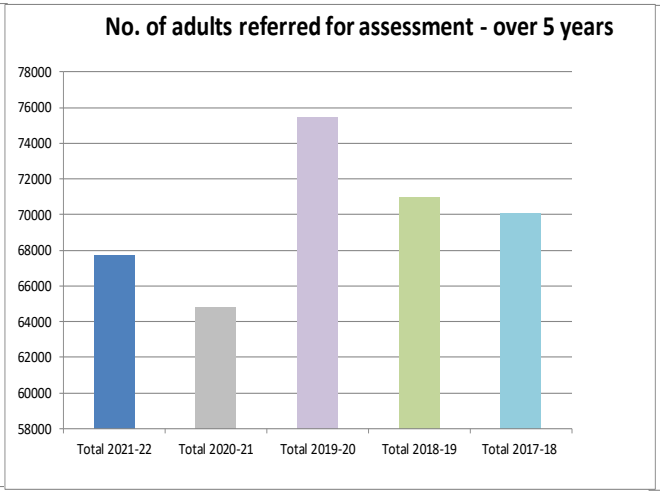
HSCB Delegated Statutory Functions/Corporate Parenting Returns
1. General Provisions

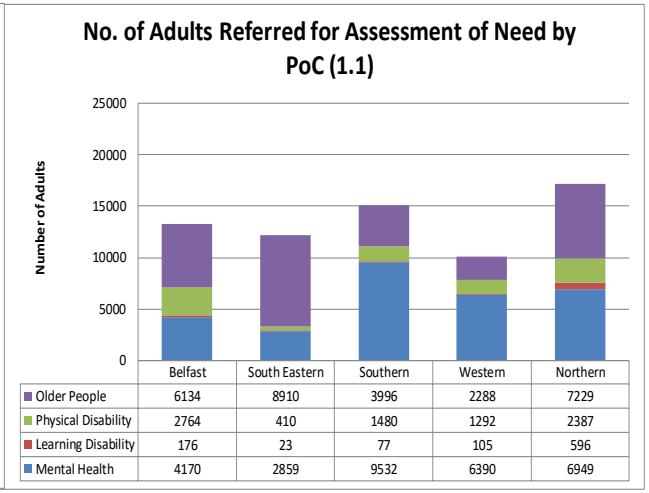
Report Title: General Provisions
Table Number 1

Period: 01/04/21 - 31/03/22

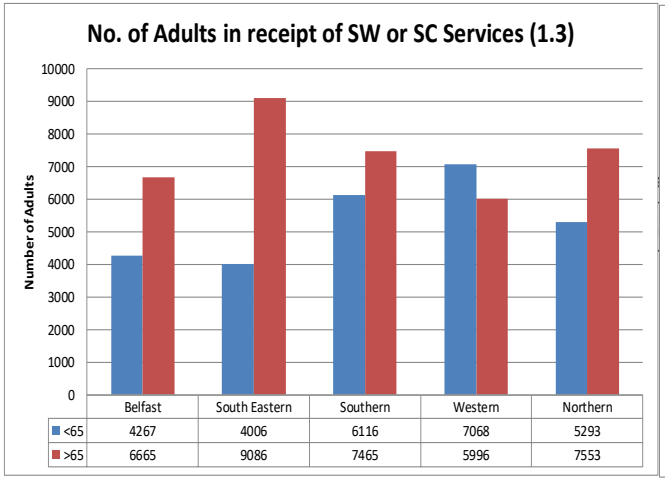
There were 67,767 adults (excluding Acute Services) referred for an assessment of need across the region in the period from 1st April 2021 - 31st March 2022.

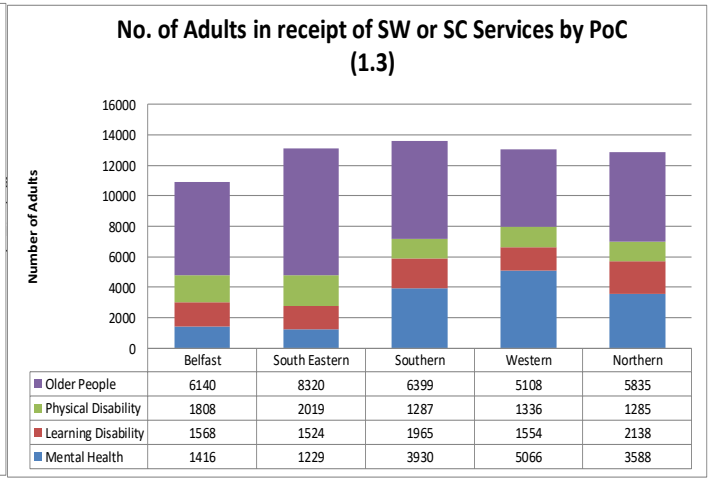






There were 63,515 adults in receipt of social work or social care services at the 31st March 2022.





MAHI - STM - 097 - 5662

NI LEVEL

Unknown/unavailable value

	General Provisions	Mental Health Adults		Mental Health Older People		Learning Disability		Physical Disability		Older People		Total 2021-22 excl Acute		Total 2020-21 excl Acute		Total 2019-20 excl Acute		Total 2018-19 excl Acute		Total 2017-18 excl Acute		Total 2016-17 excl Acute	
		<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+
1.1	How many adults were referred for assessment of social work / social care need during the year?	26296	968	57	2579	861	116	5384	2949	122	28435	**32720**	**35047**	31619	33194	39530	35963	35813	35168	33437	36649	36996	33083
1.2	Of those reported at 1.1 how many adults commenced receipt of social work or social care services during the year?	11563	261	52	2517	443	55	3807	1966	42	18522	**15907**	**23321**	16379	23385	19082	23681	16601	21086	21536	21311	17930	21551
1.3	How many adults are in receipt of social work or social care services at 31st March?	12574	1319	11	1325	7717	1032	6388	1347	60	31742	**26750**	**36765**	23367	40844	24427	41654	23844	39097	24405	41426	25820	39458
1.3a	How many adults are in receipt of social care/social work support only at 31st March (not reported at 1.4)	7721	503	9	1219	2747	38	774	306	23	2785	**11274**	**4851**	12952	5736	14151	7112	14338	7029	15183	7202	15540	7957
1.4	How many care packages are in place on 31st March in the following categories:																						
	a. Residential Home Care	139	96	5	142	422	148	55	7	4	2093	**625**	**2486**	644	2801	608	3105	615	2906	577	2912	580	2858
	b. Nursing Home Care	291	176	13	739	454	214	327	21	5	5664	**1090**	**6814**	1135	6910	1026	7562	1104	7392	956	7809	885	7671
	c. Domiciliary Care Managed	316	161	97	724	926	189	2698	138	17	13241	**4054**	**14453**	4086	15513	3016	12749	3312	12205	3107	11495	3440	11282
	d. Domiciliary Non Care Managed	70	87	24	181	438	102	858	116	13	5945	**1403**	**6431**	1687	7591	2100	7906	2103	9636	2449	10163	2686	9546
	e. Supported Living	498	60	3	0	815	242	98	0	3	144	**1417**	**446**	1490	441	1506	460	1704	493	1731	452	1739	426
	f. Permanent Adult Family Placement	0	0	0	0	89	1	0	0	0	0	**89**	**1**	111	1	88	1	73	1	70	1	76	1
1.5	Number of adults provided with respite during the year											**7499**		8853		10926		PMSI Return	PMSI Return	PMSI Return	PMSI Return	PMSI Return	PMSI Return
1.6	Number of adults known to the Programme of Care in receipt of Centre based Day Care																						
	Statutory sector	559	44	4	161	2527	222	490	1	41	1410	**3621**	**1838**	3830	2271	4136	2780	4108	3182	4292	3326	4471	3357
	Independent sector	1355	0	0	0	283	67	120	0	1	698	**1759**	**765**	1708	682	1959	942	1906	1537	1248	1506	2434	1168
1.6a	Number of adults known to the Programme of Care in receipt of Day Opportunities	1492	34	0	0	2517	110	919	11	0	552	**4928**	**707**	5377	494	5887	717	5383	502	4451	161	4338	791
1.7	Of those at 1.6 how many are EMI / dementia																						
	Statutory sector	0	0	4	127	13	13	2	0	0	365	**19**	**505**	42	531	68	500	24	574	23	602	31	682
	Independent sector	0	0	0	0	4	0	0	0	1	140	**5**	**140**	27	106	6	185	16	710	17	708	24	172
1.8	This is intentionally blank																						
1.9	How many of this Programme of Care clients are in HSC Trust funded social care placements outside Northern Ireland?	10	2	0	7	13	0	6	0	1	15	**30**	**24**	38	20	33	23	31	19	23	12	20	11
1.10	Complaints	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return

MAHI - STM - 097 - 5663

Belfast Trust

General Provisions		Mental Health		Learning Disability		Physical Disability		Older People		Total 2021-22		Total 2020-21		Total 2019-20		Total 2018-19		Total 2017-18		Total 2016-17	
		<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+
1.1	How many adults were referred for assessment of social work / social care need during the year?	4170	0	155	21	1842	922	0	6134	**6167**	**7077**	6638	5581	7036	5126	5156	4615	7088	5728	6683	6533
1.2	Of those reported at 1.1 how many adults commenced receipt of social work or social care services during the year?	2701	0	102	12	1154	808	0	2958	**3957**	**3778**	4177	3413	5911	4205	4852	3171	5456	4479	5255	3519
1.3	How many adults are in receipt of social work or social care services at 31st March?	1416	0	1303	265	1548	260	0	6140	**4267**	**6665**	4881	7881	5377	6793	6054	7262	5807	7217	5974	7677
1.3a	How many adults are in receipt of social care/social work support only at 31st March (not reported at 1.4)	1364	0	201	3			0	0	**1565**	**3**	2407	371	3036	282	3866	878	3903	702	3996	536
1.4	How many care packages are in place on 31st March in the following categories:																				
	a. Residential Home Care	74	0	85	48	20	0	0	577	**179**	**625**	196	590	159	744	178	641	169	629	164	580
	b. Nursing Home Care	142	0	96	66	106	0	0	1339	**344**	**1405**	350	1402	239	1696	336	1667	273	1704	260	1876
	c. Domiciliary Care Managed	218	0	23	11	516	0	0	2903	**757**	**2914**	764	3188	702	3120	565	2981	665	2952	922	3333
	d. Domiciliary Non Care Managed	0	0	98	20	93	0	0	314	**191**	**334**	207	377	227	457	241	729	213	914	317	830
	e. Supported Living	184	0	191	90	57	0	3	85	**435**	**175**	532	139	450	169	463	173	443	158	530	163
	f. Permanent Adult Family Placement	0	0	17	0	0	0	0	0	**17**	**0**	47	0	25	0	14	0	15	0	16	0
1.5	Number of adults provided with short break during the year									**1894**		2127		1155		PMSI Return	PMSI Return	PMSI Return	PMSI Return	PMSI Return	PMSI Return
1.6	Number of adults known to the Programme of Care in receipt of Centre based Day Care																				
	Statutory sector	166	0	539	49	181	0	0	504	**886**	**553**	978	631	1007	943	946	1316	1073	1392	951	1383
	Independent sector	0	0	71	8	2	0	0	315	**73**	**323**	89	214	212	229	149	469	110	681	628	417
1.6a	Number of adults known to the Programme of Care in receipt of Day Opportunities	306	0	489	12	573	0	0	198	**1368**	**210**	1316	269	1158	264	1253	78	1343	52	716	78
1.7	Of those at 1.6 how many are EMI / dementia																				
	Statutory sector	0	0	8	11	2	0	0	106	**10**	**117**	16	106	8	166	9	162	12	193	17	205
	Independent sector	0	0			0	0	0	0	**0**	**0**	18	14	0	0	1	0	1	0	0	1
1.8	This is intentionally blank																				
1.9	How many of this Programme of Care clients are in HSC Trust funded social care placements outside Northern Ireland?	4	0	0	0	0	0	0	3	**4**	**3**	21	2	12	3	11	5	12	4	6	2
1.10	Complaints	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return

South Eastern Trust

General Provisions		Mental Health		Learning Disability		Physical Disability		Older People		Total 2021-22		Total 2020-21		Total 2019-20		Total 2018-19		Total 2017-18		Total 2016-17	
		<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+
1.1	How many adults were referred for assessment of social work / social care need during the year?	2859	0	20	3	391	19	17	8893	**3287**	**8915**	6421	9815	4710	8082	2458	6890	2843	6266	3162	4094
1.2	Of those reported at 1.1 how many adults commenced receipt of social work or social care services during the year?	572	0	20	30	377	18	14	7998	**983**	**8046**	4077	9100	2922	7837	1440	4057	2036	5062	1634	3641
1.3	How many adults are in receipt of social work or social care services at 31st March?	1229	0	1348	176	1413	606	16	8304	**4006**	**9086**	4761	10183	4689	10673	4019	7606	4265	8399	4692	9460
1.3a	How many adults are in receipt of social care/social work support only at 31st March (not reported at 1.4)	1121	0	49	6	218	53	0	553	**1388**	**612**	2250	375	1896	1026	1539	608	1668	*2852	1252	2619
1.4	How many care packages are in place on 31st March in the following categories:																				
	a. Residential Home Care	12	1	126	21	7	4	4	556	**149**	**582**	140	578	145	666	126	587	115	608	103	594
	b. Nursing Home Care	23	12	58	37	33	11	1	1206	**115**	**1266**	119	1127	136	1324	139	1189	114	1557	91	1252
	c. Domiciliary Care Managed	41	8	288	43	560	134	10	4074	**899**	**4259**	880	3673	843	3111	959	2921	1177	2653	1006	2614
	d. Domiciliary Non Care Managed	0	0	155	20	410	95	1	1642	**566**	**1757**	550	1775	517	2212	533	2430	534	2412	451	2337
	e. Supported Living	100	6	166	24	9	0	0	45	**275**	**75**	214	111	345	111	365	111	310	95	363	78
	f. Permanent Adult Family Placement	0	0	1	0	0	0	0	0	**1**	**0**	0	0	2	0	1	0	1	0	1	0
1.5	Number of adults provided with short break during the year									**1225**		1403		1731		PMSI Return	PMSI Return	PMSI Return	PMSI Return	PMSI Return	PMSI Return
1.6	Number of adults known to the Programme of Care in receipt of Centre based Day Care																				
	Statutory sector	119	0	490	26	48	1	41	148	**698**	**175**	797	134	759	219	837	201	826	212	1008	238
	Independent sector	859	0	96	22	4	0	1	209	**960**	**231**	954	178	1051	321	1010	717	236	432	1116	318
1.6a	Number of adults known to the Programme of Care in receipt of Day Opportunities	660	0	598	5	138	10	0	5	**1396**	**20**	2126	93	2689	6	2129	0	1326	0	1135	0
1.7	Of those at 1.6 how many are EMI / dementia																				
	Statutory sector	0	0	5	2	0	0	0	55	**5**	**57**	18	33	5	45	13	51	9	43	10	50
	Independent sector	0	0	4	0	0	0	1	114	**5**	**114**	9	58	6	129	15	653	16	192	20	121
1.8	This is intentionally blank																				
1.9	How many of this Programme of Care clients are in HSC Trust funded social care placements outside Northern Ireland?	4	1	5	0	6	0	1	5	**16**	**6**	14	7	12	6	8	2	8	2	8	4
1.10	Complaints	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return

MAHI - STM - 097 - 5665

Southern Trust

General Provisions		Mental Health		Learning Disability		Physical Disability		Older People		Total 2021-22		Total 2020-21		Total 2019-20		Total 2018-19		Total 2017-18		Total 2016-17	
		<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+
1.1	How many adults were referred for assessment of social work / social care need during the year?	8735	797	71	6	749	731	105	3891	**9660**	**5425**	9036	4943	12175	5917	11835	6305	10246	7160	5372	5756
1.2	Of those reported at 1.1 how many adults commenced receipt of social work or social care services during the year?	2478	202	65	3	741	370	28	1567	**3312**	**2142**	3386	2555	4208	2368	4259	2014	7840	0	4512	3668
1.3	How many adults are in receipt of social work or social care services at 31st March?	3222	708	1738	227	1112	175	44	6355	**6116**	**7465**	6733	7119	7062	7445	7038	7555	7083	7494	8020	7369
1.3a	How many adults are in receipt of social care/social work support only at 31st March (not reported at 1.4)	2913	386	735	21	410	148	23	569	**4081**	**1124**	4430	757	4959	896	4959	1333	5031	1254	6042	1335
1.4	How many care packages are in place on 31st March in the following categories:																				
	a. Residential Home Care	10	30	62	24	4	0	0	317	**76**	**371**	71	388	78	439	83	394	83	406	88	439
	b. Nursing Home Care	51	86	107	56	47	2	2	1149	**207**	**1293**	234	1268	246	1454	244	1456	188	1443	175	1499
	c. Domiciliary Care Managed	19	93	579	59	431	4	7	3156	**1036**	**3312**	1055	3155	807	2510	529	1558	515	1114	489	758
	d. Domiciliary Non Care Managed	59	72	79	16	211	21	12	1150	**361**	**1259**	568	1460	615	2053	843	2820	873	3181	862	3266
	e. Supported Living	170	41	165	51	9	0	0	14	**344**	**106**	364	91	346	93	369	108	380	96	351	87
	f. Permanent Adult Family Placement	0	0	11	0	0	0	0	0	**11**	**0**	11	0	11	0	11	0	13	0	13	0
1.5	Number of adults provided with respite during the year									**1389**		1599		1729		PMSI Return	PMSI Return	PMSI Return	PMSI Return	PMSI Return	PMSI Return
1.6	Number of adults known to the Programme of Care in receipt of Centre based Day Care																				
	Statutory sector	3	15	348	26	60	0	0	307	**411**	**348**	425	392	419	500	455	519	463	492	479	474
	Independent sector	0	0	44	3	10	0	0	33	**54**	**36**	75	35	132	85	165	56	263	55	172	85
1.6a	Number of adults known to the Programme of Care in receipt of Day Opportunities	296	34	308	19	24	1	0	0	**628**	**54**	669	51	650	60	538	77	369	32	355	28
1.7	Of those at 1.6 how many are EMI / dementia																				
	Statutory sector	0	0	0	0	0	0	0	106	**0**	**106**	0	96	0	150	0	168	1	158	0	164
	Independent sector	0	0	0	0	0	0	0	0	**0**	**0**	0	0	0	0	0	0	0	0	0	0
1.8	This is intentionally blank																				
1.9	How many of this Programme of Care clients are in HSC Trust funded social care placements outside Northern Ireland?	0	1	0	0	0	0	0	2	**0**	**3**	0	4	0	3	0	3	0	2	1	0
1.10	Complaints	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return

MAHI - STM - 097 - 5666

Western Trust

General Provisions		Mental Health		Learning Disability		Physical Disability &		Older People		Total 2021-22		Total 2020-21		Total 2019-20		Total 2018-19		Total 2017-18		Total 2016-17	
		<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+
1.1	How many adults were referred for assessment of social work / social care need during the year?	6258	132	99	6	957	335	0	2288	**7314**	**2761**	5164	2793	10239	4029	10918	4607	7859	5262	16327	5309
1.2	Of those reported at 1.1 how many adults commenced receipt of social work or social care services during the year?	1773	24	62	3	609	287	0	1543	**2444**	**1857**	1162	1244	1799	2511	1681	2692	1864	2725	1709	2700
1.3	How many adults are in receipt of social work or social care services at 31st March?	4566	500	1389	165	1113	223	0	5108	**7068**	**5996**	2540	5292	2560	5635	2388	5758	2797	6387	2576	5691
1.3a	How many adults are in receipt of social care/social work support only at 31st March (not reported at 1.4)	301	9	195	8	123	102	0	89	**619**	**208**	1020	179	1220	562	1267	1000	1737	226	1882	825
1.4	How many care packages are in place on 31st March in the following categories:																				
	a. Residential Home Care	28	0	95	34	8	0	0	283	**131**	**317**	128	339	129	396	126	395	128	351	133	378
	b. Nursing Home Care	48	0	49	29	56	0	0	1070	**153**	**1099**	152	1089	146	1225	119	1254	123	1238	113	1192
	c. Domiciliary Care Managed	28	0	8	1	741	0	0	707	**777**	**708**	861	804	135	889	676	956	180	1248	133	1145
	d. Domiciliary Non Care Managed	8	0	99	27	32	0	0	2239	**139**	**2266**	230	2805	609	2405	340	2662	688	2774	689	2254
	e. Supported Living	0	0	155	39	22	0	0	0	**177**	**39**	178	42	167	39	285	42	272	45	244	35
	f. Permanent Adult Family Placement	0	0	26	0	0	0	0	0	**26**	**0**	26	0	22	0	20	0	18	0	18	0
1.5	Number of adults provided with respite during the year									**637**		763		900		PMSI Return	PMSI Return	PMSI Return	PMSI Return	PMSI Return	PMSI Return
1.6	Number of adults known to the Programme of Care in receipt of Centre based Day Care																				
	Statutory sector	203	0	491	29	84	0	0	241	**778**	**270**	851	298	884	401	864	398	898	423	880	404
	Independent sector	496	0	71	34	98	0	0	141	**665**	**175**	586	255	555	303	569	291	549	323	500	348
1.6a	Number of adults known to the Programme of Care in receipt of Day Opportunities	230	0	501	51	64	0	0	0	**795**	**51**	644	63	673	63	743	52	725	39	861	36
1.7	Of those at 1.6 how many are EMI / dementia																				
	Statutory sector	0	0	0	0	0	0	0	98	**0**	**98**	0	60	0	67	0	55	0	65	0	68
	Independent sector	0	0	0	0	0	0	0	26	**0**	**26**	0	34	0	56	0	57	0	511	0	50
1.8	This is intentionally blank																				
1.9	How many of this Programme of Care clients are in HSC Trust funded social care placements outside Northern Ireland?	2	0	8	0	0	0	0	2	**10**	**2**	3	2	8	3	5	2	2	1	2	2
1.10	Complaints	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return	HSCB Return

*Acute figures in DR1.3

HSCB Delegated Statutory Functions/Corporate Parenting Returns

1. General Provisions - Hospital

Report Title: General Provisions - Hospital
Table Number 2

Period: 01/04/21 - 31/03/22

NI Level

Unknown/unavailable value

1 GENERAL PROVISIONS - HOSPITAL		Mental Health Adults			Mental Health Older People			Learning Disability			Physical Disability			Older People			Total 2021-22 Acute now DR 1.3		
		<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the year?	85	4840	72	0	0	102	10	3	0	0	10	0	16	1489	3840	111	6342	4014
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the year? (Assessment is to include screening). Please note it is expected that the response for sections 1.1 & 1.2 will be the same	84	4626	72	0	0	102	10	3	0	0	10	0	16	1489	3840	110	6128	4014
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?	20	424	28	0	0	18	6	40	2	0	17	0	0	22	1305	26	503	1353

1 GENERAL PROVISIONS - HOSPITAL		Total 2020-21 Acute now DR 1.3			Total 2019-20 Acute now DR 1.3			Total 2018-19 Acute now DR 1.3			Total 2017-18 incl Acute		
		<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the year?	11	3102	3519	2	1560	677	953	3341	993	6414	11522	32018
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the year? (Assessment is to include screening). Please note it is expected that the response for sections 1.1 & 1.2 will be the same	11	3101	3517	2	1554	653	953	3332	977	6356	8299	21415
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?	5	829	203	4	271	96	460	598	176	605	1001	2033

Belfast Trust

1 GENERAL PROVISIONS - HOSPITAL		Mental Health			Learning Disability			Physical Disability			Older People			Total 2021-22		
		<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the year?	78	441	0	10	3	0	0	0	0	16	1375	2155	**104**	**1819**	**2155**
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the year? (Assessment is to include screening). Please note it is expected that the response for sections 1.1 & 1.2 will be the same	77	227	0	10	3	0	0	0	0	16	1375	2155	**103**	**1605**	**2155**
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?	20	82	0	6	40	2	0	0	0	0	0	881	**26**	**122**	**883**

1 GENERAL PROVISIONS - HOSPITAL		Total 2020-21			Total 2019-20			Total 2018-19			Total 2017-18			Total 2016-17		
		<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the year?	10	1162	1835	2	15	0	953	1192	1	5458	5359	8663	5817	6119	8686
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the year? (Assessment is to include screening). Please note it is expected that the response for sections 1.1 & 1.2 will be the same	10	1162	1835	2	15	0	953	1192	1	5418	2439	17	5766	2815	1
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?	4	47	439	4	51	1	460	228	0	485	371	1273	479	396	1332

MAHI - STM - 097 - 5668

Northern Trust

1 GENERAL PROVISIONS - HOSPITAL		Mental Health Adults			Mental Health Older People			Learning Disability			Physical Disability			Older People			Total 2021-22			Total 2020-21			Total 2019-20			Total 2018-19			Total 2017-18 inc Acute		
		<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the year?	7	785	38	0	0	102	0	0	0	0	0	0	0	0	0	**7**	**785**	**140**	**0**	**0**	**0**	**0**	**0**	**0**	0	694	125	6	1664	7045
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the year? (Assessment is to include screening). Please note it is expected that the response for sections 1.1 & 1.2 will be the same	7	785	38	0	0	102	0	0	0	0	0	0	0	0	0	**7**	**785**	**140**	**0**	**0**	**0**	**0**	**0**	**0**	0	694	125	0	1536	6256
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?	0	98	10	0	0	18	0	0	0	0	0	0	0	0	0	**0**	**98**	**28**	**0**	**0**	**0**	**0**	**0**	**0**	0	105	36	1	109	126

South Eastern Trust

1 GENERAL PROVISIONS - HOSPITAL		Mental Health			Learning Disability			Physical Disability			Older People			Total 2021-22			Total 2020-21			Total 2019-20			Total 2018-19			Total 2017-18			Total 2016-17		
		<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the year?	0	640	0	0	0	0	0	10	0	0	2	42	**0**	**652**	**42**	0	687	100	0	838	203	0	746	145	104	874	5775	153	2035	5822
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the year? (Assessment is to include screening). Please note it is expected that the response for sections 1.1 & 1.2 will be the same	0	640	0	0	0	0	0	10	0	0	2	42	**0**	**652**	**42**	0	687	100	0	836	179	0	743	140	104	874	5775	153	1734	5822
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?	0	85	0	0	0	0	0	17	0	0	2	20	**0**	**104**	**20**	0	215	32	0	129	41	0	186	35	19	138	73	19	221	469

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Southern Trust

1 GENERAL PROVISIONS - HOSPITAL		Mental Health			Learning Disability			Physical Disability			Older People			Total 2021-22			Total 2020-21			Total 2019-20			Total 2018-19			Total 2017-18 incl Acute			Total 2016-17 incl. Acute		
		<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the year?	0	477	34	0	0	0	0	0	0	0	68	1089	**0**	**545**	**1123**	0	531	900	0	701	1144	0	694	711	796	2322	5457	814	2170	6090
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the year? (Assessment is to include screening). Please note it is expected that the response for sections 1.1 & 1.2 will be the same	0	477	34	0	0	0	0	0	0	0	68	1089	**0**	**545**	**1123**	0	531	900	0	701	1144	0	694	711	796	2322	5457	814	2170	6090
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?	0	77	18	0	0	0	0	0	0	0	20	354	**0**	**97**	**372**	0	51	110	0	91	132	0	79	105	29	196	279	41	70	185

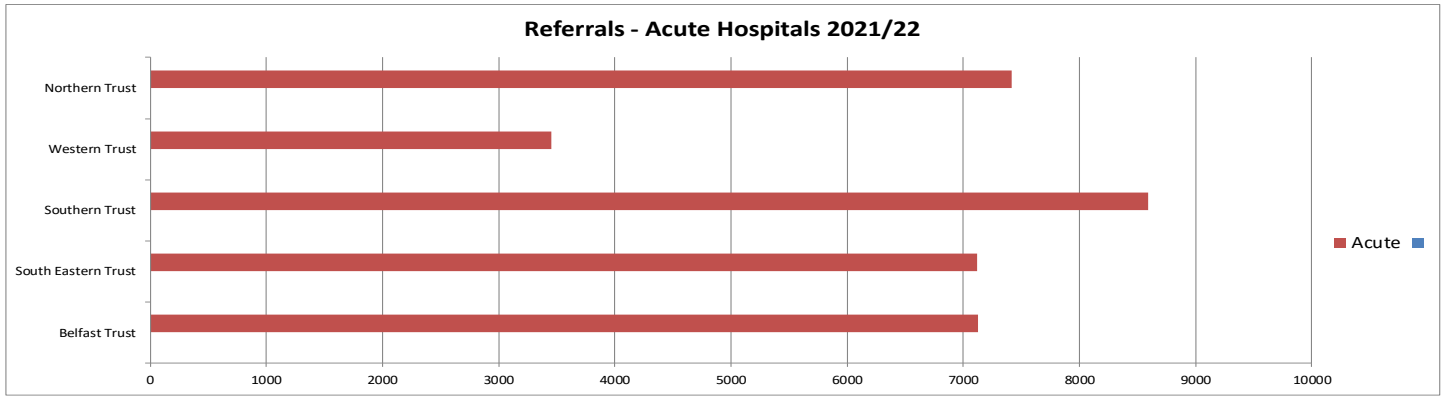
Western Trust

1 GENERAL PROVISIONS - HOSPITAL		Mental Health			Learning Disability			Physical Disability			Older People			Total 2021-22			Total 2020-21			Total 2019-20			Total 2018-19			Total 2017-18 incl Acute			Total 2016-17 incl Acute		
		<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+	<18	18-65	65+
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the year?	0	2497	0	0	0	0	0	0	0	0	44	554	**0**	**2541**	**554**	0	64	556	0	47	367	0	15	11	50	584	4172	50	774	4358
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the year? (Assessment is to include screening). Please note it is expected that the response for sections 1.1 & 1.2 will be the same	0	2497	0	0	0	0	0	0	0	0	44	554	**0**	**2541**	**554**	**0**	**0**	**0**	**0**	**0**	**0**	0	694	125	0	1536	6256	7	1315	4933
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?	0	82	0	0	0	0	0	0	0	0	0	50	**0**	**82**	**50**	0	1	28	0	3	37	0	0	0	71	1	194	30	36	89

HSCB Delegated Statutory Functions/Corporate Parenting Returns
1. General Provisions - ACUTE Hospital

Report Title: General Provisions - ACUTE Hospital
Table Number 3

Period: 01/04/21 - 31/03/22



From April 2018 referrals and assessment of needs in Acute Hospitals have been recorded seperately (DR 1.3).
Previously both Acute and Non-Acute Hospital data sets were recorded under Data Return 1.2
From April 2021 to March 2022 33,713 adults and children were referred to Hospital Social Work for assessment.
From the 33,713 referrals reported 33,616 Assessments of Need were undertaken in this period.

NI Level

Unknown/unavailable value

1 GENERAL PROVISIONS - ACUTE		Total 2021-22				Total 2020-21				Total 2019-20				Total 2018-19			
		<18	18-65	65+	Total	<18	18-65	65+	Total	<18	18-65	65+	Total	<18	18-65	65+	Total
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the year?	1010	6338	26365	**33713**	820	6957	26967	**34744**	856	6788	29403	**37047**	1038	8022	30255	**39315**
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the year?	1008	6243	26365	**33616**	818	6957	26967	**34742**	856	6786	29400	**37042**	1038	7835	29566	**38439**
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?	128	672	642	**1442**	73	924	378	**1375**	73	442	4613	**5128**	85	564	1960	**2609**

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Belfast Trust

1 GENERAL PROVISIONS - ACUTE		Total 2021-22				Total 2020-21				Total 2019-20				Total 2018-19			
		<18	18-65	65+	Total	<18	18-65	65+	Total	<18	18-65	65+	Total	<18	18-65	65+	Total
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the year?	47	1697	5386	**7130**	38	2631	5721	**8390**	18	2538	7301	**9857**	114	3259	8105	**11478**
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the year?	47	1697	5386	**7130**	38	2631	5721	**8390**	18	2538	7301	**9857**	114	3259	8105	**11478**
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?	251			**251**	626				4284				1574			

Northern Trust

1 GENERAL PROVISIONS - ACUTE		Total 2021-22				Total 2020-21				Total 2019-20				Total 2018-19			
		<18	18-65	65+	Total	<18	18-65	65+	Total	<18	18-65	65+	Total	<18	18-65	65+	Total
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the year?	2	938	6478	**7418**	3	878	6721	**7602**	0	994	7360	**8354**	0	1053	6758	**7811**
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the year?	0	843	6478	**7321**	1	878	6721	**7600**	0	994	7360	**8354**	0	910	6204	**7114**
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?	1	53	221	**275**	1	27	62	**90**	0	29	48	**77**	0	18	37	**55**

MAHI - STM - 097 - 5673

South Eastern Trust

1 GENERAL PROVISIONS - ACUTE		Total 2021-22				Total 2020-21				Total 2019-20				Total 2018-19			
					Total	<18	18-65	65+	Total	<18	18-65	65+	Total	<18	18-65	65+	Total
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the year?	144	1095	5876	**7115**	115	827	5852	**6794**	147	1020	7133	**8300**	136	988	5678	**6802**
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the year?	144	1095	5876	**7115**	115	827	5852	**6794**	147	1020	7133	**8300**	136	988	5678	**6802**
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?	16	71	98	**185**	25	125	104	**254**	8	125	86	**219**	15	142	120	**277**

Southern Trust

1 GENERAL PROVISIONS - ACUTE		Total 2021-22				Total 2020-21				Total 2019-20				Total 2018-19			
		<18	18-65	65+	Total	<18	18-65	65+	Total	<18	18-65	65+	Total	<18	18-65	65+	Total
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the year?	817	2132	5645	**8594**	664	1979	5399	**8042**	691	1581	3855	**6127**	788	2094	5546	**8428**
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the year?	817	2132	5645	**8594**	664	1979	5399	**8042**	691	1581	3855	**6127**	788	2094	5546	**8428**
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?	111	297	159	**567**	47	127	151	**325**	65	264	89	**418**	70	228	229	**527**

Western Trust

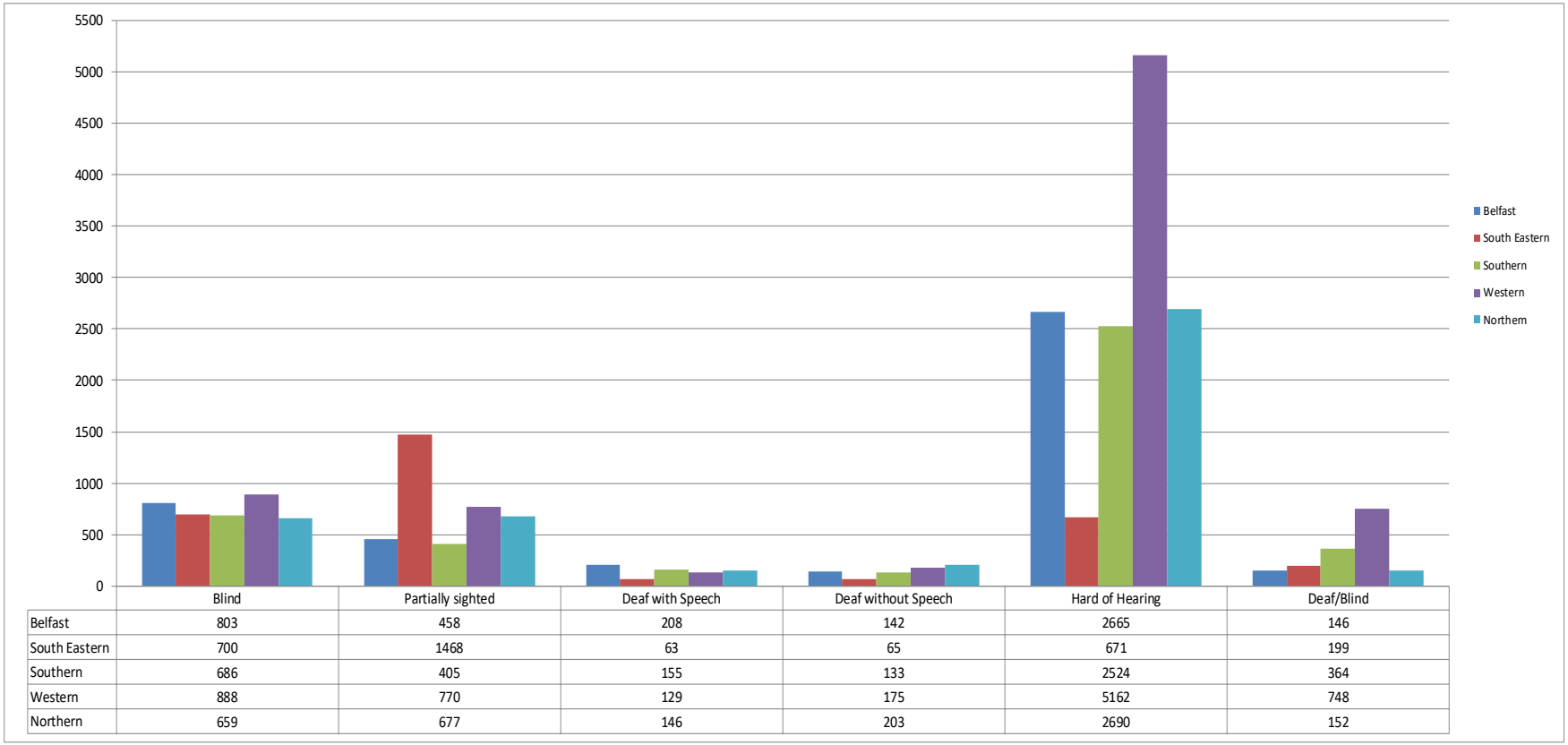
1 GENERAL PROVISIONS - ACUTE		Total 2021-22				Total 2020-21				Total 2019-20				Total 2018-19			
		<18	18-65	65+	Total	<18	18-65	65+	Total	<18	18-65	65+	Total	<18	18-65	65+	Total
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the year?	0	476	2980	**3456**	0	642	3274	**3916**	0	655	3754	**4409**	0	628	4168	**4796**
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the year?	0	476	2980	**3456**	0	642	3274	**3916**	0	653	3751	**4404**	0	584	4033	**4617**
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?	0	0	164	**164**	0	19	61	**80**	0	24	106	**130**	0	176	0	**176**

HSCB Delegated Statutory Functions/Corporate Parenting Returns

2. Chronically Sick and Disabled Persons (NI) Act 1978

Report Title: Chronically Sick and Disabled Persons (NI) Act 1978 **Period: 01/04/21 - 31/03/22**

Table Number 2



	Blind	Partially sighted	Deaf with Speech	Deaf without Speech	Hard of Hearing	Deaf/Blind
Belfast	803	458	208	142	2665	146
South Eastern	700	1468	63	65	671	199
Southern	686	405	155	133	2524	364
Western	888	770	129	175	5162	748
Northern	659	677	146	203	2690	152

MAHI - STM - 097 - 5675

NI Level

	Unknown/unavailable value

2 CHRONICALLY SICK AND DISABLED PERSONS (NI) ACT 1978;		Mental Health Adults		Mental Health Older People		Learning Disability		Physical Disability		Older People		Total 2021-22		Total 2020-21		Total 2019-20		Total 2018-19		Total 2017-18	
		<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+
2.1	Details of patients <65 in hospital for long term (>3months) care who are being treated in hospital ward for >65	2	0	0	0	7	0	0	0	0	0	**9**	**0**	16	0	90	0	9	0	8	0
2.2	Number of adults known to the Programme of Care who are:																				
	Blind	4	0	2	16	109	12	1550	1957	0	86	**1665**	**2071**	1477	1804	1858	2194	1470	1825	1293	1511
	Partially sighted	11	3	5	346	127	31	1348	1822	0	84	**1491**	**2286**	1228	2047	1753	4027	1105	2186	1188	2173
2.3	Number of adults known to the Programme of Care who are:																				
	Deaf with speech	17	0	0	10	30	3	447	178	0	16	**494**	**207**	525	189	576	222	499	183	453	149
	Deaf without speech	19	0	2	2	46	5	469	172	0	3	**536**	**182**	487	188	582	164	474	147	434	120
	Hard of hearing	31	5	4	477	169	65	3651	8575	0	735	**3855**	**9857**	3510	9737	3824	9665	3378	9192	2996	7814
2.4	Number of adults known to the Programme of Care who are:																				
	Deaf/Blind	0	0	0	0	9	5	523	1072	0	0	**532**	**1077**	**247**	**826**	258	868	152	863	140	671

Belfast Trust

2 CHRONICALLY SICK AND DISABLED PERSONS (NI) ACT 1978;		Mental Health		Learning Disability		Physical Disability		Older People		Total 2021-22		Total 2020-21		Total 2019-20		Total 2018-19		Total 2017-18	
		<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+
2.1	Details of patients <65 in hospital for long term (>3months) care who are being treated in hospital ward for >65	2	0	1	0	0	0	0	0	**3**	**0**	8	0	90	0	1	0	1	0
2.2	Number of adults known to the Programme of Care who are:																		
	Blind	1	0	6	2	313	481	0	0	**320**	**483**	334	433	343	486	321	448	288	*410
	Partially sighted	9	0	33	8	139	269	0	0	**181**	**277**	191	217	218	233	174	226	182	*220
2.3	Number of adults known to the Programme of Care who are:																		
	Deaf with speech	14	0	10	0	120	64	0	0	**144**	**64**	138	58	153	82	143	56	140	*56
	Deaf without speech	14	0	11	1	84	32	0	0	**109**	**33**	102	33	117	32	106	33	96	*29
	Hard of hearing	27	0	21	15	551	2051	0	0	**599**	**2066**	597	1887	570	2152	547	1989	541	*1935
2.4	Number of adults known to the Programme of Care who are:																		
	Deaf/Blind	0	0	2	3	21	120	0	0	**23**	**123**	24	114	35	109	3	211	24	*145
	Visually impaired	0	0	0	0	225	965	0	0	**225**	**965**	192	825						

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Northern Trust

2 CHRONICALLY SICK AND DISABLED PERSONS (NI) ACT 1978;		Mental Health Adults		Mental Health Older People		Learning Disability		Physical Disability		Older People		Total 2021-22 excl acute		Total 2020-21 excl acute		Total 2019-20 excl acute		Total 2018-19 excl acute		Total 2017-18 excl acute	
		<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+
2.1	Details of patients <65 in hospital for long term (>3months) care who are being treated in hospital ward for >65	0	0	0	0	6	0	0	0	0	0	**6**	**0**	4	0	0	0	5	0	5	0
2.2	Number of adults known to the Programme of Care who are:																				
	Blind	3	0	2	16	63	4	262	309	0	0	**330**	**329**	308	332	397	516	391	508	367	500
	Partially sighted	2	3	5	346	56	16	117	131	0	0	**181**	**496**	147	514	190	510	185	633	144	389
2.3	Number of adults known to the Programme of Care who are:																				
	Deaf with speech	3	0	0	10	17	1	89	26	0	0	**109**	**37**	114	33	116	46	112	52	115	40
	Deaf without speech	4	0	2	2	26	3	119	47	0	0	**151**	**52**	138	47	155	49	155	49	155	38
	Hard of hearing	3	5	4	477	92	30	613	1466	0	0	**712**	**1978**	673	1847	704	2979	691	3008	689	3150
2.4	Number of adults known to the Programme of Care who are:																				
	Deaf/Blind	0	0	0	0	5	2	22	123	0	0	**27**	**125**	40	293	52	292	29	180	19	174
	Visually impaired							230	578			230	578	242	597						

South Eastern Trust

2 CHRONICALLY SICK AND DISABLED PERSONS (NI) ACT 1978;		Mental Health		Learning Disability		Physical Disability		Older People		Total 2021-22		Total 2020-21		Total 2019-20		Total 2018-19		Total 2017-18	
		<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+
2.1	Details of patients <65 in hospital for long term (>3months) care who are being treated in hospital ward for >65	0	0	0	0	0	0	0	0	**0**	**0**	0	0	0	0	0	0	0	0
2.2	Number of adults known to the Programme of Care who are:																		
	Blind	0	0	0	0	283	411	0	6	**283**	**417**	270	385	552	722	254	367	261	311
	Partially sighted	0	0	0	0	449	978	0	41	**449**	**1019**	440	923	906	2916	371	1051	463	1118
2.3	Number of adults known to the Programme of Care who are:																		
	Deaf with speech	0	0	0	0	37	21	0	5	**37**	**26**	39	20	76	36	38	19	45	16
	Deaf without speech	0	0	0	0	41	24	0	0	**41**	**24**	43	26	104	34	28	18	34	21
	Hard of hearing	0	0	0	0	240	335	0	96	**240**	**431**	207	367	378	802	167	491	179	466
2.4	Number of adults known to the Programme of Care who are:																		
	Deaf/Blind	0	0	0	0	88	111	0	0	**88**	**111**	89	110	114	228	62	199	72	196

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Southern Trust

2 CHRONICALLY SICK AND DISABLED PERSONS (NI) ACT 1978;		Mental Health		Learning Disability		Physical Disability		Older People		Total 2021-22		Total 2020-21		Total 2019-20		Total 2018-19		Total 2017-18	
		<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+
2.1	Details of patients <65 in hospital for long term (>3months) care who are being treated in hospital ward for >65	0	0	0	0	0	0	0	0	**0**	**0**	4	0	0	0	3	0	2	0
2.2	Number of adults known to the Programme of Care who are:																		
	Blind	0	0	0	0	312	374	0	0	**312**	**374**	314	360	305	312	253	332	115	125
	Partially sighted	0	0	0	0	244	161	0	0	**244**	**161**	236	165	241	245	163	157	200	320
2.3	Number of adults known to the Programme of Care who are:																		
	Deaf with speech	0	0	0	0	122	33	0	0	**122**	**33**	123	32	120	31	96	31	43	10
	Deaf without speech	0	0	0	0	103	30	0	0	**103**	**30**	108	27	106	27	83	26	48	9
	Hard of hearing	0	0	0	0	766	1758	0	0	**766**	**1758**	770	1820	757	1836	617	1815	165	342
2.4	Number of adults known to the Programme of Care who are:																		
	Deaf/Blind	0	0	0	0	85	279	0	0	**85**	**279**	36	83	32	83	20	75	0	0

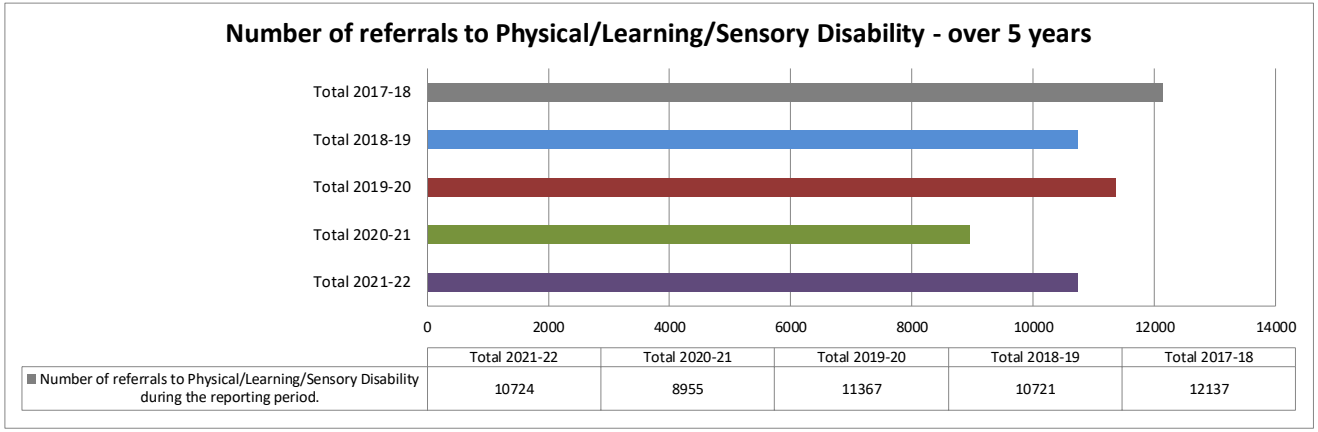
Western Trust

2 CHRONICALLY SICK AND DISABLED PERSONS (NI) ACT 1978;		Mental Health		Learning Disability		Physical Disability		Older People		Total 2021-22		Total 2020-21		Total 2019-20		Total 2018-19		Total 2017-18	
		<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+	<65	65+
2.1	Details of patients <65 in hospital for long term (>3months) care who are being treated in hospital ward for >65	0	0	0	0	0	0	0	0	**0**	**0**	0	0	0	0	0	0	0	0
2.2	Number of adults known to the Programme of Care who are:																		
	Blind	0	0	40	6	380	382	0	80	**420**	**468**	251	294	261	158	251	170	262	165
	Partially sighted	0	0	38	7	399	283	0	43	**437**	**333**	214	228	198	123	212	119	199	126
2.3	Number of adults known to the Programme of Care who are:																		
	Deaf with speech	0	0	3	2	79	34	0	11	**82**	**47**	111	46	111	27	110	25	110	27
	Deaf without speech	1	0	9	1	122	39	0	3	**132**	**43**	96	55	100	22	102	21	101	23
	Hard of hearing	1	0	56	20	1481	2965	0	639	**1538**	**3624**	1263	3816	1415	1896	1356	1889	1422	1921
2.4	Number of adults known to the Programme of Care who are:																		
	Deaf/Blind	0	0	2	0	307	439	0	0	**309**	**439**	58	226	25	156	38	198	25	156
	Visually impaired					877	936	0	238	**877**	**936**	96	90						

HSCB Delegated Statutory Functions/Corporate Parenting Returns
3. Disabled Persons (NI) Act 1989

Report Title: Disabled Persons (NI) Act 1989 **Period: 01/04/21 - 31/03/22**

Table Number 3



	Total 2021-22	Total 2020-21	Total 2019-20	Total 2018-19	Total 2017-18
Number of referrals to Physical/Learning/Sensory Disability during the reporting period.	10724	8955	11367	10721	12137

NI LEVEL

Unknown/unavailable value

	3 DISABLED PERSONS (NI) ACT 1989 Note: 'disabled people' includes individuals with physical disability, sensory impairment, learning disability	**Mental Health** Adults	**Mental Health** Older People	**Learning Disability** -	**Physical Disability** -	**Older People** -	**F&CC** includes Disability	**Total 2021-22** Excl Acute	**Total 2020-21** Excl Acute	**Total 2019-20** Excl Acute	**Total 2018-19** Excl Acute	**Total 2017-18** Excl Acute
3.1	Number of referrals to Physical/Learning/Sensory Disability during the reporting period.	29	0	1004	9022	0	669	**10724**	8955	11367	10721	12137
	Number of Disabled people known as at 31st March.	61	0	9187	17798	0	1198	**28244**	28201	27875	28106	27964
3.2	Number of assessments of need carried out during year end 31st March.	43	0	439	6806	0	569	**7857**	8050	8827	9658	9774
3.4	Number of assessments of disabled children ceasing full time education undertaken (Transition workers will be able to provide). Cross reference with Children in Need section.	0	0	36	0	0	0	**36**	89	21	34	17

Belfast Trust

3 DISABLED PERSONS (NI) ACT 1989 Note: 'disabled people' includes individuals with physical disability, sensory impairment, learning disability		Mental Health -	Learning Disability -	Physical Disability -	Older People -	Children Disability	Total 2021-22 -	Total 2020-21 -	Total 2019-20 -	Total 2018-19 -	Total 2017-18 -
3.1	Number of referrals to Physical/Learning/Sensory Disability during the reporting period.	29	176	2764	0	253	**3222**	2441	2679	2429	2799
	Number of Disabled people known as at 31st March.	38	1568	1808	0	711	**4125**	4506	4064	3622	3540
3.2	Number of assessments of need carried out during year end 31st March.	43	176	1962	0	336	**2517**	2419	1671	1990	2317
3.4	Number of assessments of disabled children ceasing full time education undertaken (Transition workers will be able to provide). Cross reference with Children in Need section.	0	31	0	0	0	**31**	20	16	34	17

Northern Trust

3 DISABLED PERSONS (NI) ACT 1989 Note: 'disabled people' includes individuals with physical disability, sensory impairment, learning disability		Mental Health Adults	Mental Health Older People	Learning Disability -	Physical Disability -	Older People -	Total 2020-21 -	Total 2020-21 -	Total 2019-20 -	Total 2018-19 -	Total 2017-18 -
3.1	Number of referrals to Physical/Learning/Sensory Disability during the reporting period.	0	0	596	2387	0	**2983**	2910	3215	2816	3022
	Number of Disabled people known as at 31st March.	0	0	2138	1285	0	**3423**	4286	4347	4231	3857
3.2	Number of assessments of need carried out during year end 31st March.	0	0	83	1409	0	**1492**	2543	2981	3010	2710
3.3	Number of assessments of disabled children ceasing full time education undertaken (Transition workers will be able to provide). Cross reference with Children in Need section.	0	0	0	0	0	**0**	46	0	0	0

South Eastern Trust

3 DISABLED PERSONS (NI) ACT 1989 Note: 'disabled people' includes individuals with physical disability, sensory impairment, learning disability		Mental Health	Learning Disability	Physical Disability	Older People	Children	Total 2021-22	Total 2020-21	Total 2019-20	Total 2018-19	Total 2017-18
		-	-	-	-	F&CC	-	-	-	-	-
3.1	Number of referrals to Physical/Learning/Sensory Disability during the reporting period.	0	50	1118	0	0	**1168**	956	1395	1311	1289
	Number of Disabled people known as at 31st March.	0	1524	4618	0	0	**6142**	6030	6134	6494	6698
3.2	Number of assessments of need carried out during year end 31st March.	0	47	1078	0	0	**1125**	913	1186	1213	1183
3.4	Number of assessments of disabled children ceasing full time education undertaken (Transition workers will be able to provide). Cross reference with Children in Need section.	0	5	0	0	0	**5**	23	5	0	0

Southern Trust

3 DISABLED PERSONS (NI) ACT 1989 Note: 'disabled people' includes individuals with physical disability, sensory impairment, learning disability		Mental Health	Learning Disability	Physical Disability	Older People	Children	Total 2021-22	Total 2020-21	Total 2019-20	Total 2018-19	Total 2017-18
		-	-	& Sensory Disability	-	F&CC	-	-	-	-	-
3.1	Number of referrals to Physical/Learning/Sensory Disability during the reporting period.	0	77	1480	0	416	**1973**	1736	2196	2258	2771
	Number of Disabled people known as at 31st March.	0	1965	1287	0	487	**3739**	3811	3946	4527	3854
3.2	Number of assessments of need carried out during year end 31st March.	0	68	1111	0	233	**1412**	1295	1461	1900	1698
3.4	Number of assessments of disabled children ceasing full time education undertaken (Transition workers will be able to provide). Cross reference with Children in Need section.	0	0	0	0	0	**0**	0	0	0	0

Western Trust

3 DISABLED PERSONS (NI) ACT 1989 Note: 'disabled people' includes individuals with physical disability, sensory impairment, learning disability		Mental Health	Learning Disability	Physical Disability	Older People	FCC	Total 2021-22	Total 2020-21	Total 2019-20	Total 2018-19	Total 2017-18
		-	-	-	-		Excl Acute	Excl Acute	Excl Acute	Excl Acute	Excl Acute
3.1	Number of referrals to Physical/Learning/Sensory Disability during the reporting period.	0	105	1273	0	0	**1378**	912	1882	1907	2256
	Number of Disabled people known as at 31st March.	23	1992	8800	0	0	**10815**	9568	9384	9232	10015
3.2	Number of assessments of need carried out during year end 31st March.	0	65	1246	0	0	**1311**	880	1528	1545	1866
3.4	Number of assessments of disabled children ceasing full time education undertaken (Transition workers will be able to provide). Cross reference with Children in Need section.	0	0	0	0	0	**0**	0	0	0	0

HSCB Delegated Statutory Functions/Corporate Parenting Returns
4. Health and Personal Social Services (NI) Order 1972

Report Title: Health & Personal Social Services (NI) Order 1972 **Period: 01/04/21 - 31/03/22**

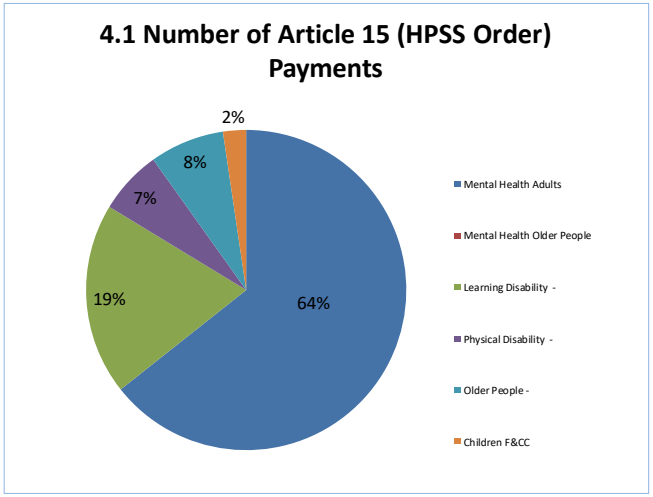
Table Number 4

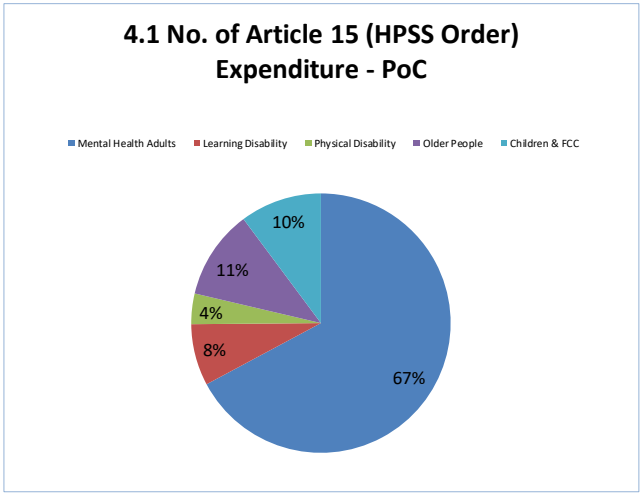
NI LEVEL

Unknown/unavailable value or

4 HEALTH AND PERSONAL SOCIAL SERVICES (NI) ORDER 1972; Article15, Article 36 [as amended by Registered Homes (NI) Order 1992]		Mental Health Adults	Mental Health Older People	Learning Disability -	Physical Disability -	Older People -	Children F&CC	Total 2021-22 -	Total 2020-21 -	Total 2019-20 -	Total 2018-19 -	Total 2017-18 -
4.1	Number of Article 15 (HPSS Order) Payments	359		108	36	42	13	**558**	601	584	687	368
	Total expenditure for the above payments (£)	£42,014		£4,806	£2,382	£6,967	£6,369	**£62,538**	£43,496	£61,224	£76,465	£53,695
4.2	Number of TRUST FUNDED people in residential care	244	314	573	59	1568	1	**2759**	2738	2951	2813	2884
4.3	Number of TRUST FUNDED people in nursing care	681	574	713	345	4517	0	**6830**	6159	6865	7308	7277
4.4	How many of those at 4.3 received only the £100 nursing care allowance?	11	44	7	10	981	0	**1053**	1015	852	946	1202
4.5	How many occasions in-year has the Trust been called upon to support Emergency Support Centres (ESC)?	NO LONGER REPORTED						**0**	0	0	8	17

Note: 4.2 and 4.3 should correspond with 1.4 (a) and (b)





MAHI - STM - 097 - 5683

Belfast Trust

4 HEALTH AND PERSONAL SOCIAL SERVICES (NI) ORDER 1972; Article15, Article 36 [as amended by Registered Homes (NI) Order 1992]		Mental Health -	Learning Disability -	Physical Disability -	Older People -	Children F&CC	Total 2021-22 -	Total 2020-21 -	Total 2019-20 -	Total 2018-19 -	Total 2017-18 -
4.1	Number of Article 15 (HPSS Order) Payments	221	77	28	28	1	**355**	329	354	479	*195
	Total expenditure for the above payments (£)	£12,455	£3,747	£2,184	£6,365	£549	**£25,300**	£23,287	£31,697	£46,148	*£38,199
4.2	Number of TRUST FUNDED people in residential care	74	133	19	420	1	**647**	561	671	672	677
4.3	Number of TRUST FUNDED people in nursing care	142	160	102	883	0	**1287**	1154	1393	1456	1457
4.4	How many of those at 4.3 received only the £100 nursing care allowance?	9	2	4	456	0	**471**	450	543	528	549
4.5	How many occasions in-year has the Trust been called upon to support Emergency Support Centres (ESC)?	NO LONGER REPORTED					**0**	0	0	3	6

*4.1 does not incl. children with disability as in previous years

Northern Trust

4 HEALTH AND PERSONAL SOCIAL SERVICES (NI) ORDER 1972; Article15, Article 36 [as amended by Registered Homes (NI) Order 1992]		Mental Health Adult	Mental Health Older People	Learning Disability -	Physical Disability -	Older People -	Children F&CC	Total 2021-22 -	Total 2020-21 -	Total 2019-20 -	Total 2018-19 -	Total 2017-18 -
4.1	Number of Article 15 (HPSS Order) Payments	94		8	0	0	0	**102**	158	84	52	42
	Total expenditure for the above payments (£)	£12,517		£325	£0	£0	£0	**£12,842**	£10,155	£11,541	£9,422	£2,267
4.2	Number of TRUST FUNDED people in residential care	69	314	73	18	255	0	**729**	807	755	803	764
4.3	Number of TRUST FUNDED people in nursing care	94	574	205	88	641	0	**1602**	1661	1773	1773	1772
4.4	How many of those at 4.3 received only the £100 nursing care allowance?	2	44	1	0	65	0	**112**	171	90	159	182
4.5	How many occasions in-year has the Trust been called upon to support Emergency Support Centres (ESC)?	NO LONGER REPORTED						**0**	0	0	4	5

South Eastern Trust

4 HEALTH AND PERSONAL SOCIAL SERVICES (NI) ORDER 1972; Article15, Article 36 [as amended by Registered Homes (NI) Order 1992]		Mental Health -	Learning Disability -	Physical Disability -	Older People -	Children FCC	Total 2021-22 -	Total 2020-21 -	Total 2019-20 -	Total 2018-19 -	Total 2017-18 -
4.1	Number of Article 15 (HPSS Order) Payments	7	1	4	0	0	**12**	10	5	15	10
	Total expenditure for the above payments (£)	£293	£50	£33	£0	0	**£376**	£353	£740	£2,487	£1,080
4.2	Number of TRUST FUNDED people in residential care	12	147	11	447	0	**617**	529	691	520	626
4.3	Number of TRUST FUNDED people in nursing care	32	95	44	1507	0	**1678**	848	1253	1669	1659
4.4	How many of those at 4.3 received only the £100 nursing care allowance?	0	3	5	454	0	**462**	393	217	259	471
4.5	How many occasions in-year has the Trust been called upon to support Emergency Support Centres (ESC)?	NO LONGER REPORTED					**0**	0	0	0	5

Southern Trust

4 HEALTH AND PERSONAL SOCIAL SERVICES (NI) ORDER 1972; Article15, Article 36 [as amended by Registered Homes (NI) Order 1992]		Mental Health -	Learning Disability -	Physical Disability -	Older People -	Children F&CC	Total 2021-22 -	Total 2020-21 -	Total 2019-20 -	Total 2018-19 -	Total 2017-18 -
4.1	Number of Article 15 (HPSS Order) Payments	0	0	0	0	12	**12**	6	8	10	7
	Total expenditure for the above payments (£)	£0	£0	£0	£0	£5,820	**£5,820**	£681	£4,221	£3,567	£2,792
4.2	Number of TRUST FUNDED people in residential care	61	91	4	202	0	**358**	367	383	374	385
4.3	Number of TRUST FUNDED people in nursing care	365	175	58	636	0	**1234**	1248	1345	1342	1306
4.4	How many of those at 4.3 received only the £100 nursing care allowance?	0	0	0	0	0	**0**	0	0	0	0
4.5	How many occasions in-year has the Trust been called upon to support Emergency Support Centres (ESC)?	NO LONGER REPORTED					**0**	0	0	0	0

Western Trust

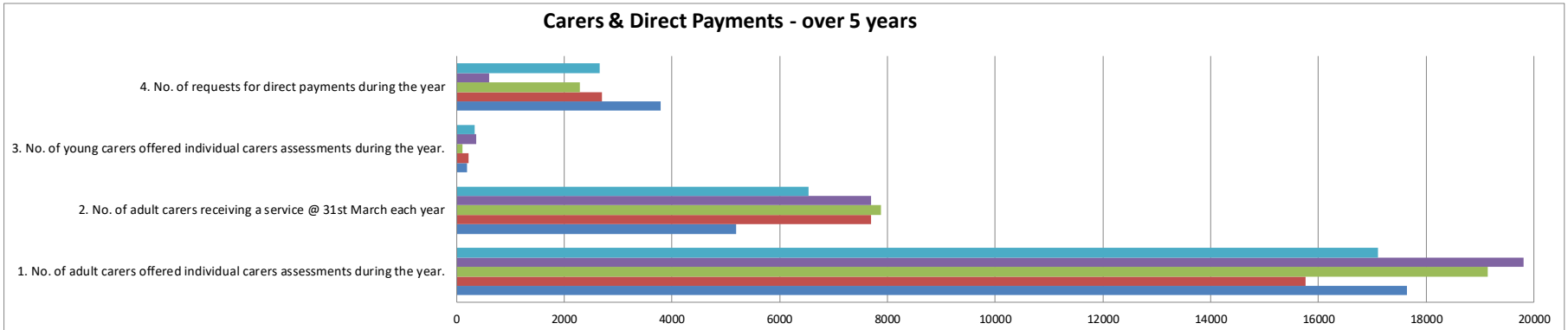
4 HEALTH AND PERSONAL SOCIAL SERVICES (NI) ORDER 1972;		Mental Health	Learning Disability	Physical Disability	Older People	FCC	Total 2021-22	Total 2020-21	Total 2019-20	Total 2018-19	Total 2017-18
Article15, Article 36 [as amended by Registered Homes (NI) Order 1992]		-	-	-	-		-	-	-	-	-
4.1	Number of Article 15 (HPSS Order) Payments	37	22	4	14	0	**77**	98	133	131	114
	Total expenditure for the above payments (£)	£16,749	£684	£165	£602	£0	**£18,200**	£9,020	£13,025	£14,841	£9,357
4.2	Number of TRUST FUNDED people in residential care	28	129	7	244	0	**408**	474	451	444	432
4.3	Number of TRUST FUNDED people in nursing care	48	78	53	850	0	**1029**	1248	1101	1068	1083
4.4	How many of those at 4.3 received only the £100 nursing care allowance?	0	1	1	6	0	**8**	1	2	0	0
4.5	How many occasions in-year has the Trust been called upon to support Emergency Support Centres (ESC)?	NO LONGER REPORTED								1	1

HSCB Delegated Statutory Functions/Corporate Parenting Returns

5. Carers and Direct Payments Act 2002

Report Title: Carers and Direct Payments Act 2002 **Period: 01/04/21- 31/03/22**

Table Number 5



	1. No. of adult carers offered individual carers assessments during the year.	2. No. of adult carers receiving a service @ 31st March each year	3. No. of young carers offered individual carers assessments during the year.	4. No. of requests for direct payments during the year
Total 2017/18	17099	6542	337	2664
Total 2018/19	19805	7701	368	603
Total 2019/20	19147	7884	107	2288
Total 2020/21	15765	7694	230	2707
Total 2021/22	17639	5189	195	3796

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NI LEVEL

	Unknown/unavailable value or

5 CARERS AND DIRECT PAYMENTS ACT 2002		Mental Health Adults			Mental Health Older People			Learning Disability			Physical Disability			Older People			FCC & Disability			Total 2021-22	Total 2020-21	Total 2019-20	Total 2018-19	Total 2017-18
		16-17	18-64	65+	16-17	18-64	65+	16-17	18-64	65+	16-17	18-64	65+	16-17	18-64	65+	16-17	18-64	65+	excl.Acute	excl.Acute	excl.Acute	excl.Acute	excl.Acute
5.1	Number of adult carers offered individual carers assessments during the year.	136	2717	56	0	840	766	0	897	232	1	2053	453	39	4353	4631	10	455	0	**17639**	15765	19147	19805	17099
5.2	Number of adult individual carers assessments completed during the year.	90	1214	98	0	603	503	0	687	164	1	1131	246	27	2521	2257	0	407	0	**9949**	8897	9718	10093	8686
5.2a	Number of adult individual carers assessments declined during the period and the reasons why	45	1209	13	0	237	263	0	210	68	0	922	207	12	1949	2374	0	48	0	**7557**	6871	9180	9149	
5.3	Of the Total at 5.2 in how many of the assessments were the carers, caring for disabled children?	0	3	0	0	0	0	0	0	0	0	3	0	0	145	0	0	319	0	**470**	838	712	728	690
5.4	Number of adult carers receiving a service @ 31st March	0	1250	515	0	0	0	3	1224	380	0	437	42	0	599	567	0	172	0	**5189**	7694	7884	7701	6542
5.5	Number of young carers offered individual carers assessments during the year.	31			0			0			24			34			106			**195**	230	107	368	337
5.6	Number of young carers assessments completed during the year.	31			0			0			24			28			98			**181**	176	80	333	276
5.7	Number of young carers receiving a service @ 31st March	216			0			3			23			69			208			**519**	417	485	498	370
5.8 a	Number of requests for direct payments during the period 1 April - 31 March	124			348			481			215			2567			61			**3796**	2707	2288	603	2664
5.8 b	Number of new approvals for direct payments during the period 1 April - 31 March	26			41			443			133			1100			139			**1882**	1184	1150	1153	739
5.8 c	Number of adults receiving direct payments @ 31st March	151			120			1299			914			1663			713			**4860**	4799	4722	3866	2904
5.9	Number of children receiving direct payments @ 31st March	0			0			0			0			0			680			**680**	480	532	508	609
5.9a	Of those at 5.8 how many of these payments are in respect of another person?	0			0			266			18			1			517			**802**	955	893	646	342
5.10	Number of carers receiving direct payments @ 31st March	5			97			190			44			173			534			**1043**	960	978	663	607
5.11	Number of one off Carers Grants made in-year.	1663			309			873			744			3395			645			**7629**	6327	5784	5459	4895

Belfast Trust

5 CARERS AND DIRECT PAYMENTS ACT 2002		Mental Health			Learning Disability			Physical Disability			Older People			Children's Disability			Total 2021-22	Total 2020-21	Total 2019-20	Total 2018-19	Total 2017-18
		16-17	18-64	65+	16-17	18-64	65+	16-17	18-64	65+	16-17	18-64	65+	16-17	18-64	65+	-	-	-	-	-
5.1	Number of adult carers offered individual carers assessments during the year.	135	1490	0	0	262	59	0	262	70	0	866	544	10	38	0	**3736**	2833	3191	3039	3750
5.2	Number of adult individual carers assessments completed during the year.	89	516	0	0	200	41	0	233	58	0	764	371	0	38	0	**2310**	2350	1785	1830	2149
5.2a	Number of adult individual carers assessments declined during the period and the reasons why	45	779	0	0	62	18	0	29	12	0	102	173	0	0	0	**1220**	490	1349	1184	
5.3	Of the Total at 5.2 in how many of the assessments were the carers, caring for disabled children?	0	3	0	0	0	0	0	0	0	0	0	0	0	38	0	**41**	683	359	407	217
5.4	Number of adult carers receiving a service @ 31st March		342	0	3	872	141	0	104	16	0	439	192	0	38	0	**2147**	2103	2183	2260	2191
5.5	Number of young carers offered individual carers assessments during the year.	26			0			23			2			72			**123**	108	66	207	201
5.6	Number of young carers assessments completed during the year.	26			0			23			0			72			**121**	102	60	199	181
5.7	Number of young carers receiving a service @ 31st March	23			3			23			0			160			**209**	93	49	102	118
5.8 a	Number of requests for direct payments during the period 1 April - 31 March	5			62			17			0			42			**126**	394	256	323	183
5.8 b	Number of new approvals for direct payments during the period 1 April - 31 March	12			62			17			55			42			**188**	392	252	301	170
5.8 c	Number of adults receiving direct payments @ 31 March	33			244			176			232			210			**895**	989	889	594	501
5.9	Number of children receiving direct payments @ 31st March	0			0			0			0			210			**210**	206	45	102	159
5.9a	Of those at 5.8 how many of these payments are in respect of another person?	0			202			0			0			210			**412**	549	470	339	164
5.10	Number of carers receiving direct payments @ 31st March	1			11			0			2			210			**224**	18	276	27	79
5.11	Number of one off Carers Grants made in-year.	763			309			417			909			366			**2764**	2501	2265	2253	2170

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Northern Trust

5 CARERS AND DIRECT PAYMENTS ACT 2002		Mental Health Adults			Mental Health Older People			Learning Disability			Physical Disability			Older People			Children's Services			Total 2021-22 excl Acute	Total 2020-21 excl Acute	Total 2019-20 excl Acute	Total 2018-19 excl Acute	Total 2017-18 excl Acute
		16-17	18-64	65+	16-17	18-64	65+	16-17	18-64	65+	16-17	18-64	65+	16-17	18-64	65+	16-17	18-64	65+	-	-	-	-	-
5.1	Number of adult carers offered individual carers assessments during the year.	1	404	54	0	840	766	0	143	35	0	658	222	1	1738	1141	0	158	0	**6161**	6932	9136	7995	6073
5.2	Number of adult individual carers assessments completed during the year.	1	298	41	0	603	503	0	85	18	0	222	65	1	678	510	0	154	0	**3179**	3494	5162	5159	3464
5.2a	Number of adult individual carers assessments declined during the period and the reasons why	0	106	13	0	237	263	0	58	17	0	436	157	0	1060	631	0	4	0	**2982**	3439	3974	2836	
5.3	Of the Total at 5.2 in how many of the assessments were the carers, caring for disabled children?	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	69	0	**69**	127	137	161	0
5.4	Number of adult carers receiving a service @ 31st March	0	373	481	0	0	0	0	143	34	0	178	0	0	0	336	0	0	0	**1545**	3399	3141	3495	2264
5.5	Number of young carers offered individual carers assessments during the year.		5			0			0			0			0			2		**7**	0	8	12	2
5.6	Number of young carers assessments completed during the year.		5			0			0			0			0			2		**7**	0	2	12	2
5.7	Number of young carers receiving a service @ 31st March		0			0			0			0			0			0		**0**	0	109	150	11
5.8 a	Number of requests for direct payments during the period 1 April - 31 March		78			348			64			112			983			0		**1585**	1747	1699	0	2271
5.8 b	Number of new approvals for direct payments during the period 1 April - 31 March		8			41			35			23			76			39		**222**	232	199	246	168
5.8 c	Number of adults receiving direct payments @ 31 March		23			120			257			145			170			0		**715**	760	692	663	634
5.9	Number of children receiving direct payments @ 31st March		0			0			0			0			0			194		**194**	0	181	156	0
5.9a	Of those at 5.8 how many of these payments are in respect of another person?																	0		**0**	51	106	0	0
5.10	Number of carers receiving direct payments @ 31st March		4			97			153			11			24			17		**306**	479	300	264	247
5.11	Number of one off Carers Grants made in-year.		306			309			91			56			234			67		**1063**	509	507	333	137

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South Eastern Trust

5 CARERS AND DIRECT PAYMENTS ACT 2002		Mental Health			Learning Disability			Physical Disability			Older People			FCC			Total 2021-22
		16-17	18-64	65+	16-17	18-64	65+	16-17	18-64	65+	16-17	18-64	65+	16-17	18-64	65+	-
5.1	Number of adult carers offered individual carers assessments during the year.	0	375	0	0	172	111	0	142	53	38	1148	1627	0	134	0	**3800**
5.2	Number of adult individual carers assessments completed during the year.	0	291	56	0	140	85	0	95	45	26	802	630	0	134	0	**2304**
5.2a	Number of adult individual carers assessments declined during the period and the reasons why	0	28	0	0	32	26	0	47	8	12	463	997	0	0	0	**1613**
5.3	Of the Total at 5.2 in how many of the assessments were the carers, caring for disabled children?	0	0	0	0	0	0	0	0	0	0	145	0	0	134	0	**279**
5.4	Number of adult carers receiving a service @ 31st March	0	421	34	0	209	205	0	139	26	0	95	39	0	134	0	**1302**
5.5	Number of young carers offered individual carers assessments during the year.	0			0			0			32			10			**42**
5.6	Number of young carers assessments completed during the year.	0			0			0			28			6			**34**
5.7	Number of young carers receiving a service @ 31st March	48			0			0			69			48			**165**
5.8 a	Number of requests for direct payments during the period 1 April - 31 March	2			21			44			130			19			**216**
5.8 b	Number of new approvals for direct payments during the period 1 April - 31 March	2			21			44			130			19			**216**
5.8 c	Number of adults receiving direct payments @ 31 March	14			194			305			253			307			**1073**
5.9	Number of children receiving direct payments @ 31st March	0			0			0			0			0			**0**
5.9a	Of those at 5.8 how many of these payments are in respect of another person?	0			64			2			1			307			**374**
5.10	Number of carers receiving direct payments @ 31st March	0			26			17			144			307			**494**
5.11	Number of one off Carers Grants made in-year.	321			101			101			1362			128			**2013**

Total 2020-21	Total 2019-20	Total 2018-19	Total 2017-18
-	-	-	-
2397	2854	2886	2394
1389	1522	1267	1193
1115	1386	1268	
28	112	96	54
2072	2551	1907	2087
89	33	56	40
73	18	48	26
170	76	101	96
206	301	280	210
168	289	257	207
1005	1156	1065	654
0	0	0	0
355	308	307	178
460	390	369	278
1343	1437	1139	977

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Southern Trust

5 CARERS AND DIRECT PAYMENTS ACT 2002		Mental Health			Learning Disability			Physical Disability			Older People			F&CC			Total 2021-22	Total 2020-21	Total 2019-20	Total 2018-19	Total 2017-18
		16-17	18-64	65+	16-17	18-64	65+	16-17	18-64	65+	16-17	18-64	65+	16-17	18-64	65+	-	-	-	-	-
5.1	Number of adult carers offered individual carers assessments during the year.	0	384	0	0	125	0	0	446	0	0	0	998	0	125	0	**2078**	2204	2615	4129	3080
5.2	Number of adult individual carers assessments completed during the year.	0	104	0	0	108	0	0	203	0	0	0	596	0	81	0	**1092**	1027	820	928	1008
5.2a	Number of adult individual carers assessments declined during the period and the reasons why	0	280	0	0	17	0	0	243	0	0	0	402	0	44	0	**986**	1177	1795	3201	
5.3	Of the Total at 5.2 in how many of the assessments were the carers, caring for disabled children?	0	0	0	0	0	0	0	0	0	0	0	0	0	78	0	**78**	0	104	60	121
5.4	Number of adult carers receiving a service @ 31st March		0			0			0			0			0		**0**	0	0	0	0
5.5	Number of young carers offered individual carers assessments during the year.		0			0			0			0			22		**22**	32	0	84	81
5.6	Number of young carers assessments completed during the year.		0			0			0			0			18		**18**	0	0	72	64
5.7	Number of young carers receiving a service @ 31st March		145														**145**	154	251	145	139
5.8 a	Number of requests for direct payments during the period 1 April - 31 March		0			0			0			0			0		**0**	0	0	0	0
5.8 b	Number of new approvals for direct payments during the period 1 April - 31 March		0			0			0			0			0		**0**	0	0	0	0
5.8 c	Number of adults receiving direct payments @ 31 March		42			255			157			226			0		**680**	661	606	604	545
5.9	Number of children receiving direct payments @ 31st March		0			0			0			0			276		**276**	274	269	213	210
5.9a	Of those at 5.8 how many of these payments are in respect of another person?		0			0			0			0			0		**0**	0	0	0	0
5.10	Number of carers receiving direct payments @ 31st March		0			0			0			0			0		**0**	0	0	0	0
5.11	Number of one off Carers Grants made in-year.		180			291			108			408			84		**1071**	1153	937	987	775

Western Trust

5 CARERS AND DIRECT PAYMENTS ACT 2002		Mental Health			Learning Disability			Physical Disability			Older People			FCC			Total 2021-22 excl Acute	Total 2020-21 excl Acute	Total 2019-20 excl Acute	Total 2018-19 excl Acute	Total 2017-18 excl Acute
		16-17	18-64	65+	16-17	18-64	65+	16-17	18-64	65+	16-17	18-64	65+				-	-	-	-	-
5.1	Number of adult carers offered individual carers assessments during the year.	0	64	2	0	195	27	1	545	108	0	601	321	0	0	0	**1864**	1399	1351	1756	1802
5.2	Number of adult individual carers assessments completed during the year.	0	5	1	0	154	20	1	378	78	0	277	150	0	0	0	**1064**	637	429	909	872
5.2a	Number of adult individual carers assessments declined during the period and the reasons why	0	16	0	0	41	7	0	167	30	0	324	171	0	0	0	**756**	650	676	660	
5.3	Of the Total at 5.2 in how many of the assessments were the carers, caring for disabled children?		0			0			3			0			0		**3**	0	0	4	298
5.4	Number of adult carers receiving a service @ 31st March		114			0			16			65			0		**195**	120	9	39	0
5.5	Number of young carers offered individual carers assessments during the year.		0			0			1			0			0		**1**	1	0	9	13
5.6	Number of young carers assessments completed during the year.		0			0			1			0			0		**1**	1	0	2	3
5.7	Number of young carers receiving a service @ 31st March		0			0			0			0			0		**0**	0	0	0	6
5.8 a	Number of requests for direct payments during the period 1 April - 31 March		39			334			42			1454			0		**1869**	360	32	0	0
5.8 b	Number of new approvals for direct payments during the period 1 April - 31 March		4			325			49			839			39		**1256**	392	410	349	194
5.8 c	Number of adults receiving direct payments @ 31 March		39			349			131			782			196		**1497**	1384	1379	940	570
5.9	Number of children receiving direct payments @ 31st March		0			0			0			0			0		**0**	0	37	37	*240
5.9a	Of those at 5.8 how many of these payments are in respect of another person?		0			0			16			0			0		**16**	0	9	0	0
5.10	Number of carers receiving direct payments @ 31st March		0			0			16			3			0		**19**	3	12	3	3
5.11	Number of one off Carers Grants made in-year.		93			81			62			482			0		**718**	821	638	747	836

5.8a **194** 5.8b **193** 5.8c **203 Community & Public Health**

*community & public health

HSCB Delegated Statutory Functions/Corporate Parenting Returns
6. Safeguarding Adults

Report Title: Safeguarding Adults Period: 01/04/21 - 31/03/22

Table Number 6

NI LEVEL

* 2021/22 figures from PMSI and previous figures from HSC Trusts

6.1 Number of adult protection referrals within the period

Type of Abuse	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total 2021-22
Mental Health	1981	389	237	184	138	**2929**
Learning Disability	477	225	87	109	78	**976**
Physical Disability	187	70	40	43	25	**365**
Older People	960	670	146	239	226	**2241**
Hospital Social Work and Intermediate Care	172	19	18	102	37	**348**
Family & Childcare	0	0	0	0	0	**0**
Primary Health & Adult Community	0	0	6	0	32	**38**
Health Promotion and Disease Prevention	0	0	0	0	0	**0**
Total	**3777**	**1373**	**534**	**677**	**536**	**6897**

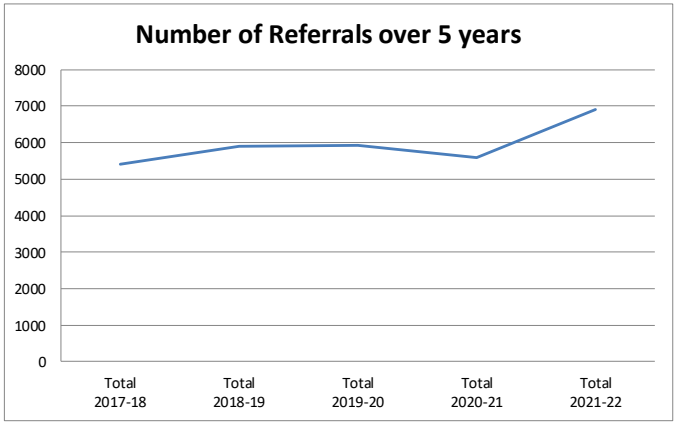
Total 2020-21	Total 2019-20
1937	**1750**
1117	**1657**
274	**275**
2219	**2024**
52	**209**
0	**0**
0	**0**
0	**0**
5599	**5915**

Figures from Trusts

	No. of referrals
Belfast Trust	3777
Northern Trust	1373
South Eastern Trust	534
Southern Trust	677
Western Trust	536
TOTAL	**6897**

BT - No. of referrals - Gateway

Total 2020-21	Total 2019-20	Total 2018-19	Total 2017-18
5599	5915	5904	5419



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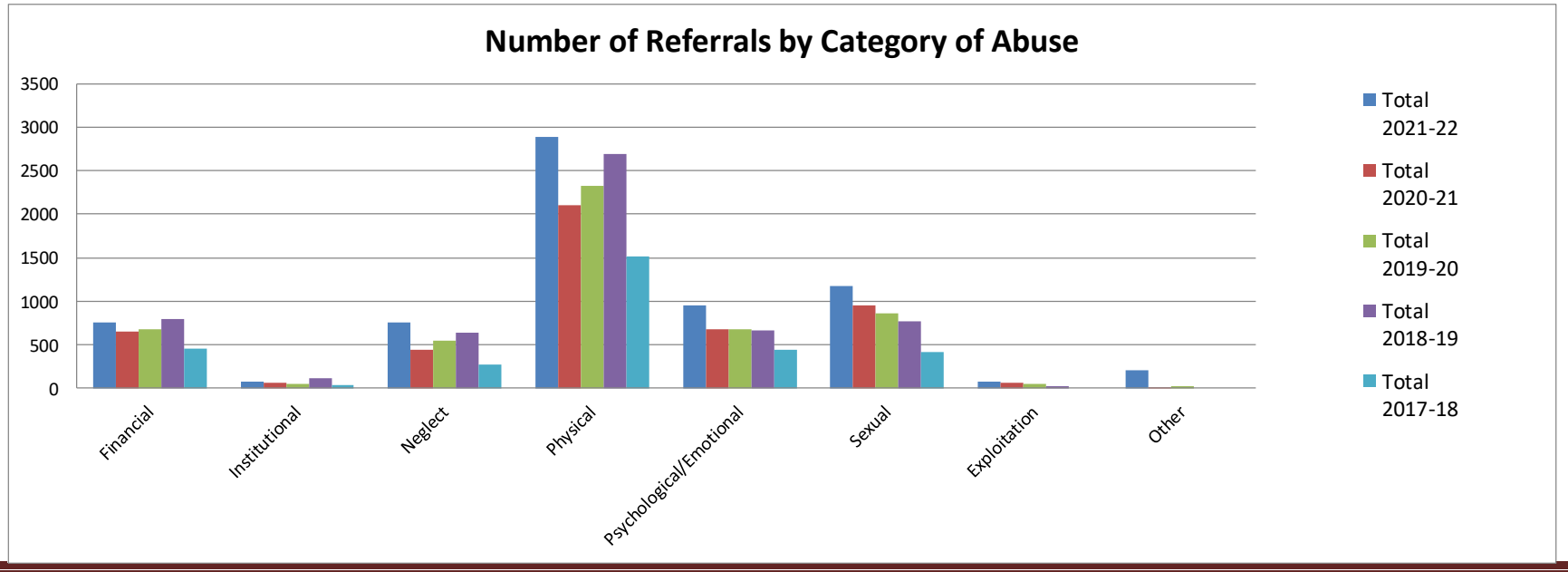
6.2 Number of adult protection referrals within the period broken down by the following categories of abuse:

Type of Abuse	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total 2021-22	Total 2020-21	Total 2019-20	Total 2018-19	Total 2017-18
Financial	350	190	85	71	62	**758**	650	677	792	462
Institutional	29	17	4	19	13	**82**	68	54	122	36
Neglect	204	355	28	75	93	**755**	443	547	640	280
Physical	1627	490	206	337	225	**2885**	2099	2325	2693	1509
Psychological/Emotional	520	186	85	95	71	**957**	681	677	670	439
Sexual	797	116	119	73	70	**1175**	952	867	765	411
Exploitation	43	19	4	7	2	**75**	60	45	25	-
Other	207	0	3	0	0	**210**	6	22	-	-
Total	**3777**	**1373**	**534**	**677**	**536**	**6897**	**4959**	**5214**	**5707**	**3137**

*** Difference in numbers returned under categories and 6.1 - some referrals screened as inappropriate referrals**



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6.3 Number of investigations commenced within the period

PoC	2021-22	2020-21	2019-20
Belfast Trust	579	1601	1743
Northern Trust	617	362	485
South Eastern Trust	218	206	234
Southern Trust	317	219	345
Western Trust	129	153	178
TOTAL	**1860**	**2541**	**2985**

includes 345 MAH

6.4 Number of cases closed to adults in need of protection

PoC	2021-22	2020-21	2019-20
Belfast Trust	348	888	769
Northern Trust	371		
South Eastern Trust	177	201	
Southern Trust	237	80	15
Western Trust	39	70	88
TOTAL	**1172**	**1239**	**872**

6.5 Number of protection plans commenced within the period = NOT COLLECTED BY PMSI

PoC	No. of care & protection plans commenced
Belfast Trust	
Northern Trust	
South Eastern Trust	
Southern Trust	
Western Trust	
TOTAL	**0**

Total 2020-21	Total 2019-20
1421	1539

TOTAL NUMBER OF CARE PLANS IN PLACE 31ST MARCH

6.6 Number of care and protection plans implemented = NO LONGER REQUIRED

Total 2020-21	Total 2019-20	Total 2018-19	Total 2017-18
1796	2858	2666	2518

TOTAL NUMBER OF CARE & PROTECTION PLANS IMPLEMENTED

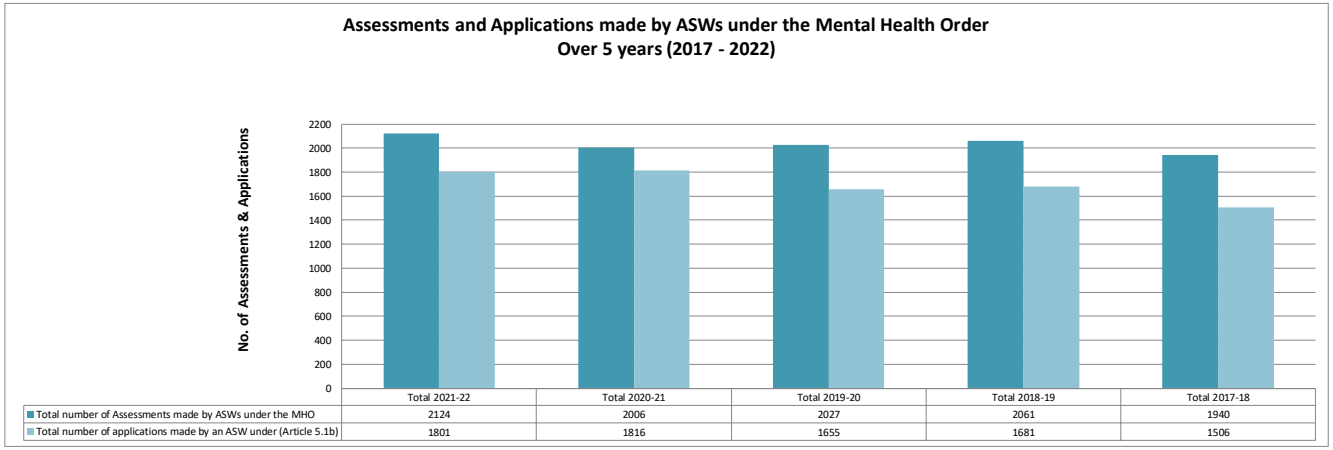
HSCB Delegated Statutory Functions/Corporate Parenting Returns

9. The Mental Health Order

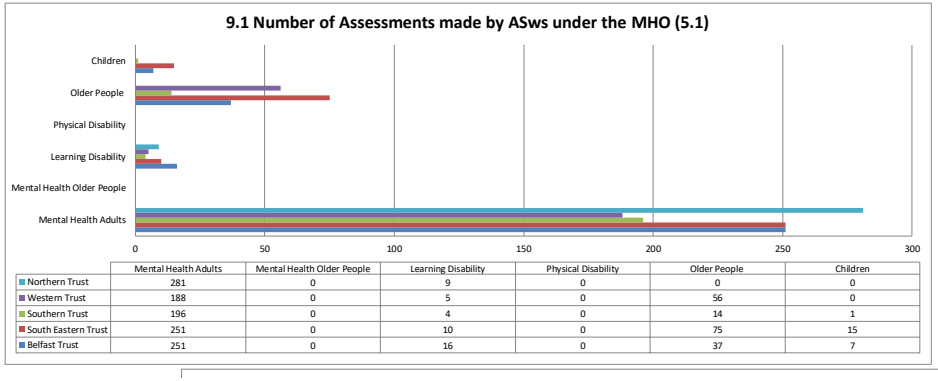
Report Title: The Mental Health Order
Table Number 9

Period: 01/04/21 - 31/03/22

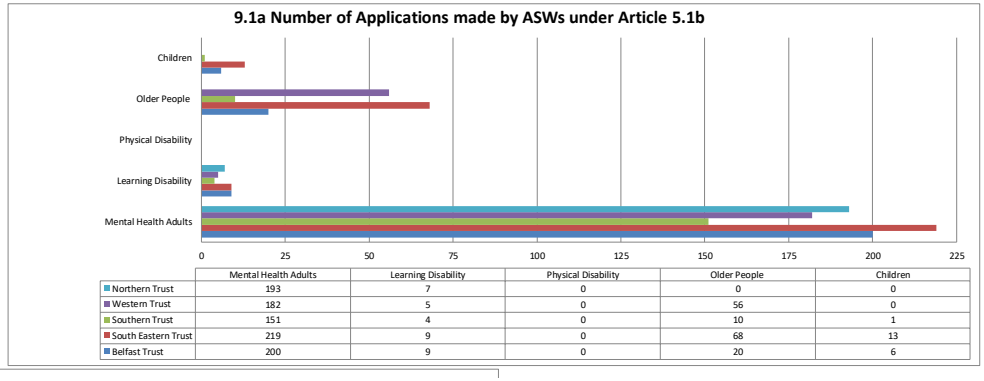
During 2021/22 a total of 2124 assessments (1416 by Trusts and 708 by the Regional Emergency Social Work Service) were made by ASWs under the Mental Health Order.
Of these assessments 1801 (1153 by Trusts and 648 by the Regional Emergency Social Work) resulted in an application being made by an ASW under Article 5.1b.
Charts below show the number of assessments and applications made by approved Social Workers broken down by Programme of Care and Trust.



	Total 2021-22	Total 2020-21	Total 2019-20	Total 2018-19	Total 2017-18
Total number of Assessments made by ASWs under the MHO	2124	2006	2027	2061	1940
Total number of applications made by an ASW under (Article 5.1b)	1801	1816	1655	1681	1506



	Mental Health Adults	Mental Health Older People	Learning Disability	Physical Disability	Older People	Children
Northern Trust	281	0	9	0	0	0
Western Trust	188	0	5	0	56	0
Southern Trust	196	0	4	0	14	1
South Eastern Trust	251	0	10	0	75	15
Belfast Trust	251	0	16	0	37	7



	Mental Health Adults	Learning Disability	Physical Disability	Older People	Children
Northern Trust	193	7	0	0	0
Western Trust	182	5	0	56	0
Southern Trust	151	4	0	10	1
South Eastern Trust	219	9	0	68	13
Belfast Trust	200	9	0	20	6

NI Level

RESWS data (by Trust breakdown) extracted from the Regional Emergency Social Work Services Report from BHSCT

Unknown/unavailable

9 The Mental Health (NI) Order 1986 Article 4 (4) (b) Article 5 (1) Article 5 (6) Article 18 (6) Article 115		Mental Health Adults	Mental Health Older People	Learning Disability	Physical Disability	Older People	Children	Total 2021-22		Total 2020-21	Total 2019-20	Total 2018-19	Total 2017-18
		Trust ASW	Trust ASW	Trust ASW	Trust ASW	Trust ASW	Trust ASW	Trust ASW	RESWS ASW	Excl Acute	Excl Acute	Excl Acute	Excl Acute
Admission for Assessment Process Article 4 and 5													
9.1	Total Number of Assessments made by ASWs under the MHO	1167	0	44	0	182	23	**1416**	**708**	2006	2027	2061	1940
9.1.a	Of these how many resulted in an application being made by an ASW under (Article 5.1b)	945	0	34	0	154	20	**1153**	**648**	1816	1655	1681	1506
9.1.b	How many assessments required the input of a second ASW (Article 5.4a)	4	0	0	0	0	0	**4**	**14**	25	25	22	22
9.1.c	Number of applications made by the nearest relative (Article 5.1.a)	6	0	1	0	0	0	**7**		13	11	18	30
~~Form 5s~~ Use of Doctors Holding Powers (Article 7)													
9.2	How many times did a hospital doctor use holding powers?	500	0	6	0	41	12	**559**		749	666	557	484
9.2a	Of these, how many resulted in an application being made	395	0	6	0	36	12	**449**		647	543	493	404
ASW Applicant Reports													
9.3	Number of ASW Applicant reports completed	1256	0	46	0	197	23	**1522**		1628	1473	1523	1196
9.3.a	Confirm if these reports were completed within 5 working days YES or NO									1512	1386	1389	1156
Social Circumstances Reports (Article 5.6)													
9.4	Total number of Social Circumstances Reports completed	4	0	1	0	0	0	**5**		11	12	15	27
9.4.a	Confirm if these reports were completed within 14 working days YES or NO									11	12	13	27
Guardianships Article 18		**MH Adults**	**MH OP**	**LD**	**PHY DIS**	**OP**	**CAMHS**	**Total**		excl Acute	excl Acute	excl Acute	excl Acute
9.5	Total number of applications to MHRT in relation to detained patients	193	0	12	0	1	7	**213**		197	221	225	249
	~~Number of patients regraded by timescales:~~												
	~~a. < 6 weeks before MHRT hearing~~												
9.5.a	~~b. > 6 weeks before MHRT hearing~~												
Guardianships Article 18		**MH Adults**	**MH OP**	**LD**	**PHY DIS**	**OP**	**CAMHS**	**Total**				excl Acute	excl Acute
9.6	Number of Guardianships in place in Trust at year end	16	0	1	0	1	0	**18**		14	27	36	38
9.6.a	New Applications for Guardianship during year (Article 19(1))	7	0	0	0	1	0	**8**		4	11	7	10
9.6.b	How many of these were transfers from detention (Article 28 (5) (b))	5	0	0	0	1	0	**6**		3	10	5	10
9.6.c	How many were Guardianship Orders made by Court (Article 44)	0	0	0	0	0	0	**0**		0	0	0	0
9.6.d	Number of new Guardianships accepted during the year (Article 22 (1))	5	0	0	0	1	0	**6**		5	11	6	6
9.6.e	Number of Guardianships Renewed (Article 23)	14	0	1	0	1	0	**16**		19	27	32	36
9.6.f	Number of Guardianships accepted by a nominated other person	0	0	0	0	0	0	**0**		0	0	0	1
9.6.g	Total number of MHRT hearings	9	0	1	0	1	0	**11**		12	17	8	15
9.6.h	~~Number discharged from guardianship following MHRT~~ Total number of Discharges from Guardianship during the reporting period (Article 24)	**MH Adults**	**MH OP**	**LD**	**PHY DIS**	**OP**	**CHILDREN**	**Total**		excl. Acute	excl. Acute	excl. Acute	excl. Acute
	Discharges as a result of an agreed multi-disciplinary care plan	3	0	0	0	1	0	**4**		8	7	10	9
	Lapsed	0	0	0	0	0	0	**0**		2	8	1	3
	Discharged by MHRT	0	0	1	0	0	0	**1**		0	0	0	0
	Discharged by Nearest Relative	0	0	0	0	0	0	**0**		0	0	0	0
	Total	3	0	1	0	1	0	**5**		10	15	11	12
ASW Register		**MH Adults**	**MH OP**	**LD**	**PHY DIS**	**OP**	**CHILDREN**						
9.7	Number of newly Approved Social Workers during year	18	0	3	0	1	1	**23**		25	36	23	15
9.7.a	Number of Approved Social Workers removed during year	22	0	1	0	3	0	**26**		22	18	34	23
9.7.b	Number of Approved Social Workers at year end (who have fulfilled Requirements consistent with quality standards)	158	0	22	3	8	2	**193**		195	212	232	215
9.9	How many times during the reporting period has the Trust notified the Office of Care and Protection under Article 107? **Stats also include Short Procedure Orders*	15	65	27	3	73	0	**183**		196	104	196	227
The Mental Health Order (NI) 1986 as amended by The Criminal Justice (NI) Order 1996. Article 50A(6). Schedule 2A Supervision and Treatment Orders													
9.10	Number of supervision and treatment orders, where a Trust social worker is the supervising officer in force at the 31st March	5	0	3	0	0	0	**8**		7	5	7	9
9.11	Of the Total shown at 9.10 how many have their treatment required as:	**MH Adults**	**MH OP**	**LD**	**PHY DIS**	**OP**	**CHILDREN**						
	Treatment as an in-patient	0	0	0	0	0	0	**0**		0	0	1	1
	Treatment as an out patient	5	0	3	0	0	0	**8**		4	5	5	7
	Treatment by a specified medical practitioner.	4	0	0	0	0	0	**4**		3	3	3	2
9.12	Of the total shown at 9.10 how many include requirements as to the residence of the supervised person (excluding in-patients)	3	0	1	0	0	0	**4**		4	2	4	4
9.13	Of the total shown at 9.10 how many of these supervision and treatment orders were made during the reporting period. Please advise of any issues presenting	1	0	1	0	0	0	**2**		3	4	2	5

Belfast Trust

9 The Mental Health (NI) Order 1986 Article 4 (4) (b) Article 5 (1) Article 5 (6) Article 18 (6) Article 115		Mental Health Adults	Learning Disability	Physical Disability -	Older People -	CAMHS	Total 2021-22		Total 2020-21	Total 2019-20	Total 2018-19	Total 2017-18
		Trust ASW	Trust ASW	Trust ASW	Trust ASW	Trust ASW	Trust ASW	RESWS				
Admission for Asessment Process Article 4 and 5												
9.1	Total Number of Assessments made by ASWs under the MHO	251	16	0	37	7	**311**	**170**	485	474	542	477
9.1.a	Of these how many resulted in an application being made by an ASW under (Article 5.1b)	200	9	0	20	6	**235**	**154**	418	383	435	412
9.1.b	How many assessments required the input of a second ASW (Article 5.4a)	0	0	0	0	0	**0**	**4**	5	7	2	9
9.1.c	Number of applications made by the nearest relative (Article 5.1.a)	0	0	0	0	0	**0**		0	1	0	3
~~Form 5s~~ Use of Doctors Holding Powers (Article 7)												
9.2	How many times did a hospital doctor use holding powers?	94	1	0	10	5	**110**		136	82	137	108
9.2a	Of these, how many resulted in an application being made	76	1	0	6	5	**88**		119	76	122	95
ASW Applicant Reports												
9.3	Number of ASW Applicant reports completed	258	16	0	37	0	**311**		362	323	378	317
9.3.a	Confirm if these reports were completed within 5 working days YES or NO	No	No	0	Yes	0			360	305	348	286
Social Circumstances Reports (Article 5.6)												
9.4	Total number of Social Circumstances Reports completed	0	0	0	0		**0**		0	1	1	4
9.4.a	Confirm if these reports were completed within 14 working days YES or NO	0	0	0	0		**0**		0	1	1	4
		MH Adults	**LD**	**PHY DIS**	**OP**	**CHILDREN**	**Total**					
9.5	Number of applications to MHRT hearings in relation to detained patients	71	10	0	1	7	**89**		86	95	132	80
	~~Number of patients regraded by timescales:~~											
	~~a. < 6 weeks before MHRT hearing~~											
9.5.a	~~b. > 6 weeks before MHRT hearing~~											
Guardianships Article 18		**MH Adults**	**LD**	**PHY DIS**	**OP**	**CHILDREN**						
9.6	Number of Guardianships in place in Trust at year end	4	1	0	1	0	**6**		7	7	9	8
9.6.a	New Applications for Guardianship during year (Article 19(1))	0	0	0	1	0	**1**		1	2	2	1
9.6.b	How many of these were transfers from detention (Article 28 (5) (b))	0	0	0	1	0	**1**		2	2	1	0
9.6.c	How many were Guardianship Orders made by Court (Article 44)	0	0	0	0	0	**0**		0	0	0	0
9.6.d	Number of new Guardianships accepted during the year (Article 22 (1))	1	0	0	1	0	**2**		2	2	2	1
9.6.e	Number of Guardianships Renewed (Article 23)	4	1	0	1	0	**6**		5	6	7	7
9.6.f	Number of Guardianships accepted by a nominated other person	0	0	0	0	0	**0**		0	0	0	0
9.6.g	Number of MHRT Hearings in respect of people in Guardianship	5	0	0	1	0	**6**		4	2	3	1
9.6.h	~~Number discharged from guardianship following MHRT~~ Total number of Discharges from Guardianship during the reporting period (Article 24)	**MH Adults**	**LD**	**PHY DIS**	**OP**	**CHILDREN**						
	Discharges as a result of an agreed multi-disciplinary care plan	0	0	0	1	0	**1**		2	2	0	1
	Lapsed	0	0	0	0	0	**0**		0	1	1	0
	Discharged by MHRT	0	0	0	0	0	**0**		0	0	0	0
	Discharged by Nearest Relative	0	0	0	0	0	**0**		0	0	0	0
	Total	0	0	0	1	0	**1**		2	3	1	1
ASW Register		**MH Adults**	**LD**	**PHY DIS**	**OP**	**CHILDREN**						
9.7	Number of newly Approved Social Workers during year	4	0	0	0	0	**4**		8	6	6	2
9.7.a	Number of Approved Social Workers removed during year	5	0	0	0	0	**5**		9	6	15	5
9.7.b	Number of Approved Social Workers at year end (who have fulfilled Requirements consistent with quality standards)	29	0	0	0	0	**29**		36	38	61	32
9.9	How many times during the reporting period has the Trust notified the Office of Care and Protection under Article 107? **Stats also include Short Procedure Orders*	2	0	0	51	0	**53**		42	46	34	9
The Mental Health Order (NI) 1986 as amended by The Criminal Justice (NI) Order 1996. Article 50A(6). Schedule 2A Supervision and Treatment Orders												
9.10	Number of supervision and treatment orders, where a Trust social worker is the supervising officer in force at the 31st March	0	0	0	0	0	**0**		1	1	2	4
9.11	Of the Total shown at 9.10 how many have their treatment required as:	**MH Adults**	**LD**	**PHY DIS**	**OP**							
	Treatment as an in-patient	0	0	0	0	0	**0**		0	0	0	0
	Treatment as an out patient	0	0	0	0	0	**0**		1	1	2	4
	Treatment by a specified medical practitioner.	0	0	0	0	0	**0**		0	0	0	0
9.12	Of the total shown at 9.10 how many include requirements as to the residence of the supervised person (excluding in-patients)	0	0	0	0	0	**0**		0	0	2	2
9.13	Of the total shown at 9.10 how many of these supervision and treatment orders were made during the reporting period. Please advise of any issues presenting	0	0	0	0	0	**0**		0	1	0	2

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Northern Trust

9 The Mental Health (NI) Order 1986 Article 4 (4) (b) Article 5 (1) Article 5 (6) Article 18 (6) Article 115		Mental Health Adults Trust ASW	Mental Health Older People Trust ASW	Learning Disability - Trust ASW	Physical Disability - Trust ASW	Older People - Trust ASW	Children - Trust ASW	Total excl Acute Trust ASW	 RESWS ASW	Total 2020-21 excl Acute	Total 2019-20 excl Acute	Total 2018-19 excl Acute	Total 2017-18 excl Acute
Admission for Asessment Process Article 4 and 5													
9.1	Total Number of Assessments made by ASWs under the MHO	281	0	9	0	0	0	**290**	**142**	464	427	388	434
9.1.a	Of these how many resulted in an application being made by an ASW under (Article 5.1b)	193	0	7	0	0	0	**200**	**132**	391	350	317	271
9.1.b	How many assessments required the input of a second ASW (Article 5.4a)	1	0	0	0	0	0	**1**	**6**	5	1	1	0
9.1.c	Number of applications made by the nearest relative (Article 5.1.a)	1	0	0	0	0	0	**1**		4	2	0	6
~~Form 5s~~ Use of Doctors Holding Powers (Article 7)													
9.2	How many times did a hospital doctor use holding powers?	91	0	0	0	0	0	**91**		118	122	44	120
9.2a	Of these, how many resulted in an application being made	34	0	0	0	0	0	**34**		97	88	34	98
ASW Applicant Reports													
9.3	Number of ASW Applicant reports completed	281	0	9	0	0	0	**290**		308	281	287	181
9.3.a	Confirm if these reports were completed within 5 working days YES or NO	Yes	0	Yes	0	0	0			308	281	287	181
Social Circumstances Reports (Article 5.6)													
9.4	Total number of Social Circumstances Reports completed	1	0	0	0	0	0	**1**		4	2	0	5
9.4.a	Confirm if these reports were completed within 14 working days YES or NO	Yes	0	0	0	0	0	**0**		4	2	0	5
Mental Health Review Tribunal													
9.5	Total number of applications to MHRT in relation to detained patients	46	0	2	0	0	0	**48**		24	28	28	83
9.5.a	~~Number of patients regraded by timescales:~~ ~~a. < 6 weeks before MHRT hearing~~ ~~b. > 6 weeks before MHRT hearing~~												
Guardianships Article 18		**MH Adults**	**MH OP**	**LD**	**PHY DIS**	**OP**	**Children**						
9.6	Number of Guardianships in place in Trust at year end	3	0	0	0	0	0	**3**		3	6	10	15
9.6.a	New Applications for Guardianship during year (Article 19(1))	4	0	0	0	0	0	**4**		1	4	4	5
9.6.b	How many of these were transfers from detention (Article 28 (5) (b))	3	0	0	0	0	0	**3**		1	4	3	4
9.6.c	How many were Guardianship Orders made by Court (Article 44)	0	0	0	0	0	0	**0**		0	0	0	0
9.6.d	Number of new Guardianships accepted during the year (Article 22 (1))	2	0	0	0	0	0	**2**		1	4	4	1
9.6.e	Number of Guardianships Renewed (Article 23)	2	0	0	0	0	0	**2**		4	8	9	19
9.6.f	Number of Guardianships accepted by a nominated other person	0	0	0	0	0	0	**0**		0	0	0	0
9.6.g	Number of MHRT Hearings in respect of people in Guardianship	1	0	0	0	0	0	**1**		**1**	**3**	**3**	**10**
9.6.h	Total number of Discharges from Guardianship during the reporting period (Article 24)	**MH Adults**	**MH OP**	**LD**	**PHY DIS**	**OP**	**Children**						
	Discharges as a result of an agreed multi-disciplinary care plan	2	0	0	0	0	0	**2**		3	5	9	6
	Lapsed	0	0	0	0	0	0	**0**		1	3	0	1
	Discharged by MHRT	0	0	0	0	0	0	**0**		0	0	0	0
	Discharged by Nearest Relative	0	0	0	0	0	0	**0**		0	0	0	0
	Total	2	0	0	0	0	0	**2**		4	8	9	7
ASW Register		**MH Adults**	**MH OP**	**LD**	**PHY DIS**	**OP**	**Children**						
9.7	Number of newly Approved Social Workers during year	4	0	0	0	0	0	**4**		4	8	4	2
9.7.a	Number of Approved Social Workers removed during year	8	0	1	0	0	0	**9**		4	3	2	4
9.7.b	Number of Approved Social Workers at year end (who have fulfilled Requirements consistent with quality standards)	50	0	10	1	0	0	**61**		55	62	57	57
9.9	How many times during the reporting period has the Trust notified the Office of Care and Protection under Article 107? **Stats also include Short Procedure Orders*	6	65	7	3	20	0	**101**		85	2	74	91
The Mental Health Order (NI) 1986 as amended by The Criminal Justice (NI) Order 1996. Article 50A(6). Schedule 2A Supervision and Treatment Orders													
9.10	the supervising officer in force at the 31st March	0	0	3	0	0	0	**3**		3	1	1	1
9.11	Of the Total shown at 9.10 how many have their treatment required as:	**MH Adults**	**MH OP**	**LD**	**PHY DIS**	**OP**	**Children**						
	Treatment as an in-patient	0	0	0	0	0	0	**0**		0	0	0	0
	Treatment as an out patient	0	0	3	0	0	0	**3**		1	1	1	1
	Treatment by a specified medical practitioner.	0	0	0	0	0	0	**0**		1	1	1	0
9.12	Of the total shown at 9.10 how many include requirements as to the residence of the supervised person (excluding in-patients)	0	0	1	0	0	0	**1**		2	0	1	1
9.13	Of the total shown at 9.10 how many of these supervision and treatment orders were made during the reporting period. Please advise of any issues presenting	0	0	1	0	0	0	**1**		2	1	1	1

South Eastern Trust

*9.1 amended Jan 22 - 285 for all PoCs

9 The Mental Health (NI) Order 1986 Article 4 (4) (b) Article 5 (1) Article 5 (6) Article 18 (6) Article 115		Mental Health Adults -	Learning Disability -	Physical Disability -	Older People -	Children -	Total 2021-22		Total 2020-21	Total 2019-20	Total 2018-19	Total 2017-18
		Trust ASW	Trust ASW	Trust ASW	Trust ASW	Trust ASW	Trust ASW	RESWS ASW				
Admission for Asessment Process Article 4 and 5												
9.1	Total Number of Assessments made by ASWs under the MHO	251	10	0	75	15	**351**	**123**	382	500	459	360
9.1.a	Of these how many resulted in an application being made by an ASW under (Article 5.1b)	219	9	0	68	13	**309**	**110**	442	407	383	295
9.1.b	How many assessments required the input of a second ASW (Article 5.4a)	2	0	0	0	0	**2**	**0**	7	14	10	6
9.1.c	Number of applications made by the nearest relative (Article 5.1.a)	0	0	0	0	0	**0**		1	3	7	5
~~Form 5s~~ Use of Doctors Holding Powers (Article 7)												
9.2	How many times did a hospital doctor use holding powers?	114	0	0	15	7	**136**		172	153	132	80
9.2a	Of these, how many resulted in an application being made	108	0	0	15	7	**130**		147	129	122	54
ASW Applicant Reports												
9.3	Number of ASW Applicant reports completed	346	12	0	90	22	**470**		526	488	465	359
9.3.a	Confirm if these reports were completed within 5 working days YES or NO	No	Yes	0	Yes	Yes			412	422	362	350
Social Circumstances Reports (Article 5.6)												
9.4	Total number of Social Circumstances Reports completed	0	0	0	0	0	**0**		1	4	7	5
9.4.a	Confirm if these reports were completed within 14 working days YES or NO	0	0	0	0	0	**0**		1	4	5	5
Guardianships Article 18		**MH Adults**	**LD**	**PHY DIS**	**OP**	**CHILDREN**						
9.5.	Total number of applications to MHRT in relation to detained patients	39	0	0	0	0	**39**		44	45	40	49
	~~Number of patients regraded by timescales:~~											
	~~a. < 6 weeks before MHRT hearing~~											
9.5.a	~~b. > 6 weeks before MHRT hearing~~											
Guardianships Article 18		**MH Adults**	**LD**	**PHY DIS**	**OP**	**CHILDREN**						
9.6	Number of Guardianships in place in Trust at year end	4	0	0	0	0	**4**		4	7	7	4
9.6.a	New Applications for Guardianship during year (Article 19(1))	0	0	0	0	0	**0**		0	2	0	1
9.6.b	How many of these were transfers from detention (Article 28 (5) (b))	0	0	0	0	0	**0**		0	2	1	4
9.6.c	How many were Guardianship Orders made by Court (Article 44)	0	0	0	0	0	**0**		0	0	0	0
9.6.d	Number of new Guardianships accepted during the year (Article 22 (1))	0	0	0	0	0	**0**		0	2	0	1
9.6.e	Number of Guardianships Renewed (Article 23)	4	0	0	0	0	**4**		4	6	6	4
9.6.f	Number of Guardianships accepted by a nominated other person	0	0	0	0	0	**0**		0	0	0	1
9.6.g	Number of MHRT Hearings in respect of people in Guardianship	1	0	0	0	0	**1**		4	3	1	1
9.6.h	Total number of Discharges from Guardianship during the reporting period	**MH Adults**	**LD**	**PHY DIS**	**OP**	**CHILDREN**						
	Discharges as a result of an agreed multi-disciplinary care plan	0	0	0	0	0	**0**		2	0	1	0
	Lapsed	0	0	0	0	0	**0**		0	0	0	0
	Discharged by MHRT	0	0	0	0	0	**0**		0	0	0	0
	Discharged by Nearest Relative	0	0	0	0	0	**0**		0	0	0	0
	Total	0	0	0	0	0	**0**		2	0	1	0
ASW Register		**MH Adults**	**LD**	**PHY DIS**	**OP**	**CHILDREN**						
9.7	Number of newly Approved Social Workers during year	2	0	0	0	0	**2**		8	13	6	4
9.7.a	Number of Approved Social Workers removed during year	7	0	0	2	0	**9**		4	4	5	2
9.7.b	Number of Approved Social Workers at year end (who have fulfilled Requirements consistent with quality standards)	35	2	0	3	1	**41**		43	49	42	30
9.9	How many times during the reporting period has the Trust notified the Office of Care and Protection under Article 107? **Stats also include Short Procedure Orders*	4	1	0	2	0	**7**		47	29	46	87
The Mental Health Order (NI) 1986 as amended by The Criminal Justice (NI) Order 1996. Article 50A(6). Schedule 2A Supervision and Treatment Orders												
9.10	Number of supervision and treatment orders, where a Trust social worker is the supervising officer in force at the 31st March	1	0	0	0	0	**1**		1	2	1	1
9.11	Of the Total shown at 9.10 how many have their treatment required as:	**MH Adults**	**LD**	**PHY DIS**	**OP**	**CHILDREN**						
	Treatment as an in-patient	0	0	0	0	0	**0**		0	0	1	1
	Treatment as an out patient	1	0	0	0	0	**1**		1	2	0	0
	Treatment by a specified medical practitioner.	1	0	0	0	0	**1**		1	2	0	0
9.12	Of the total shown at 9.10 how many include requirements as to the residence of the supervised person (excluding in-patients)	1	0	0	0	0	**1**		1	2	0	0
9.13	Of the total shown at 9.10 how many of these supervision and treatment orders were made during the reporting period. Please advise of any issues presenting	0	0	0	0	0	**0**		0	2	0	1

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Southern Trust

9 The Mental Health (NI) Order 1986 Article 4 (4) (b) Article 5 (1) Article 5 (6) Article 18 (6) Article 115		Mental Health Adults Trust ASW	Learning Disability - Trust ASW	Physical Disability - Trust ASW	Older People - Trust ASW	Children - Trust ASW	Total 2021-22 Trust ASW	 RESWS	Total 2020-21	Total 2019-20	Total 2018-19	Total 2017-18
Admission for Asessment Process Article 4 and 5												
9.1	Total Number of Assessments made by ASWs under the MHO	196	4	0	14	1	**215**	**101**	337	295	333	377
9.1.a	Of these how many resulted in an application being made by an ASW under (Article 5.1b)	151	4	0	10	1	**166**	**92**	278	231	261	264
9.1.b	How many assessments required the input of a second ASW (Article 5.4a)	0	0	0	0	0	**0**	**3**	3	0	3	5
9.1.c	Number of applications made by the nearest relative (Article 5.1.a)	2	1	0	0	0	**3**		6	3	5	3
~~Form 5s~~ Use of Doctors Holding Powers (Article 7)												
9.2	How many times did a hospital doctor use holding powers?	108	4	0	3	0	**115**		194	186	169	113
9.2a	Of these, how many resulted in an application being made	102	4	0	3	0	**109**		187	154	150	99
ASW Applicant Reports												
9.3	Number of ASW Applicant reports completed	183	4	0	14	1	**202**		221	188	198	199
9.3.a	Confirm if these reports were completed within 5 working days YES or NO	No	Yes	0	Yes	Yes			221	185	197	199
Social Circumstances Reports (Article 5.6)												
9.4	Total number of Social Circumstances Reports completed	0	1	0	0	0	**1**		4	3	1	3
9.4.a	Confirm if these reports were completed within 14 working days YES or NO	Yes	Yes	0	0	0			4	3	1	3
Guardianships Article 18		**MH Adults**	**LD**	**PHY DIS**	**OP**	**CHILDREN**						
9.5	Total number of applications to MHRT in relation to detained patients	24	0	0	0	0	24		39	26	16	23
	~~Number of patients regraded by timescales:~~											
	~~a. < 6 weeks before MHRT hearing~~											
9.5.a	~~b. > 6 weeks before MHRT hearing~~											
Guardianships Article 18		**MH Adults**	**LD**	**PHY DIS**	**OP**	**FCC**						
9.6	Number of Guardianships in place in Trust at year end	4	0	0	0	0	**4**		0	7	10	11
9.6.a	New Applications for Guardianship during year (Article 19(1))	3	0	0	0	0	**3**		2	3	0	3
9.6.b	How many of these were transfers from detention (Article 28 (5) (b))	1	0	0	0	0	**1**		0	2	0	2
9.6.c	How many were Guardianship Orders made by Court (Article 44)	0	0	0	0	0	**0**		0	0	0	0
9.6.d	Number of new Guardianships accepted during the year (Article 22 (1))	2	0	0	0	0	**2**		2	3	0	3
9.6.e	Number of Guardianships Renewed (Article 23)	3	0	0	0	0	**3**		6	7	10	6
9.6.f	Number of Guardianships accepted by a nominated other person	0	0	0	0	0	**0**		0	0	0	0
9.6.g	Number of MHRT Hearings in respect of people in Guardianship	2	1	0	0	0	**3**		3	9	0	3
9.6.h	Total number of Discharges from Guardianship during the reporting period	**MH Adults**	**LD**	**PHY DIS**	**OP**	**FCC**						
	Discharges as a result of an agreed multi-disciplinary care plan	1	0	0	0	0	**1**		1	0	0	1
	Lapsed	0	0	0	0	0	**0**		1	4	0	2
	Discharged by MHRT	0	1	0	0	0	**1**		0	0	0	0
	Discharged by Nearest Relative	0	0	0	0	0	**0**		0	0	0	0
	Total	1	1	0	0	0	**2**		2	4	0	3
ASW Register		**MH Adults**	**LD**	**PHY DIS**	**OP**	**FCC**						
9.7	Number of newly Approved Social Workers during year	3	1	0	1	1	**6**		2	2	3	5
9.7.a	Number of Approved Social Workers removed during year	0	0	0	1	0	**1**		1	1	8	4
9.7.b	Number of Approved Social Workers at year end (who have fulfilled Requirements consistent with quality standards)	22	6	2	5	1	**36**		29	25	32	33
9.9	How many times during the reporting period has the Trust notified the Office of Care and Protection under Article 107? **Stats also include Short Procedure Orders*	0	0	0	0	0	**0**		0	14	4	19
The Mental Health Order (NI) 1986 as amended by The Criminal Justice (NI) Order 1996. Article 50A(6). Schedule 2A Supervision and Treatment Orders												
9.10	the supervising officer in force at the 31st March	3	0	0	0	0	**3**		0	0	1	1
9.11	Of the Total shown at 9.10 how many have their treatment required as:	**MH Adults**	**LD**	**PHY DIS**	**OP**	**FCC**						
	Treatment as an in-patient	0	0	0	0	0	**0**		0	0	0	0
	Treatment as an out patient	3	0	0	0	0	**3**		0	0	0	0
	Treatment by a specified medical practitioner.	3	0	0	0	0	**3**		0	0	1	1
9.12	Of the total shown at 9.10 how many include requirements as to the residence of the supervised person (excluding in-patients)	2	0	0	0	0	**2**		0	0	1	1
9.13	Of the total shown at 9.10 how many of these supervision and treatment orders were made during the reporting period. Please advise of any issues presenting	1	0	0	0	0	**1**		0	0	1	1

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Western Trust

9 The Mental Health (NI) Order 1986 Article 4 (4) (b) Article 5 (1) Article 5 (6) Article 18 (6) Article 115		Mental Health Adults		Learning Disability -		Physical Disability -		Older People -		FCC	Total 2021-22		Total 2020-21	Total 2019-20	Total 2018-19	Total 2017-18
		Trust ASW	RESWS	Trust ASW		Trust ASW		Trust ASW		Trust ASW	Trust ASW	RESWS ASW				
Admission for Asessment Process Article 4 and 5																
9.1	Total Number of Assessments made by ASWs under the MHO	188		5		0		56		0	**249**	**172**	338	331	347	292
9.1.a	Of these how many resulted in an application being made by an ASW under (Article 5.1b)	182		5		0		56		0	**243**	**160**	287	284	285	264
9.1.b	How many assessments required the input of a second ASW (Article 5.4a)	1		0		0		0		0	**1**	**1**	5	3	6	2
9.1.c	Number of applications made by the nearest relative (Article 5.1.a)	3		0		0		0		0	**3**		2	2	6	13
~~Form 5s~~ **Use of Doctors Holding Powers (Article 7)**																
9.2	How many times did a hospital doctor use holding powers?	93		1		0		13		0	**107**		129	123	75	63
9.2a	Of these, how many resulted in an application being made	75		1		0		12		0	**88**		97	96	65	58
ASW Applicant Reports																
9.3	Number of ASW Applicant reports completed	188		5		0		56		0	**249**		211	193	195	140
9.3.a	Confirm if these reports were completed within 5 working days YES or NO	Yes		Yes		0				0			211	193	195	140
Social Circumstances Reports (Article 5.6)																
9.4	Total number of Social Circumstances Reports completed	3		0		0		0		0	**3**		2	2	6	10
9.4.a	Confirm if these reports were completed within 14 working days YES or NO	Yes		0		0		0		0			2	2	6	10
Social Circumstances Reports (Article 5.6)																
		MH Adults		**LD**		**PHY DIS**		**OP**		**FCC**	**Total**					
9.5	Total number of applications to MHRT in relation to detained patients	13		0		0		0		0	**13**		4	4	9	14
	~~Number of patients regraded by timescales:~~															
	~~a. < 6 weeks before MHRT hearing~~															
9.5.a	~~b. > 6 weeks before MHRT hearing~~															
Guardianships Article 18		**MH Adults**		**LD**		**PHY DIS**		**OP**		**FCC**						
9.6	Number of Guardianships in place in Trust at period end	1		0		0		0		0	**1**		0	0	0	0
9.6.a	New Applications for Guardianship during year (Article 19(1))	0		0		0		0		0	**0**		0	0	1	0
9.6.b	How many of these were transfers from detention (Article 28 (5) (b))	1		0		0		0		0	**1**		0	0	0	0
9.6.c	How many were Guardianship Orders made by Court (Article 44)	0		0		0		0		0	**0**		0	0	0	0
9.6.d	Number of new Guardianships accepted during the year (Article 22 (1))	0		0		0		0		0	**0**		0	0	0	0
9.6.e	Number of Guardianships Renewed (Article 23)	1		0		0		0		0	**1**		0	0	0	0
9.6.f	Number of Guardianships accepted by a nominated other person	0		0		0		0		0	**0**		0	0	0	0
9.6.g	Number of MHRT Hearings in respect of people in Guardianship	0		0		0		0		0	**0**		0	0	0	0
9.6.h	Total number of Discharges from Guardianship during the reporting period (Article 24)	**MH Adults**		**LD**		**PHY DIS**		**OP**		**FCC**						
	Discharges as a result of an agreed multi-disciplinary care plan	0		0		0		0		0	**0**		0	0	0	1
	Lapsed	0		0		0		0		0	**0**		0	0	0	0
	Discharged by MHRT	0		0		0		0		0	**0**		0	0	0	0
	Discharged by Nearest Relative	0		0		0		0		0	**0**		0	0	0	0
	Total	0		0		0		0		0	**0**		0	0	0	1
ASW Register		**MH Adults**		**LD**		**PHY DIS**		**OP**		**FCC**						
9.7	Number of newly Approved Social Workers during year	5		2		0		0		0	**7**		3	7	4	2
9.7.a	Number of Approved Social Workers removed during year	2		0		0		0		0	**2**		4	4	4	8
9.7.b	Number of Approved Social Workers at year end (who have fulfilled Requirements consistent with quality standards)	22		4		0		0		0	**26**		32	38	40	37
9.9	How many times during the reporting period has the Trust notified the Office of Care and Protection under Article 107? **Stats also include Short Procedure Orders*	3		19		0		0		0	**22**		22	13	38	21
The Mental Health Order (NI) 1986 as amended by The Criminal Justice (NI) Order 1996. Article 50A(6). Schedule 2A Supervision and Treatment Orders																
9.10	the supervising officer in force at the 31st March	1		0		0		0		0	**1**		2	1	2	2
9.11	Of the Total shown at 9.10 how many have their treatment required as:	**MH Adults**		**LD**		**PHY DIS**		**OP**		**FCC**						
	Treatment as an in-patient	0		0		0		0		0	**0**		0	0	0	0
	Treatment as an out patient	1		0		0		0		0	**1**		1	1	2	2
	Treatment by a specified medical practitioner.	0		0		0		0		0	**0**		1	0	1	1
9.12	Of the total shown at 9.10 how many include requirements as to the residence of the supervised person (excluding in-patients)	0		0		0		0		0	**0**		1	0	0	0
9.13	Of the total shown at 9.10 how many of these supervision and treatment orders were made during the reporting period. Please advise of any issues presenting	0		0		0		0		0	**0**		1	0	0	0

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APPENDIX 1

HEALTH AND SOCIAL CARE BOARD

SOCIAL CARE AND CHILDREN'S DIRECTORATE

DSF - REGIONAL ACTION PLAN 2021/22 - YEAR END UPDATE - MARCH 2022

Programme of Care	Total Number of Issues	Red RAG	Amber RAG	Green RAG
Family and Children	10	3	4	3
Mental Health	8	0	4	4
Learning Disability	4	1	3	0
Older People and Adults	3	0	0	3
Physical Disability	2	0	1	1
Total	**27**	**4**	**12**	**11**

APPENDIX 1

Issue	Action Required	By When	Owner	Progress update at mid point - Sept 2021	Progress update at year end - March 2022	RAG Status
Children's Services						
1 Issue: Children with complex needs, inc. placement needs, short breaks and community supports and delayed discharges	Actions: • Disability Framework to be completed setting out comprehensive regional approach to supporting children with a disability and their families. • HSCB to establish a regional group and work with Trusts to progress remaining discharge plans from Iveagh. • HSCB to work with Trusts and Iveagh to review operational protocols for Iveagh to strengthen intake and discharge procedures • Regular monitoring of short breaks units to ensure service continuity through Heads of Service meeting	September 2021 Ongoing December 2021 On-going	Maurice Leeson, Programme Manager, Children's Services, HSCB (Social care lead Kieran McShane)	Framework completed and submitted to DoH Monthly meetings of working group being held with all Trusts and Iveagh. Meetings will continue. Work on operational protocols underway and will be completed on time Monitoring is a standing item on AD Disability group and Disability	Framework is completed and with DoH Policy for review. This group is established and continues to meet monthly Paper on new intake process has been prepared by Disability Sub Group. will be signed of in April 2022 Monitoring of short breaks is now a standing item on AD Disability group	

				Heads of Service meeting		
2 Issue: Placement Availability for Looked After Children	**Actions:** • Placement Options paper to be presented to CSIB by September 2021 and strategic plan to be established setting out priorities for action to address placement pressures and demand	Sept 2021	Judith Brunt, Programme Manager, Children's Services, HSCB	Placement Options Workshop held with Trusts in August 2021. Progress report paper and options being presented to CSLB in October 2021. Implementation Workshop with Trusts to be facilitated in November 2021.	Based on the outcomes of the paper priorities i.e. additional placements sought through bespoke arrangements, ECR placements, contingency arrangements for separated and unaccompanied children and increased bed capacity in Children's homes. Workshop in November did not proceed because a wider strategic whole system approach needed to be adopted. A further workshop was planned for April 2022	
	• ECR review paper to be completed by October 2021	Oct 2021		ECR Task and Finish Group established to progress recommendations from ECR Review. Action plan agreed and working to conclude by End Dec 21	ECR Task and Finish Group has concluded and the Action plan has been completed. The proposed Regional Trust Internal ECR process is to be reviewed for regional agreement and sign off by CSLB on 15th April.	
	• Review of Jointly Commissioned Supported Accommodation Projects to complete in September 2021	September 2021		Completed - Review Report and Recommendations to be presented to CSLB in November 2021	Review report presented to Assistant Directors Group and scheduled to be presented to CSLB at May 22 meeting.	

3 Issue: Provision of Services for Care Leavers	**Actions:** • Review of leaving / after care services to complete by March 2022	March 2022	Judith Brunt, Programme Manager	Terms of reference drafted for approval / circulation. Review commencing October 2021. Lead staff member identified to progress Review	Unable to progress due to workforce pressures and call back of lead staff member to the Trust on a part time basis.	
	• Structure to be established in each Trust for implementation of recommendations arising from Review of jointly commissioned projects to ensure best use of funded services and access to appropriate housing provision is in place.	January 2022		Will be established following sign off on the Review Report in November 2021	Implementation Plan to be developed in partnership with NIHE post May 22 sign off by CSLB.	
	• Regional Benchmarking forum for Leaving Care provision to be re-established as a vehicle for reviewing practice in line with statutory duties and for	January 2022		Regional Benchmarking Forum re-established with initial meeting scheduled for 12 October 2021. Review of Leaving Care Services includes examination of models of provision, delivery of services in line with statutory functions, capacity /	Ongoing and addressing standardisation of financial support to care leavers.	

	identification of unmet need			demand and service improvement. This Forum is a key structure to supporting the work of the Review.		
4 Issue: Complexity of Kinship Assessments leading to delays/backlog	**Actions:** • Reviewing demand/capacity across trusts	September 2021	Judith Brunt, Programme Manager	Snapshot data regarding demands / capacity collated in June 2021 across each Trust. Regular review of unregulated placement notifications and Trust liaison to ensure accuracy.	Ongoing monitoring of capacity and assessments for allocation across fostering (kinship / non-kin) and adoption. Trusts continue increase workforce capacity by exploring / identifying and use of independent social workers where appropriate and available. Children's services staff have also been offered additional hours to undertake assessments.	
	• Prepare an improvement plan	October 2021		Assurance and monitoring of action plan 1 x Trust through DSF process and Liaison meetings. 2 x Trusts engaged in change management process to align fostering teams better meet current demands. Regional agreement to continue use of streamlined fostering assessment reporting proforma to reduce bureaucracy when when presenting to	Further regional HoS workshop to be held in April 22 to review the assessment tools and reporting format for fostering (kinship / non-kinship). Trusts continue to report workforce pressures leading to capacity issues across their teams. Workforce/vacancies data capture across children's services is ongoing.	

				Trusts statutory fostering panels.		
	• Consider role of peripatetic team in supporting this work	January 2022		Proposal to develop peripatetic team / support staff within fostering has been highlighted within budget proposals/bids to DoH August 2021.	Budget allocation and prioritisation awaited from DoH.	
5 Issue: Unallocated cases	**Actions:** • ongoing work with the HSCT's to review and update the unallocated cases policy	October 2021	Judith Brunt, Programme Manager	Draft Unallocated cases Policy has been completed. A further T&F group is currently working to complete this policy within agreed timescales.	Unallocated cases Policy has been completed	
	• A preliminary unallocated cases template has been completed for the HSCT's to complete to monitor progress	July 2021		Progress has been made in respect of the Unallocated cases Template. Trusts are now submitting monthly returns since July 2021.	Monthly returns are sent through to the HSCB re unallocated cases. Ongoing pressures within the HSCT's re unallocated cases due to workforce pressures	
	• Ongoing work with the HSCT's re workforce challenges	On-going		Within Family and Childcare Services sufficient workforce remains a challenge In the recruitment and retainment of social work and family support staff. The HSCB has developed a return in	Workforce continues to be an extreme pressure within frontline teams HSCB maintain an overview of the pressures within the HSCT areas	

				relation to vacancies which is being monitored on a monthly basis all Trusts have developed specific action plans to improve the workforce. We continue to work with DoH and Trusts regarding the Social Work Strategy to improve capacity within Children's Services.	Each HSCT have developed an Action plan in relation to the pressures. This is escalated to HSCB, Trust Directors and Chief Executives.	
6 Issue: Children's Disability – thresholds to services	**Actions:** • Paper prepared and shared with all trusts for agreement on a regional approach.		Maurice Leeson, Programme Manager, HSCB (Social care lead Kieran McShane)	Paper has been prepared and is with Trusts for comment.	This is delayed as there is a capacity issue as Social care lead is off work and due to retire.	
7 Issue: Increase in young people being detained on admission to Beechcroft	**Actions:** • Establish monitoring process to track the trend and analyse what is happening to drive this increase • Standing agenda item on managed care network to determine what regional actions can be taken to address the issue	On-going in 2021/22	Maurice Leeson, Programme Manager, HSCB (Social care lead Paul Millar)	Monitoring process has been established through MCN. Now established as standing item on the MCN agenda for analysis and action	In 2021 the number of YP detained at point of admission rose to 36% compared to 10% on previous year. Impact of Covid has been cited as major contributing factor. Further data and analysis is required to determine if detentions are returning to pre-pandemic levels so this work will be ongoing. Systems and processes are now established to review data and inform service design.	

					MCN Clinical Director in post from 1/3/22.	
8 Issue: Breach of CAMHS waiting list	**Actions:** • Monitor numbers of referrals to CAMHS following reduction during 2020/21 due to impact of Pandemic • Regular monitoring of breach of 9 week target	On-going in 2021/22	Maurice Leeson, Programme Manager, HSCB (Paul Millar, Social Care Lead)	Monitoring process established to track numbers. On-going as part of AD CAMHS monthly meeting	By benchmarking Trusts it has been recognised that performance and breach positions vary. This has been raised in CAMHS managers meeting. Agreed that this needs further consideration in light of increased acuity and workforce pressures in some trusts. Planned workshop in March 2022 to review and discuss these issues had to be postponed. This will take place in first quarter of 2022/23.	
9 Issue: Waiting lists for Autism Services	**Actions:** • Meet with 3 Trusts where autism waiting lists are causing concern to understand the issues and establish plans for improvement. • Establish regular monitoring meetings with the Trusts where waiting lists are a concern • Review learning from trusts where waiting lists are not	On-going On-going for 21/22 December 2021	Maurice Leeson, Programme Manager, HSCB	Meetings with 3 Trusts have been held. Follow up monitoring meetings are planned Work on-going to establish regional	Work is being undertaken by the new Emotional Health and Wellbeing Coordinator to take forward learning with respect to those Trusts who are effectively manging their waiting lists. Further individual meetings have been held with all Trusts. This will include work on standardisation of processes. This work is informed also by the work of the regional	

	a concern to establish if a regional approach to the assessment process would address part of the problem			learning/regional model to apply to three Trusts	Emotional Health and wellbeing Framework group which includes all Trusts	
10 Issue: Workforce Vacancies	**Actions:** • Identify Regional Learning from recent recruitment campaign in the Northern Trust • Continue to monitor vacancies in childcare teams • Other actions as determined by the DoH Regional Workforce Review (not yet published)	Ongoing for 2021/22	Maurice Leeson, Programme Manager & Judith Brunt, Programme Manager		Data monitoring process has been established and is now producing regular data. Vacancies in children's disability services remain a significant concern in BHSCT/SEHSCT/WHSCT	

APPENDIX 1

Issue	Action Required	By When	Owner	Progress update at midpoint Sept 21	Progress update at year end March 22	RAG Status
Mental Health Services						
11 Issue: Mental Health social work vacancies DoH Mental Health Action Plan, Action 13.1, Initiate a review of mental health workforce subject to funding is outstanding	**Actions:** • Review role of HSCB in progressing outcomes of the workforce review • HSCB to continue to monitor and assess impact. • Other actions are determined by DOH review • Attend ASW Forum	March 2022	Lorna Conn, Programme Manager J Haslett SC Lead Ciara Quinn SC Lead	HSCB continuing to monitor and assess impact through DSF review meetings, attendance at ASW forum and through MCA monthly meetings with trusts.	HSCB continuing to monitor and assess impact through DSF review meetings, attendance at ASW forum, DSF processes and through MCA monthly meetings with trusts.	
12 Issue: Approved Social Work training places	**Action:** • HSCB to continue to explore potential of increase in training places • To review uptake with HSCTs of training and need for training • Attend ASW Forum	March 2022	Lorna Conn, Programme Manager J Haslett SC Lead Ciara Quinn SC Lead	ASW Quality Standards have published by DoH specifying number of ASWs required per trust DSF meetings with 5 Trusts focus on the monitoring the update of training places and the required numbers.	Attendance at ASW forums Continued monitoring of HSCT training places required.	

13 Issue: Acute Inpatient Bed pressures	**Actions:** • Establish a Regional Bed Management Network. • Set up a regional Bed Capacity Co-ordinator Forum. • Develop and progress a Bed Capacity Action Plan. • Deliver key actions set out in the 'Briefing Paper on Acute Mental Health Bed Pressures In Northern Ireland'.	In line with the Mental Health Strategy Implementation Plan – Yearly Plan – to end March 2022 (initially).	Lorna Conn, Programme Manager Martina McCafferty, SC lead	Regional Bed Manager appointed and Regional Bed Network and Capacity forum established. Action plan being developed aligning key recommendations from multiple relevant sources.	Daily huddles re bed flow established. Regional Bed Management Protocol for Acute Psychiatric Beds is being finalised for issue 31 March 2022 Mental Health Dashboard for Acute Services is underway –reporting bed state and acuity.	
14 Issue: Rebuild and Recovery from Mental health surge due to COVID-19 pandemic	**Actions:** • Implementation of Rebuild and Recovery Plan • Continue to monitor daily levels of demand reported daily via Regional Daily Bed Management return • Discussed at weekly COVID-19 Asst. Director meetings and	To end March 2022 (initially).	Lorna Conn, Programme Manager Martina McCafferty, SC Lead John Doherty Bed Manager	MH Surge plan modelling is being progressed & MH surge modelling analysis undertaken Rebuild plan is closely monitored via fortnightly meetings with Trust ADs. Regional Bed Manager appointed and Regional	Action plan monitored via MHLD Leadership Board. Analysis of surge will be carried out using end March 2022 NIMH and NIPT mental health metric returns.	

	monthly Adult Mental Health Group - chaired by HSCB • Progress the 'Regional Mental Health Surge & Rebuild Plan* 2021-26' and 'Regional Mental Health Acute Bed Pressures in Northern Ireland'.			Bed Network and Capacity forum established.		
15 Issue: Mental Capacity Act **Cross cutting Issue- C&YP; OPS & MHLD**	**Actions:** • Regional Implementation of MCA including DoLS Provisions. • Analysis of Assurance reports and actions plans as received as from HSCTs. • Liaison between HSCB SCCD and CSWO Sean Holland as to Trusts positions and issues impacting upon implementation. • HSCB to write an overview paper of all training needs. • Chairing of the monthly Strategic	March 2022	Lorna Conn, Programme Manager DoH & HSCTs J Haslett (MH & LD) Ruth Donaldson OP Kieran McShane C&YP	Monthly meetings have been established chaired by HSCB. IPTs administered – 2 Trusts have returned as at October 21. Training paper has been completed. Links with Integrated care made. Progress monitored via Strategic Advisory Group meetings, DSF meetings and POC AD meetings	Continual monitoring of HSCT progress via Strategic Advisory Group meetings, MCA Multi-agency meetings and analysis of HSCT Assurance Returns and associated action plans. Monitoring also includes DSF meetings and POC AD meetings	

	advisory group has been established led by HSCB which reviews compliance. • Review Trust action plans for compliance • Administration and oversight of MCA IPTs.					
16 Issue: Mental Health Carers assessments	**Action** • Continue to monitor numbers offered and uptake and work with Trust to improve data accuracy • Chair and review above at quarterly DSF meetings • HSCB continue to monitor update of carers assessments and work with Trust to standardise and improve data accuracy.	March 2022	Lorna Conn, Programme Manager Joy Peters Martina McCafferty, SC Lead 2 new SC leads	HSCB continuing to monitor and assess data and impact through quarterly DSF review meetings.	HSCB continuing to monitor and assess data and impact through quarterly DSF review meetings.	
17 Issue: Insufficient Community Placements/Resources	**Actions:** • Represent the HSCB on the MHS Strategic Board and	March 2022	Lorna Conn, Programme Manager	HSCB is represented on the MHS Strategic Board and the relevant work streams	Investments provided and attendance at MHS Strategic Board	

	the relevant work streams • Provide financial investments through IPTs and monitor spend.		Martina McCafferty SC lead	Investments provided to support development of community resources		
18 Issue: Admissions to Mental Health beds for people with dual diagnosis	**Actions:** • To implement the recommendations of the Substance Misuse Strategy	March 2022	Lorna Conn, Programme Manager Martina McCafferty, SC Lead Julie Haslett SC Lead	New Strategy developed for Substance Misuse which along with MH Strategy will help shape how services need to work collectively to meet need. A Regional Strategic Planning Group chaired by HSCB/PHA is being established to identify the priorities and how to best progress these.	Regional Strategic Planning Group for Substance Use has identified that Co-occurring mental health and substance use should be considered within separate working group as a priority. Further work is planned.	

Issue	Action Required	By When	Owner	Progress update at mid point Sept 21	Progress update at year end March 22	RAG Status
Learning Disability Services						
19 Issue: Insufficient Learning Disability Beds	**Actions:** • Monitor levels of demand and progress discharges • Attend and chair a MAH focused Resettlement meeting to progress discharges • Completion of New model and care pathway for	March 2022	Lorna Conn, Programme Manager J Haslett SC Lead Caroline McGonigle, SC lead	Monthly meetings between the HSCB and BHSCT / SEHSCT / NHSCT. Review the HSC Action Plan on a bi monthly basis with the DoH. (ongoing) Attend Community integration Meetings on a monthly basis. HSCB chairs the Regional Learning Disability Operational Delivery Group on a monthly basis. Engaged specific resource from Leadership centre to drive resettlements forward (October 2021) Significant research and engagement undertaken to co-produce proposals for the new model of community provision.	The need for Trusts to expedite resettlements was also discussed at DSF meetings (autumn and Spring) and reflected in updated action plans as appropriate Proposals have been sought from Trusts with respect to resettlement.	

	community assessment & treatment • Support and monitor progress of 3 Bedded Unit In NHSCT and re-configuration of Beds in MAH			Consolidation of work to date and analysis of resources required to complete this. Successful application made to June Monitoring rounds to step up 3 inpatient beds on Holywell Site for access by NHSCT and SEHSCT. (June 2021) DSF process utilised to ensure trust action plans were updated to reflect the need to expedite resettlement and discharges from hospitals as well as step up acute provision on MAH site (June 2021)		
20 Issue: Insufficient Community Placements/Resources	**Actions:** • To bring forward proposals for future Learning Disability service provision in Tier 4.	To end March 2022 (initially)	Lorna Conn, Programme Manager Julie Haslett, SC Lead Caroline McGonigle SC lead	Significant research and engagement undertaken to co-produce proposals Consolidation of work to date and analysis of resources required to complete this.	Paper is being finalised by 31 March 2022 for consideration by Director .	

	• Following approval of LDSM by DoH consider if a Public Consultation is required. • Forward proposal for approval by senior personnel within DoH and the Minister.		Una Cushnahan Project manager	Timescales for the Public Consultation need to be considered. Fortnightly meetings with Assistant Directors and monthly meetings with MHLD Improvement Board.		
	• Finalise the "We Matter" Learning Disability Service model Delivery Plan 2021-2024. • Submit the Model to the DoH for approval. • Following approval SCCD will develop an implementation plan.			Submission to DoH of LDSM and the Strategic Delivery Plan with costings in July 2021. Presentation and follow up of submission of LDSM with DoH provided on 5 October 2021. HSCB await approval from DoH	Completed July 2021	
21 Issue: Implementation Of DOLs Mental Capacity Act	**Actions:** • Regional Implementation of MCA including DoLS Provisions. • ~~Clear overview of current Trust positions and barriers to full implementation,~~	March 2022	Lorna Conn, Programme Manager Julie Haslett SC Lead	Monthly meetings have been established chaired by HSCB. IPTs administered – 2 Trusts have returned as at October 21 Training paper has been completed.	Monitoring work is ongoing through monthly meetings and DSF processes. All IPTS have been reviewed and funding allocated	

	~~facilitating regional discussion and decision making~~. • Chairing of the monthly Strategic advisory group has been established led by HSCB which reviews compliance. • Review Trust action plans for compliance • Administration and oversight of MCA IPTs.		Caroline McGonigle, SC Lead Ruth Donaldson OP Kieran McShane Children YP	Links with Integrated care made. Progress monitored via Strategic Advisory Group meetings, DSF meetings and POC AD meetings		
22 Issue: Recruitment of workforce in general and specifically to ASW; STD Approvers and IO/DAPO roles.	**Action:** • Review role of HSCB in progressing outcomes of the workforce review • HSCB to continue to monitor and assess impact on service delivery through Strategic advisory group and ASW forum • Deliver on other actions which are	March 2022	Lorna Conn, Programme Manager Martina McCafferty, SC Lead Julie Haslett, SC Lead Ciara Quinn, SC Lead Caroline McGonigle , SC Lead	HSCB continuing to monitor and assess impact through DSF review meetings, attendance at ASW forum and through MCA monthly meetings with Trusts.	HSCB continuing to monitor and assess impact through DSF review meetings, attendance at ASW forum, DSF processes and through MCA monthly meetings with Trusts.	

	determined by DOH review for HSCB		Also applies OPS			

Issue	Action Required	By When	Owner	Progress update at mid point Sept 21	Progress update at year end March 22	RAG Status
Older Peoples Services						
23 Issue: Care Homes **Monitor impact of COVID 19 pandemic on care home residents and work with HSC Trusts and providers to alleviate this impact wherever possible:**	**Action:** ▪ Develop revised Covid-19 Care Home Action Plan in partnership with Trusts and PHA.	August 2021	David Petticrew, Programme Manager Older People, Physical Disability and Sensory Impairment, HSCB	Completed August 2021		
	▪ Devise reporting arrangements on stakeholder compliance with Actions in plan.	September 2021		Completed September 2021		
	▪ Ensure Social Care attendance and contribution to weekly Covid Care	July 2021/ ongoing		Ongoing		

<table>
<tr><td></td><td>Home Cell meetings</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>▪ Keep actions on agenda of AD Forum for review and response.</td><td>Ongoing</td><td></td><td>Ongoing</td><td></td><td></td></tr>
<tr><td>24 Issue: Mental Capacity Act

Ensure all legacy DoLS assessments in care homes are completed</td><td>Actions:

▪ Review HSC Trusts Action Plans via the MCA Regional Strategic Advisory Group Meetings. Meetings Chaired by SCCD</td><td>Ongoing</td><td>David Petticrew, Programme Manager, Older People, Physical Disability and Sensory Impairment, HSCB

Ruth Donaldson</td><td>The legacy position for each Trust is discussed at each MCA Regional Strategic Advisory Group Meetings.</td><td>Improved position as of 31st Jan 2022 – Source OAGNI
Legacy Cases
<table><tr><td></td><td>TRUSTS TO COMPLETE</td></tr><tr><td>Trust</td><td>Total No. Existing Legacy Cases</td></tr><tr><td>Belfast</td><td>0</td></tr><tr><td>Northern</td><td>0</td></tr><tr><td>South Eastern</td><td>35</td></tr><tr><td>Southern</td><td>82</td></tr><tr><td>Western</td><td>84</td></tr><tr><td></td><td>201</td></tr></table></td><td></td></tr>
<tr><td></td><td>▪ Monthly MCA meetings now established to</td><td>Monthly/ ongoing</td><td></td><td>The legacy Action Plan has been developed and</td><td>The DoH subsequently developed a regional MCA Progress Report</td><td></td></tr>
</table>

	focus on progress and legacy cases outstanding with updated information/ expected date of completion being reported by Trusts.			is with HSCTs and DOH for consultation.	which includes reporting on legacy cases. In situ from Nov 2021. Progress Report seeks information on legacy care homes/supported living cases (phase 1) and also legacy day care (phase 2). Trusts now advise they are MCA compliant.	
	▪ Standing agenda item at mid-year DSF meetings tabled for Oct 2021 and Feb 2022.	October 2021		Trust Assurance Reports sought from DOH and circulated within Older People Team. On-going	As above	
25 Issue: Domiciliary Care Capacity **Develop and maintain domiciliary care capacity and resilience.**	**Actions:** ▪ Devise Covid-19 Domiciliary Care Action Plan and develop processes for monitoring and assuring compliance	August 2021	David Petticrew, Programme Manager, Older People, Physical Disability and Sensory Impairment, HSCB	Completed (September 21)		
	▪ Work with Trusts via OPLB and AD forum to ensure Direct Payments are simplified and uptake promoted to	Ongoing		Completed (September 21)		

	create wider sector capacity.					
	▪ Submit funding bid to DOH for additional funding to address waiting list inescapable pressures	August 2021		Completed (August 21)		
	▪ Progress regional pilot work of SEHSCT and BHSCT via IPT investments and take steps on outcome of this work.	March 2021		IPTs completed August 21 – on-going		
	▪ Devise a system for Trust regular reporting of domiciliary care unmet need (full and partial)	December 2021		Completed January 2022		

Issue	Action Required	By When	Owner	Progress update at mid point Sept 21	Progress update at year end March 22	RAG Status
Physical and Sensory Disability Services						
26 Issue: Acquired Brain Injury – insufficient community placement/supports	**Actions:** ▪ Meet with Supporting People	December 2021	David Petticrew, Programme	To be progressed	Date for meeting agreed for 30th March 2022.	

	Thematic Group to explore housing options for people with acquired brain injury		Manager, Older People, Physical Disability and Sensory Impairment, HSCB Jane McMillan			
	▪ Carry out scoping options work with Trusts re current resources available and potential for cross-Trust collaborations.	March 2022		To be progressed	To be progressed following meeting with NIHE Supporting People.	
27 Issue: Complex Discharges across Adult Service areas	**Actions:** ▪ Scope current cost pressure and complexity needs with Trusts.	July 2021	David Petticrew, Programme Manager, Older People, Physical Disability and Sensory Impairment, HSCB Jane McMillan	Completed August 21		
	▪ Submit funding bid to DOH for	August 2021		Completed August 21		

	'inescapable pressures' around the issue of high cost/ complex care packages.					
	▪ Review robustness of Trust systems for submitting/ validating pressures in this area.	December 2021		On-going	HSC Trusts Physical Disability Leads and HSCB reviewed existing processes and systems re: management of enhanced tariff care home placements and high cost cases (August 21) Information shared with LD team to inform review of the Muckamore action plan (October 21)	

RAG Rating	
Completed/Confident of Delivery on Actions	
Work in progress and on track for completion within agreed timescales	
Not Complete/ Not on track for completion within agreed timescales	

The above Regional Action Plan is reviewed and updated at Directorate Accountability Meetings in September and March.

This is to confirm that the above Action Plan has been reviewed and signed off by the Directorate of Hospital and Community Care Directorate Management Team on 18/07/22*. Any outstanding issues requiring further progress will be presented alongside any new and emerging issues in the 2022/23 Regional Action Plan.

Signature: _____ (Brendan Whittle)

(Director of Hospital and Community Care)

Date: 18th July 2022

* In Attendance at the Directorate Management Team meeting:

Brendan Whittle, Director
Catherine Cassidy, Deputy Director
David Petticrew, Deputy Director
Roisin Doyle, Programme Manager, Older People, Physical Health and Sensory Impairment Services
Lorna Conn, Programme Manager, Mental Health and Learning Disability Services
Una Lernihan, Programme Manager, Children's Services
Maurice Leeson, Programme Manager, Children's Services
Michaela Glover, Head of Social Work Governance

MAHI - STM - 097 - 5732

BHSCT DSF ACTION Plan 2021/22 - YEAR END UPDATE MARCH 2022

Programme of Care	Total Number of Issues	Red RAG	Amber RAG	Green RAG
Family and Children	10	0	8	2
Mental Health	1	0	0	1
Learning Disability	7	3	2	2
Older People and Adults	6	1	2	3
Physical Disability	2	0	0	2
Total	**26**	**4**	**12**	**10**

Issue	Action Required	By When	Owner	Progress Update	RAG Status
Family & Childcare Issues					
1. Issue: Early Years inspections In order to undertake the 355 outstanding inspection as well as the additional inspections the Trust will follow Departmental and HSCB guidance as it evolves. Due to covid restrictions Trust have only been permitted to undertake one inspection per day, per SW. Trust to provide an Action Plan outlining timeframes to complete backlog (31/07/21) Trust to update HSCB Lead monthly on progress. **Discussion at DSF meeting 25.6.21** Outside of Covid period, the Trust advise the Early Years team have managed their inspection process well. With lifting of restrictions, the team have been able to increase inspections. Backlog now sits at 232.	**Actions:** • Trust to provide an action plan detailing how the remaining backlog will be resolved.	31/07/21	Edel McKenna Co-Director Early years and Safeguarding	**Update 13.12.21** Action plan received on 03.12.21, detailing current position of 47 outstanding inspections which are now allocated and due to be completed within the reporting period. Meetings continue fortnightly with Una Lernihan, Social Care Commissioning Lead to review Covid related issues and pressures and to monitor actions both regional and Trust specific. **Update 14.03.22** Regional meeting forums continue with HoS and Una Lernihan. The remaining backlog assessments have been allocated and are	

Trust report a trajectory to clear backlog by Nov 2021				nearing completion. Action deemed completed.	
	• Trust to clear backlog by November 2021	30/11/21	Edel McKenna Co-Director Early years and Safeguarding	**Update 13.12.21** See above **Update 14.03.22** See above	
2. Issue: Children with a disability - short breaks availability / numbers on child protection register The HSCB notes: • Trust have reported no CWD on the CPR • Trust report the highest number on ASD waiting list • Trust report highest per capita SEN statements • Trust report highest level of Children on high level DLA. • Trust report a decline in number of CWD but increase in pressure in this area HSCB and Trusts are still unaware of the consequences or impact arising from the Girvan case relating to	**Actions:** • Trust to provide Action Plan in relation to the management of Autism waiting list	31/07/21	Sarah Meekin Head of Psychology	**Update 13.12.21** Update required from ASD service. **Update 14.03.22** Deputy Executive Director of Social Work (Eileen McKay) had met with and acquired update from the ADS service. They are projected to deliver on commissioned assessment activity (600 p.a.) following COVID19 restrictions. Diagnostic rate is 95% following triage which would indicate	

Educational application to the MCA and this will need to be kept under review. **Discussion at DSF meeting 25.6.21** Relevant staff from Autism service were not at the meeting and therefore the detail could not be provided Children with short breaks (LD services) – Trust have not met their statutory functions in relation to provision of short breaks. Willow lodge is continued to be paused. Trust have accessed an ECR placement. Unit child is discharged the Trust will be unable to effect short breaks. Trust have plans in place to step up levels of support to other families requiring short breaks, inc. Increase in Social Work support, SDS. Currently 11 children with disability on CPR as of June 2021. The Trust are not able to lift data from Paris and rely on manual lift. The Trust advise they are satisfied with their threshold decisions regarding Child Protection within CwD teams.				appropriate referral and triage processes. BHSCT intervention WL < 13 weeks. Level of demand continues; upward trend is projected at 883 p.a. for 21/22. This is in addition to WL created by historical capacity/demand gap and COVID19 impact.	
	• Trust to provide report to the HSCB outlining mitigations in place in terms of levels of support in absence of short breaks	31/07/21	Edel McKenna Co-Director Early years and Safeguarding	**Update 13.12.21** Action plan update received on 03.12.21. There is acknowledgement of the pressures for families in the community who are struggling with reduced service provision as a result of the pandemic and also the impact of changes to educational programmes / in schools. The Trust advised engagement with relevant families continues; They have	

				been able to step up face to face contact and provide additionality via Community and Voluntary partners. The Trust has also increased self-directed support payments. **Update 14.03.22** Action plan update received 22.03.22 which outlines ongoing use of SDS, Article 18 payments and increased contacts with families through community and voluntary partners. Co-Director advised that mitigations remain in place with short breaks being paused. Two pre-action notices have been received. One concluded without progression to full Judicial Review. The second is more recent – outcome awaited.	
	• Trust to provide action plan outlining how they	31/07/21	Edel McKenna	**Update 13.12.21**	

	are re-instating short break capacity by October 2021		Co-Director Early years and Safeguarding	Updated action plan received 03.12.21. Challenges remain – Willow Lodge continues to be paused in respect of short-breaks. Care planning continues in relation to the child remaining in Willow Lodge at present; ECR agreed. Use of Forest Lodge is being addressed in consultation with RQIA and some adaptations may be required. Forest Lodge Staff are redeployed to assist with Trusts Covid response. Workforce pressures for both facilities are acknowledged. Staffing recruitment continues for Willow, Forest Lodge and Somerton Rd. **Update 14.03.22** The Trust advised that funding for an	

				appropriate single occupancy ECR placement was secured and Article 33 granted for the young person currently in the short breaks facility. This placement offer has since been rescinded due the young person's refusal to move. Alternatives are being sourced. Current situation remains challenging in relation to young person's behaviours and needs being met within the home. Exploration of alternatives (Forest Lodge) to reinstate short-breaks has not been achieved due to workforce pressures. Revised 3 month target has been outlined for moving young person to an appropriate long-term placement and thereafter repairs to	

				the home and return of staff team is required. Revised timeframe - June 22. Action plan update received 22.03.22	
	• Trust to examine their data reporting in relation to CwD to ensure appropriate reporting	30/09/21	Edel McKenna Co-Director Early years and Safeguarding	**Update 13.12.21** Data lifts and PARIS system updates are ongoing. **Update 14.03.22** Previous manual return has been problematic. Children's information manager has established a new reporting system under PARIS. This is fully operational and final testing against quality assurances measures will be completed at end of March. Action deemed complete.	

3. Issue: Personal Advisors 109 young people did not have a personal advisor appointed at 31st March 2021. This is a key role for this group of very vulnerable young people Trust to provide action plan outlining steps/measures taken to ensure all young people have a personal advisor (01/07/21) **Discussion at DSF meeting 25.6.21** HSCB would request an analysis of Leaving Aftercare/SAI's to identify unmet need and the impacts on young people. Trust are reviewing 18+ teams with a view to changing to16+. They are also working with Paris to appropriately identify yp requiring a PA. Trust reviewing case closures monthly which all assists in projecting numbers of yp coming into the service.	**Actions:** • Trust to provide an action plan outlining how they are to reduce this figure (to include: staffing levels, data collection and forecasting)	01/07/21	Kerrylee Weatherall Co-Director Corporate Parenting	**Update 13.12.21** Action plan received and update requested by end January 22 for period to 31.12.21. September's data showed reduction from 109 to 63 young people with no PA appointed. Unfortunately some of the Band 4 staff that were recruited have moved on and the figure is currently 72. The PARIS system review continues to allow for data pulls and trends to be overseen easily. These have been forwarded to the HSCB monthly. The Band 4 Staff in the LAC teams to reduce pressures remain at risk to the Trust as unfunded posts. The 16+ young people assessed as low risk /	

				stable with no SW are being managed through the Trusts duty system. **Update 14.03.22** Action plan update received 11.03.22. Service model review paper, process map and action plan monitoring template received. Unallocated cases figures have fluctuated across previous months in relation to PA support staff which correlates to workforce absences. Recruitment to vacant posts continues.	
	• Plan to outline timeframes and outline projected reduction in waiting list	01/07/21	Kerrylee Weatherall Co-Director Corporate Parenting	**Update 13.12.21** See above update. Closures completed Nov 21 and young people assessed as low risk are managed via the Trusts duty system. **Update 14.03.22** Recruitment process ongoing (at short-listing	

				stage). Previous vacancies filled however, some moved to alternative posts and those filled via temporary staff / agency have not provided level of stability the service requires. Overall significant workforce challenges remain. Vacancies and unallocated cases being reported via HSCB monthly returns.	
	• Trust and HSCB to undertake a review of SAI's	Review period 01/09/21 – 30/10/21	Kerrylee Weatherall Co-Director Corporate Parenting	Update 13.12.21 DoH review was completed. Three SAI's have been allocated to an independent consultant for review. Trust plan to further review those YP who are known to Mental Health services and SAIs to be completed. **Update 14.03.22**	

				Two independent associates have been identified and are being trained for undertaking this specific role. Triaging of priority cases for immediate learning has been completed. Governance system in place to identify SAIs in timely manner.	
4. Issue: Unallocated cases/Named Social Worker 35 young people did not have a named social worker at 31st March and team members via a duty system were undertaking their statutory visits. This impacts significantly on the development of a meaningful relationship between social worker and young person which is a key support for every looked after child. Unallocated cases at time of DSF meeting June 21: LAC - 17 CwD – 83 FS – 19	**Actions:** • Action plan from the Trust to explain how they are ensuring each child looked after has a social worker, receives statutory visits and statutory reviews	31.08.21	Kerrylee Weatherall Co-Director Corporate Parenting	**Update 13.12.21** Action plan received and further updated on 26th Oct 21. Update to be forwarded for period to end Dec 21. The figure in Oct = 60 LAC cases with unallocated SW who are being managed via the Trusts duty system. The Trust reported their unallocated cases across Children's Services Oct 21:	

Gateway – 10 Total: 129 (an increase of 13 from March 21) **Discussion at DSF meeting 25.6.21** 2.5 staff were brought in to LAC, current unallocated in LAC this is now 0. FS/Gateway – Trust have been unable to meet their statutory function in allocation of a SW to children. Trust submit monthly returns submitted. Figures above are correct. CwD, 4 SP's allocated from IPT monies. Gateway/FS, there has been an increase since March 2021. Trust report these figures are manageable. No actions identified for unallocated cases.				LAC- 60 CwD – 173 FS - 81 Gateway - 60 Monthly returns continue to be submitted to the HSCB in respect of unallocated cases and workforce pressures. The Trust have escalated workforce pressures to their Trust Board and is recorded on the Trusts risk register. A meeting was held in respect of current issues across Children's Services (workforce, unallocated cases, placements, short-breaks, complexity of need etc.) with DoH and HSCB on 28.10.21. **Update 14.03.22** See above mitigations to increase workforce capacity within LAC teams. LAC unallocated numbers are:	

				124 - end January. 86 - end February. The Trust reported significant workforce challenges with 56% absences across children's disability teams and combined children's services absence of 33% in February. The Trust are noting an increase of referrals across Tier 2 and 3 services which compounds current difficulties. The unallocated cases are noted as follows(end January): LAC- 124 CwD – 273 FS - 131 Gateway - 88 The Trust outlined the governance system in place across Gateway to review and prioritise allocations and further action to bolster FIS	

				teams via transfer of appropriate cases identified staff in family centre. This process is overseen by principal practitioners. A second principal social worker post has been created to strengthen management structure for children with disabilities alongside the previous 4 x B7 Senior Practitioner roles from the unallocated cases transformation funding. Monthly returns continue to be submitted to the HSCB in respect of unallocated cases and workforce pressures.	
5. Issue: Statutory Visits 72 statutory visits did not take place within the regulatory timescales.	**Actions:** • Action plan from the Trust to explain how they are ensuring each child looked after has a social	31.08.21	Kerrylee Weatherall Co-Director Corporate Parenting	**Update 13.12.21** The Trust advise that both statutory visiting and statutory reviews	

Discussion at DSF meeting 25.6.21 Refer to discussion at Unallocated section	worker, receives statutory visits and statutory reviews			have been impacted by workforce challenges. The figures for October show that 18 visits and 35 LAC reviews did not take place within timescales. **Update 14.03.22** The Trust report that for January 22, there were 12 statutory visits and 41 statutory reviews that did not take place within timescale. As per the Trusts business continuity plan there has been a move to a blended approach of face to face and virtual visiting. LAC Reviews that have not taken place are re-scheduled within 4 weeks. Using the workforce appeal, an out of hours LAC team (with appropriate governance structure) has been established to	

				cover some unallocated cases. Colleagues across children's teams are undertaking statutory and reviews. The additional LAC team that was created (funded by the Trust at risk), now has a Team Leader via the retire and return scheme. The Senior Management Team meet on a monthly basis to monitor progress, manage risks and target action where necessary.	
6. Issue: Statutory reviews 94 statutory looked after children reviews did not take place within the required timescales. **Discussion at DSF meeting 25.6.21** Refer to discussion at Unallocated section	**Actions:** Action plan from the Trust to explain how they are ensuring each child looked after has a social worker, receives statutory visits and statutory reviews	31.08.21	Kerrylee Weatherall Co-Director Corporate Parenting	**Update 13.12.21** See above. **Update 14.03.22** See above	
7. Issue:				**Update 13.12.21**	

Placement Moves for children 117 children experienced a move in placement during the reporting period. **Discussion at DSF meeting 25.6.21** Trust are managing very complex situations, including younger children coming into care. Trust are increasing recruitment, wrap around support, edge of care services. However despite this, the Trust are struggling to manage their looked after population and adequately responding to their needs. HSCB are satisfied with actions being taken by the Trust and therefore do not require this to be taken forward as a specific action. Will be considered as part of the review of LAC services as outlined in 'Unallocated/Stat Visits/Stat Review' above	**Actions:** • **No actions required – included for information only.**			Currently there are 913 children in care in Belfast Trust. The increase in number of LAC and in fostering breakdowns has been noted by the Trust. Additional support from utilisation of B4 staff (unfunded posts /at risk) and packages of support from Community and Voluntary partners has been put in place E.g. additional timeout with Extern for fragile foster placements (35 families have been in receipt of this service/support) and there is a bid submitted via Covid monitoring process ref: same. Challenges remain and pressures within fostering service have been highlighted. The Trust are reviewing their unallocated	

				fostering placements and vacancies in the fostering team. In addition, LAC TSS pressures also shared with HSCB on 08.12.21 and an escalated meeting with HSCB programme manager has been requested. **Update 14.03.22** Fostering team are seeking to improve capacity to complete assessments utilising sessional staff from the independent sector providers and from internal trawls across existing children's teams for additional hours.	
8. Issue: Iveagh delayed discharges **Discussion at DSF meeting 25.6.21** Operational policy requires review during 2021/22	**Actions:** • Review and amend Operational Procedures to prevent future delayed discharges	30/09/21	Tracy Kennedy Co-Director Adult Learning Disability	**Update 13.12.21** Update to be requested from Adult LD service. Process ongoing with AD CwD group and Independent Review are looking at some of the ongoing issues.	

				Iveagh and Beechcroft are included in DoH regional review of Children's Services. The importance of good working and strengthened links between Adult and Children's services was highlighted in relation to Iveagh. A Judicial review is ongoing regarding 1 x YP in Iveagh at present. **Update 14.03.22** Young person remains in Iveagh and Judicial Review hearing is scheduled. Trus continue to work to navigate the issues presenting. Further update should be sought via DSF meeting for LD Services - (Tracy Kennedy Co-Director Adult Learning Disability).	
9. Issue:				**Update 13.12.21**	

Increase in numbers on Child Protection Register March 20 = 251 March 21 = 335 An increase of 84 (33%) Regionally March 2020 = 2,298 March 2021 = 2,298 **Discussion at DSF meeting 25.6.21** Trust undertook an analysis of thresholds, and were satisfied with decision made.	**Actions:** • **No action required – included for information only**			Trust advise that Child Protection Register figures remain fairly static. As of 10.12.21 the figure was 347. **Update 14.03.22** Current figures are 344. Increase of 9 noted from March 21.	
10 Issue: Increased numbers of Looked After Children March 2020 = 866 March 2021 = 875 An increase of 9 (I %) Regionally March 2020 = 3,383 March 2021 = 3,530 An increase of 147 (4%) **Discussion at DSF meeting 25.6.21** Trust undertook an analysis of thresholds, and were satisfied with decisions made.	**Actions:** • **No Action required – included for information only**			**Update 13.12.21** Trust advise ongoing upward trajectory in respect of LAC figures which is now = 913. Action planning and reporting remains regional issue. Further work ongoing via AD Corporate Parenting Forum and actions agreed from Regional HSCB workshop on 06.08.21.	

				See Issue on Placement Moves above for further detail. **Update 14.03.22** Upward trajectory continues which causes significant demands on teams and regarding care placement availability. The number of looked after children has increased to 946 (8.1% since March 21).	

Issue	Action Required	By When	Owner	Progress Report	RAG status
Mental Health Issues					
11. Issue: Continuing difficulties faced by the ASW service in fulfilling requirements under the Order as detailed in 2.1b • Conveyance difficulties • Significant delays in Out of Trust admissions • Access to on call manager after 5pm for ASW staff. **Discussion at DSF meeting 25.6.21** Trust have adopted a conveyance pilot. There is a protocol in place to reduce delays. Trust report this has been a	**Actions:** • Trust to update HSCB on governance arrangements with conveyance protocol now in place	Update at each HSCB/Trust interface meeting	Mary O'Brien DSW Mental Health	**Update 3/3/22** Conveyance protocol is in place	
	• Out of Trust admission delay to be raised at Regional Bed Management meeting	Update at each HSCB/Trust interface meeting	Julia Lewis Co-Director of MH	**Update 3/3/22** Actioned and work ongoing within the Regional Bed Capacity Co-ordinator group through daily huddle process	

positive development. HSCB note potential learning across Trusts. Out of Trust admissions. There is a delay in accessing Consultants for admissions. Some Trusts have introduced a further layer to admissions (to contact an ASM in order to get in contact with a Consultant). On call manager at 5pm. Trust have arrangements in place, HSCB are satisfied and do not require any further actions carried forward.					

Issue	Action Required	By When	Owner	Progress Update	RAG Status
Learning Disability Issues					
12. Issue: Domiciliary Waiting List There are 12 service users on the waiting list for domiciliary care within Learning disability. This presents a potential risk to service users as the Trust is unable to meet their assessed needs in a timely way. This can also impact on carer stress levels **Discussion at DSF meeting 25.6.21**	**Actions:** • Trust to provide an action plan outlining the mitigating measures put in place, to include role of care manager in monitoring unmet need	31/08/21	Magda Keeling, Service Manager	**Update 29.10.21-** • There are currently 11 service users awaiting packages. • The project group introduced time bands which increased flexibility for Providers and enabled them to offer more packages. The time band is for example, 7am –	

Currently 15 people on the waiting list. Trust have introduced time bands for care packages and are encouraging uptake of SDS. Cases are kept under review by Care Manager regularly. Needs are re-assessed as part of monitoring process.				8.59am or 9am – 10.59am and if a Provider can offer a call in that time band, for example 7.45am, the call can then be delivered anywhere between 7.15am and 8.15am. • Unmet needs audit is carried out on a monthly basis to ensure that all packages on the Care Bureau Circulation list are still required. • Care Managers check with key workers that packages are still required. • Key workers maintain contact with service users and carers to determine how well they are managing in the absence of a package. Frequency of contact is determined	

				individually but is at least monthly • Key workers offer supports to families, for example, SDS/ Direct Payments, carer assessments etc. • Key workers inform Care Managers when circumstances deteriorate and package needs to be escalated. • Care Managers participate in escalation calls twice weekly to try to prioritise urgent cases. This is sometimes successful, but it is dependent on how many packages are required for hospital discharges and palliative care, which are always prioritised. • Even if packages reach the escalation	

				list, there still continues to be difficulties securing packages, particularly in East Belfast where several providers are in contingency and only able to provide packages to existing urgent calls. **Up-date at DSF meeting 09.12.21:** Trust confirmed considerable work undertaken by project group, flexibility re time band had some positive impact. Currently 11 service users requiring dom packages. Trust continues to work with families to explore direct payments, offer carer's assessments, carer grants, short breaks and explore community and voluntary options as appropriate. Trust to continue to monitor issue. Service users reviewed at least monthly. Rag rating agreed to remain amber.	

				Update at DSF Meeting 04/03/22: Rhoda McBride updated that the Trust continue to work with service providers, families, C&V groups in an attempt to resolve this issue. Given the impact of the COVID pandemic, reduction in short breaks and Day Centre attendance, demand for domiciliary care appears to be outstripping supply. However, despite remaining solution focused the situation has exacerbated. Currently 21 service users with a Learning Disability require a domiciliary care package. Service users continue to be reviewed monthly and unmet need continues to be flagged through appropriate channels. Rhoda noted that currently there were severe staffing issues in Community Learning Disability Teams. This issue is on the Trust Risk Register, 4 Team Leaders and 8A staff have left. In MAH two Social Workers also due to	

				retire. Impact on ability to maintain service noted, business continuity plans require consideration. On a positive note a Service Manager has been in post this past three weeks and Team Leader posts have been filled via expression of interest, due to commence post April 2022. It was agreed given the significant increase in service users requiring a domiciliary care package and the staffing issues raised the action is to be rated red and carried forward into the next reporting period. Trust to provide HSCB with regular update on staffing and domiciliary care service provision via LDAD Forum.	
13. Issue: Potential failure to provide people deprived of their liberty with adequate legal safeguards Compliance date set at December 2021. **Discussion at DSF meeting 25.6.21** Trust have reviewed case loads and met with MCA panel in terms of	**Actions:** • Trust to provide monthly update on compliance at each interface meeting with HSCB	Monthly updates	Steph Kerr (Trust MCA Lead)	Updates provided through Mary O'Brien in MH via the interface meetings with HSCB. **Up-date at DSF meeting 09.12.21** HSCB contacted Trust yesterday to confirm level of MCA funding available.	

thresholds for DoLs. Central MCA team in BT has appointed 10 additional SP to assist other teams with legacy work. LD has provided a list of legacy cases to the central team.				Trust had requested additional funding and consider available funding will impact on activity levels from 1st April 22. Lorna Conn noted HSCB could move to funding allocation re original funding figures pending response at Senior Level in Trust. Trust to provide response to HSCB. Rag rating agreed to remain as amber.	
14. Issue: Accommodation needs for those being discharged from Muckamore Abbey Hospital • Trust to provide Resettlement Plan **Discussion at DSF meeting 25.6.21** Trust confirm they have a resettlement plan in place for 15 service user, there is 1 service user without a plan. Monthly meetings with the HSCB where updates are given. The Trust currently do not have a timeframe for the 1 service user without a plan.	Actions: • Trust to submit Resettlement Plan to HSCB for 15 service user	31/07/21	Magda Keeling, Service Manager	**Update 31.10.21** A summary document setting out the resettlement options for the BHSCT patients in Muckamore Abbey Hospital is enclosed with the updated position as of 31.10.21. **Update at DSF meeting 09.12.21:** Resettlement Summary document submitted to HSCB prior to meeting. Discussion re specific arrangements for patients. BT patient discharged on trial leave/resettlement on 08.11.21 as planned. 1	

				patient currently without a plan, Trust to progress discharge plan. Discharges anticipated within coming months. Significant number of discharges dependent on business cases e.g. forensic, on-site, Minnowburn which to date have been slow to progress. It was noted that a number of patients have discharged on trial resettlement/article 15, with the potential for beds to be required in the event of resettlement breaking down. DOJ recently requested patient to return to MAH. Consideration required re enhanced working with DoJ, DoH & Trust to support resettlement. Rating therefore agreed as amber. **Update at DSF Meeting 04/03/22:** Rhoda McBride updated that currently 16 BHSCT service users, 14 inpatient in MAH and two on trial leave. Rhoda noted two of these 14 individuals were admitted recently and	

				require a confirmed plan. Rhoda McBride noted recent difficulties re service user being returned to hospital via DOJ. Caroline McGonigle noted regular updates are provided at CIP and RLDODG meetings but progress is required re discharges, particularly given the ongoing pressure for beds. Rhoda noted ongoing pressure re beds and particular difficulty/ risk this places on Community Learning Disability Teams, issues noted in Early alert. Rhoda keen to be involved in Workshop planned April to look at regional admissions criteria to support bed flow. It was agreed given the issues noted this action should be red and carried forward into the next reporting period.	
	• Trust to confirm plan for remaining service user	30/09/21	Magda Keeling, Service Manager	**Update 11.10.21-** There is currently no confirmed plan identified. However the Trust are	

				exploring a possible option with Praxis in South Belfast. **Update at DSF meeting 09.12.21**: Praxis not considered a suitable resettlement option so this service user currently still has no discharge plan. Trust to progress discharge plan. Trust held accommodation workshop this week in attempt to attract potential service providers to support the resettlement agenda as a whole. As still no plan in place for this patient, rating therefore agreed as red. Lorna Conn confirmed this issue to be escalated to Brendan Whittle, HSCB SCCD Director. **Update at DSF meeting 04/03/22:** Caroline McGonigle noted the last CIP report for BHSCT indicated there was no plan for 1 individual. Rhoda McBride noted that she did not have an update on individual service users but given the difficulties discussed re service	

				provision it was agreed this action should remain red and carry through into next reporting period.	
	• Trust to provide a timeline for offsite business cases	31/07/21	Tracy Kennedy, Co Director	A summary document setting out the resettlement options for the BHSCT patients in Muckamore Abbey Hospital is enclosed, which includes timeframes in respect of business cases. **Update 31.10.21** • In relation to the Off site business cases • Lanthorne – was presented & passed at the September Strategic Advisory Board, with reprovision for 5 people. The work is likely to start January 2022 • Minnowburn – Capital Redevelopment advised the site is now "live" for other public organisations to express interest	

				(i.e. NIHE). Capital business case presented at September SAB & agreed in principle, however NIHE do have concerns re: value for money / costs (5 tenants) • Forensic – no site identified as yet. MDT in MAH have expressed concerns that the model that passed in 2019 is no longer suitable for the identified tenants – further update are being sought. • The Cairns – capital redevelopment have been approached for an update on the valuation of this site before we could propose further LD accommodation. This would then need to go through	

				the same process as Minnowburn. **Up-date at DSF meeting 09.12.21:** Trust confirmed Lanthorne relates to community provision rather than resettlement from MAH. Minnowburn- Site currently going through public disposal process. Trust has submitted all relevant paperwork and awaiting an outcome re same. If site secured BHSCT will have to staff service. Building work (new build) required, initial indications re completion date 2023. Forensic: Triangle agreed housing provider. Number of potential sites recently identified but consideration required re their suitability e.g. proximity to schools/ urban area. Cairns ruled out as not suitable. Lorna Conn HSCB noted that lack of progress re business cases would be escalated to HSCB SCCD Director Brendan Whittle.	

				Rag rating agreed to remain red. **Update at DSF Meeting 04/03/22:** Rhoda McBride noted in terms of business cases ongoing work is required. Minnowburn Site currently going through land disposal process. Capital and revenue funding require consideration and will go through relevant processes. Further work required in respect of the Forensic Business Case. Trust to continue to update HSCB re CIP and RLDODG meetings. It was agreed that this action will remain red and be carried through into the next reporting period.	
	• Trust to provide timeline for submission of onsite proposal	31/08/21	Tracy Kennedy, Co-Director	**Update 29.10.21** • There are 2 resettlement options • a. New rebuild at a cost of £3.8m or b.Refurbishment at a cost of £1.5m • Refurbuishment would either be at the old football	

				pitch or at the back of the site which would entail some demolition. • A feasibility study is needed and capital development indicated this would take 3 months to complete albeit could not confirm when the completion timeline was for this and indicated this would be confirmed at the next meeting. • There is an understanding that the number of people that would be accommodated would up to a maximum of 5. • SET are in discussions re another potential person but this has not been agreed and therefore this	

				would impact on the building brief. **Update at DSF meeting 09.12.21:** Feasibility Study currently being underway by Capital Development, to be completed Jan 22. Trust confirmed it is important for environment to be positive for patients. If new build needed planning permission may have lapsed. Lorna Conn HSCB advised the lack of progress required escalation to HSCB SCCD Director Brendan Whittle. Rag rating agreed to remain as red. **Update at DSF meeting 04/03/22**: Rhoda McBride updated meetings continue to be chaired by the MHID Director. Caroline McGonigle noted the Feasibility Study has been delayed, now due for completion early March. Numbers for the scheme are being finalised. It was agreed this action remains red due to the delays in process and is to be carried	

				forward into the next reporting period.	
15. Issue: MAH admissions The Service Area continues to struggle to make admission beds available as required most significantly including detained admissions. There have been no admissions in the last financial year. **Discussion at DSF meeting 25.6.21** HSCB notes a rise in the numbers of people with LD being admitted to MH wards. Trust to cross reference across MH/LD and across Trusts.	**Actions:** HSCB require the Trust to provide a plan outlining the following: • Provide detail regarding the numbers of requests for admission • Outline their process for admission for HSCB consideration (Regionally) • Trust to identify the number of discharges over the previous 6 month period • Trust to provide projections of number of discharges over next 6 month period • Trust to confirm when they will be receiving admissions	31/07/21	Owen Lambert, service manager	• Information on the number of requests for admission made to Muckamore Abbey Hospital in the period 1 April 2020 to 31 May 2021 has been provided. In summary, there were 8 requests made by WHSCT, NHSCT and SEHSCT. No requests were made by BHSCT community teams. **Update as of 31.10.21** • There have been no requests from other Trusts over the past 6 months. There have been 2 BHSCT admissions to MAH- 1 in Sept and 1 in Oct • The Trust would recommend the regional implementation of Care and Treatment Reviews and a Blue Light	

				Protocol which has been implemented by NHS England as a key part of its approach to early intervention and reducing inappropriate admissions. Two documents from NHS England are enclosed. • In the last six months there were 3 discharges from Muckamore Abbey Hospital. **Update 31.10.21** • In the last 6 months there have been 3 full discharges – 2 from BHSCT and 1 from NHSCT. • Resettlement plans across Trusts would indicate the potential for 4 discharges to be achieved in the next six months. **Update 31.10.21** • There is a potential for 5 discharges to be achieved within the next 6 months– 1 BHSCT. 4 NHSCT.	

				• HSCB colleagues are aware of the proposal to open 3 assessment and treatment beds for learning disability services in NHSCT. The proposal put forward by BHSCT to reopen a small number of assessment and treatment beds in Muckamore Abbey Hospital remains paused due to ongoing staffing challenges and slippage in some resettlement dates. **Up-date DSF meeting 09.12.21**: Trust confirmed until a number of patients are resettled, given current staffing issues MAH cannot accept admissions. Impact on region noted given MAH is the regional facility, particular impact on individuals requiring a forensic inpatient bed. Trust monitor requests for admission. Lorna Conn requested this must continue. Consideration	

				required re regional admissions criteria and associated pathways, work commenced in recent T&F group led by HSCB. Trust to forward to HSCB the internal processes to manage admissions. Trust submitted two documents referenced above re implementation of Care and Treatment Reviews and a Blue Light Protocol to HSCB. Trust to continue to monitor requests for admissions. Rag rating agreed to remain amber. **Update at DSF meeting 04/03/22:** Rhoda McBride updated since the last meeting there had been two BHSCT admissions to MAH. Caroline enquired how many requests for admissions had been made to MAH. Rhoda agreed to submit this information to HSCB. The importance of this data was noted in terms of determining service demand. In terms of discharges Rhoda updated since the DSF meeting in	

				December 2021 there has been 2 full discharges (1 NHSCT and I recent SEHSCT discharge). Currently 2 BHSCT on trial/article 15 leave and 2 NHSCT recently commenced transition/trial leave). Although there has been some discharges progressed, given the ongoing issues noted re accessing beds and facilitating discharges, it was agreed that the action should be rag rated as red and carried forward into the next reporting period.	
16. Issue: Safeguarding concerns regarding Shannon/Trench Park and Annadale RQIA report Dec 2020, outlines concerns relating to lack of safeguarding training/staff knowledge of safeguarding/referral process HSCB require the Trust to provide action plan to address recommendations from the RQIA report	Actions: • Report on addressing concerns regarding recording of restrictive practices in Trenchpark and Annadale	31/07/21	Aisling Curran, Service Manager	Action plans in respect of the RQIA Inspections of Trench Park and Annadale are enclosed. **Update 31.10.21** • In relation to Annadale as follows- • All staff have received adult safeguarding training and Mapa training	

Discussion at DSF meeting 25.6.21 Trenchpark/Annadale – Concerns regarding recording of restrictive practices. Shannon – a number of concerns in relation to safeguarding				• Any restraint used is clearly recorded on Datix. • There has been work undertaken with the Behaviour Support Team and Psychology Department in relation to the PBS plan and care plans • Staff have received training which is regularly reviewed and updated to ensure everyone is aware of how to best support the service user to minimise the need for restraint. • There are however ongoing challenges due to staffing predominantly within the core team at Annadale, in terms of sickness , recruiting new staff and lack of band 5 cover, leaving some shifts short. This has also	

				had an impact on facilitating training. • There has been successful recruitment in relation to band 3 staff and currently the service area is shortlisting for the B5 posts. • There was a recent inspection on the 14/10/21 and the inspector was satisfied all actions from last QIP had been completed except the staffing levels as outlined above. • Update in relation to Trench as follows- • In relation to issues identified in RQIA inspection in 2020 relating to safeguarding and DOLS have been addressed and accepted by RQIA	

	• Trust to complete action plan on recommendations from RQIA report regarding Shannon	01/07/21		**Up-date at DSF meeting on 09.12.21** HSCB confirmed up-dates noted in Action Plan had not been received by HSCB. Trust advised these had been forwarded from Carol Diffin to Brendan Whittle. Trust forwarded Trench Park Action Plan, & Annadale Action Plan to HSCB on 09.12.21. Moving forward it was agreed Trust to forward information regarding MH Services to Martina McCafferty HSCB. Information relating to LD Services to be sent to Caroline McGonigle, HSCB. Up-date provided re Shannon. Work conducted in MAH rolled out in MH. Considering deep dive into community teams and roll out to Beechcroft in New Year. Strengthening of systems, role clarity and audit noted. Trust to consider opportunity to scale up and spread. Action plans re Shannon to be forwarded to HSCB.	

17. Issue: Learning Disability Adult Safeguarding Workforce Pressures Trust outlines a range of issues regarding low numbers of DAPOs/ I/Os; diversion of ASG resource to MAH with corresponding gaps in community; business support and admin vacancies exacerbating pressures on staff; staff under pressure with demand outstripping ASG capacity. Trust to provide HSCB with assurances that its Adult Safeguarding service is working effectively and that investigations and related work are undertaken in a timely manner? Trust to provide an outline of the Governance Assurance process. **Discussion at DSF meeting 25.6.21** HSCB outlined concerns as outlined above. Trust have undertaken a review of the numbers of DAPO's in place and are finalising a paper to request additional resource into LD. Divisional SW also requires additional support to undertake role.	**Actions:** • Trust to undertake an internal review of the effectiveness of safeguarding services and report back to HSCB	30/09/21	Mark Johnston, ASG Lead	**Update 31.10.21** • During July the DOH completed an audit into ASG in MAH and this was followed by an RQIA inspection into MAH in July/August. • Unfortunately the completion of this audit has been delayed due to staff having to focus on these other two processes and also due to challenges with staffing levels. As we are also still awaiting the completion of the RQIA inspection report the EDSW, Carol Diffin has requested an extension until the end of November for the Trust to complete this. This will also allow us to take account of the findings of the	

				other two pieces of work that have been carried out by DOH and RQIA. **Up-date at DSF meeting 09.12.21:** Trust to forward audit findings to HSCB. IPT for LD Principal Practitioner to provide professional support to Divisional Social Worker. **Update at DSF meeting 04/03/22:** Caroline McGonigle thanked Rhoda McBride for forwarding the Action Plan to HSCB. Rhoda updated that given the inquiry, thresholds for safeguarding in MAH meant all staff incidents reported in respect of service users were considered under safeguarding. CCTV footage is viewed in any safeguardinginvestigation ensuring a robust though slower process. Rhoda stated she had devised a series of Escalation Forms and Aide Memoirs to assist in respect of safeguarding. Ciara Rooney facilitating bespoke training. As noted	

				in Action Plan ongoing work required. Rhoda and newly appointed Service Manager Colette Johnson intend to revisit Action Plan and ensure it takes cognisance of audit findings and any other recommendations. Rhoda to send updated action plan to Caroline McGonigle in HSCB.	
18. Issue: Iveagh delayed discharges **Discussion at DSF meeting 25.6.21** Operational policy requires review during 2021/22	**Actions:** • Review and amend Operational Procedures to prevent future delayed discharges	30/09/21	Michael McBride, ASM Iveagh	**Update 11.10.21**- The Operational policy for Iveagh was updated in July 2021- please see attached. **Up-date at DSF meeting 09.12.21** MHLD HSCB Programme Representatives agreed to share Iveagh Operational Policy with HSCB Children's Services Colleagues for review.	

Older People & Adults Issues					
Issue	**Action Required**	**By when**	**Owner**	**Progress Report**	**RAG status**
19. Issue: Domiciliary Care Provision – Unmet need	**Actions:**			**Discussion at DSF meeting 6.10.21**	

31 March 2021, 278 service users were awaiting care packages, this equated to 1588.75hrs. This represents a significant risk to service users and carers, in terms of unmet assessed need and additional carer stress **Discussion at DSF meeting 25.6.21** Trust report situation has deteriorated, and numbers of unmet need has risen. Significant rise in attendance at ED over recent months. People on waiting lists for medical intervention, and impact on their health needs. People are also much more reluctant to go into care homes as a result of Covid attention in this area. Steps Trust are taking: Increase capacity within Homecare service Weekly review of unmet need Structural changes, modernisation of homecare. New model proposal is almost near completion. Increasing Band 3 staff to increase capacity.	• Trust to share the review undertake within the service area, including identification of skill mix	31/08/21	Natalie Magee Co-Director ACOPS	Level of unmet need continues to be a significant issue, current position is 695(387 new) outstanding packages totalling 5, 326hrs. Trust has achieved 8% increase in uptake of Direct Payments. Domiciliary Care Action Plan in place to address in-house and independent sector capacity. **Update 2/3/22** Current unmet need is 873 clients requiring 6,106.25hrs with all cases (including transfers from reablement) subject to weekly review. West Belfast Direct Payments project ongoing. Acknowledgement this is a regional issue which has HSCB and DOH input.	
	• Trust to share outcome of review to utilise/increase use of direct payment	30/09/21	Natalie Magee Co-Director ACOPS		

20. Issue: Mental Capacity Act The inability of Older People's Services to meet full compliance by 31st May 2021 **Discussion at DSF meeting 25.6.21** Trust have reviewed case loads and met with MCA panel in terms of thresholds for DoLs. Central MCA team in BT has appointed 10 additional SP to assist other teams with legacy work. OPPC has provided a list of legacy cases to the central team. There is fortnightly updates to the Trust Exec team with regards to compliance.	**Actions:** • Trust to provide monthly update on compliance at each interface meeting with HSCB		Director of ACOPs supported by Co-Director of MH	**Discussion at DSF meeting 6.10.21** At 31 August 21 there were 84 outstanding DOLs legacy cases, these have now been completed	
21. Issue: Annual reviews Trust report approx. 5,500 face to face reviews require completion. The service areas have significant non-compliance in relation to statutory annual reviews for both care home and domiciliary settings. **Discussion at DSF meeting 25.6.21**	**Actions:** • Trust to provide outline of timeframe to ensure compliance – updated on a monthly basis	31/07/21 Updates then monthly	Natalie Magee Co-Director ACOPS / Tracy Reid DSW Community & Hospital Adult Community &	**Discussion at DSF meeting 6.10.21** There is acknowledgment that within OP services , there remains a very significant risk of non-compliance by March 22. CREST & CSW action plans in place with set target number of monthly reviews.	

Trust report they are going to be compliant by December 2021. HSCB expressed concern as to the Trust's ability to meet this timeline.			Older Peoples Services	All cases are rag rated and prioritised in line with level of risk. Workforce review submitted to Senior Management. **Update 2/3/22** Acknowledgement of non-compliance by March '22. CSW projected 51% compliance & CREST projected 57% compliance by Mar'22. Impact of C-19 acknowledged. CSW and CREST action plans in place with set targets for number of completed reviews by practitioner. Successful period of recruitment into CREST bringing potentially 7 additional staff by June'22(5 additional already in place). Staffing review planned for CSW to include caseload weighting & skill mix.	
22. Issue: Historical Case Closures in Hospital Social Work	**Actions:** • Trust to provide update	01/09/21	Natalie Magee Co-Director ACOPS / Tracy	**Discussion at DSF meeting 6.10.21** Outstanding Case Closures now at 2680 as of 20/9/21.Target set of a minimum of 900 per	

Data indicates 3,824 cases not closed. Target date for closure of 1st August 2021 This presents a significant risk to Trust assurance processes and delays in recording and closures can impact on timely information sharing. **Discussion at DSF meeting 25.6.21** Trust are working on this, and have an action plan in place. They request an extension to target date to 31/08/21			Reid DSW Community & Hospital Adult Community & Older Peoples Services	month to achieve full compliance by 30 November 2021. Staffing has stabilised (particularly RVH and MIH). HSW action plan in place **Update 2.3.22** Approx. 2,000 cases require closure with plan in place for weekly review of staff caseloads. Trust hopeful for full compliance by end March'22. RAG rating to remain as amber in acknowledgement this may be a challenging target to achieve. **Update 1.6.22** This issue to be taken forward in another forum as per B Whittle.	
23. Issue: Inappropriate Referrals to Adult Protection Gateway Team (APGT) 242 of the 1121 referrals (21%) made to APGT (Older People and Physical Disability services) are screened out as inappropriate with no category of abuse noted. Given the resource implications of this, can the Trust provide information on actions taken to improve the referral pathway and related data?	**Actions:** • Trust to provide analysis report on data and activity levels.	31/08/21	Natalie Magee Co-Director ACOPS / Tracy Reid DSW Community & Hospital Adult Community &	**Discussion at DSF meeting 6.10.21** Analysis report indicates that for 2020/21 45% of referrals were screened out as inappropriate for APGT. These referrals were largely welfare concerns with PSNI being the main referral agent. Analysis revealed there is significant	

Discussion at DSF meeting 25.6.21 Action Plan in place, which addresses pathways and development of central team. Important to identify if there high levels of inappropriate referrals which should be signposted to other areas, in order to increase capacity to Gateway service. An additional resource has been brought in which has provided an analysis of pathways.			Older Peoples Services	misunderstanding across the Trust and beyond as to the role and remit of the APGT. Training is ongoing within the Trust and to Care Homes (AS Champions training). Review of arrangements for the management of Adult Protection referrals and required resource, is being led by Executive Director of Social Work. **Update 2/3/22** Trust acknowledges this continues to be an issue. CREST and APGT have agreed care home reporting to come to key workers , not APGT. Work ongoing via Exec Dir of SW on external reporting with acknowledgement that universal agreement on thresholds is a key issue. Trust to give consideration to adoption of multiagency forum for welfare concerns.	
24. Issue: Adult Protection - Learning and Actions from Level 2 SAI	**Actions:** • Agreed that HSCB will link with DRO to clarify if there is	31/07/21	Tracy Reid DSW	**Discussion at DSF meeting 6.10.21** HSCB has now received the SAI action plan with all	

Significant shortcomings in Trust Adult Safeguarding services were identified in respect of a vulnerable adult and a subsequent Court ruling that Trust should initiate an SAI review because of a range of serious failures. Trust to update on its action plan to address these issues with timeframe for completion? **Discussion at DSF meeting 25.6.21** Trust have an action plan in place and had not forwarded to HSCB. They have also met with DRO and updated the plan.	an issue in relation to statutory functions. If so, this will be escalated to the Director, SCCD to Exec Director of the Trust.		Community & Hospital Adult Community & Older Peoples Services	recommendations completed, providing HSCB with the necessary assurances. Interim AS Manager has facilitated a session with Trust APGT and Care Home managers and the learning from the case has been presented to Trust Adult Safeguarding committee and to Service Managers and the Collective Leadership Team across Adult Community Older Peoples Service. Shared Learning Letter to be redacted to ensure client confidentiality Learning to be shared across all IO and DAPO staff and incorporated into all future IO/DAPO and Joint Protocol training.	
Issue	**Action Required**	**By when**	**Owner**	**Progress Report**	**RAG status**
Physical Disability and Sensory Impairment Issues					
25. Issue: Mental Capacity Act	**Actions:**			**Discussion at DSF meeting 6.10.21**	

65 Legacy cases As stated above the service area continues to work through outstanding legacy MCA cases, which have had a significant impact upon staff within PSD Care Management. Whilst the service area has made good progress and continues to work towards completion by 31 May 2021, this increasingly complex work involves significant professional time without additional investment **Discussion at DSF meeting 25.6.21** Trust have reviewed case loads and met with MCA panel in terms of thresholds for DoLs. Central MCA team in BT has appointed 10 additional SP to assist other teams with legacy work. PDSI has provided a list of legacy cases to the central team. There is fortnightly updates to the Trust Exec team with regards to compliance.	• Trust to provide monthly update on compliance at each interface meeting with HSCB		Director of ACOPS supported by Co-Director MH	The outstanding 65 Legacy cases have now been completed.	
26. Issue: Care Home Annual Reviews 283 Reviews outstanding **Discussion at DSF meeting 25.6.21** Trust report they are going to be compliant by December 2021. HSCB expressed concern as to the Trust's ability to meet this timeline	**Actions:** • Trust to provide outline of timeframe to ensure compliance – updated on a monthly basis	31/07/21 Updates then monthly	Natalie Magee Co-Director ACOPS /Tracy Reid DSW Community & Hospital Adult Community &	**Discussion at DSF meeting 6.10.21** 183 outstanding reviews at 24/9/21. PD care management action plan in place with target of 57 reviews per month for compliance by December 21.	

			Older Peoples Services	Sensory Social work team to commence undertaking of reviews. **Update 2/3/22** All outstanding reviews have now been completed.	

RAG Rating	
Completed/Confident of Delivery on Actions	
Work in progress and on track for completion within agreed timescales	
Not Complete/ Not on track for completion within agreed timescales	

The above action plan was reviewed at interface meetings with SPPG and Trusts (minimum 3 times yearly). Progress updates were completed after each interface meeting and reviewed by Senior Operational Management Team, SPPG.

This is to confirm that the above Action Plan has been reviewed by the Social Care and Children's Directorate on 01/06/22 and will be signed off at the DSF meeting on 16/06/22. Any outstanding issues requiring further progress will be reviewed at the DSF Meeting with the Belfast Trust and these alongside any new issues will be presented in the 2022/23 Action Plan.

Signed_____ _____ Date _____

Brendan Whittle, Director of Hospital & Community Care

2.6 NHSCT DSF Plan 2021/22 – YEAR END UPDATE MARCH 2022

Programme of Care	Total Number of Issues	Red RAG	Amber RAG	Green RAG
Family and Children	5	0	3	2
Mental Health	1	1	0	0
Learning Disability	1	0	1	0
Older People and Adults	1	0	1	0
Physical Disability / Acute	1	0	1	0
Total	**9**	**1**	**6**	**2**

Issue	Action Required	By When	Owner	Progress Update	RAG Status
Family & Childcare Issues					
1 Issue: Unregulated placements – lack of options for young people leaving care or requiring accommodation. 72 Kinship Placements not yet approved 12 unregulated placements **Discussion at DSF meeting 16.6.21** Unregulated - Trust advised these have reduced. The STAY project is in place, and the Trust have confidence that numbers will remain low Kinship – a further team is being developed. Pressures meeting fortnightly. Management of change process required, however Trust highlight financial constraints and impact on this	**Actions:** • Trust to provide action plan to reduce numbers of unregulated placements	31/7/21	Julie Patterson (JP)	**DSF meeting on 06.09.21:** Action Plan was submitted to HSCB on 4th August. Fiona Gunn & HoS have scheduled meetings to review actions outside formal DSF meetings. Hos reviews plan fortnightly and AD at monthly fostering meeting. **Action:** JP will update plan and forward to PM by 13.9.21 **DSF meeting held on 13&20.12.21:** The Trust continues to experience pressure across the system as demand for placement increases. 72 at beginning of year stands at 53 as of 8/12/21. Recognised that Trust Kinship action plan is innovative in trying to meet	

				all pressures. Despite this unlikely that number of unregulated placements will be in single digits by 31/3/22. **Discussion @ 16.3.22 meeting** All actions within plan are ongoing-some minor changes across plan since Dec. As per above demand remains high. Unregulated kinship placements up by 6 since Dec whilst unallocated kinship placements up 1. Situation ensures RAG status remains at Amber	
2 Issue: Shortage of stranger foster placements **Discussion at DSF meeting 16.6.21** Trust brought this up at recent AD meeting to discuss Social Media and impact of regional team	**Actions:** • Trust to progress their own media as well as regional campaign		Julie Patterson	NHSCT Social Media activity took place week ending 18/6/21 resulting in a high level of enquiries **Discussion @ 6.9.21 DSF meeting** PM/DC enquired what was outcome of activity and requested that additional information be provided on	

				outcome so any regional learning can be shared. Action: JP to update PM by 13.9.21 **Discussion @ Dec DSF meeting** Own media campaign did bring forward positive benefits and Trust plan to do another event.	
	• Refer to Action Plan to be submitted on unregulated placements, will also include foster placements (31/07/21)			Trust requested that this action be removed. Action: PM to discuss this with Michaela Glover, HSCB PM spoke with MG on 8/9 who confirmed that Trust agreed to submit a plan on how they would increase stranger foster placements- HSCB expect plan asap. Action: JP to submit plan to PM by 30/9/21 Discussion @ Dec DSF meeting Trust recently put out a broadcast appeal across total workforce and a number of 30+ families came forward and more	

				than 20 assessments underway. **Discussion @ March DSF meeting** 20 private assessments continue and Trust have been proactive in engaging stranger foster carers. Trust provided following update on outcome of media campaigns. From the 18 that were approved at Christmas 11 provided emergency/short break placements. We now have 2 households that are providing short term placements (change of registration completed to enable this to occur), 1 household that assists with OOHS at weekends and short breaks. In addition to this another 5 households provide emergency/short break placements when required. Given Trusts response RAG agreed at Green	

3 Issue: Pressure on Kinship team due to high number of assessments required **Discussion at DSF meeting 16.6.21** See unregulated placement above.	**Actions:** • Refer to Action Plan to be submitted on unregulated placements, will also include foster placements (31/07/21)		Julie Patterson	Kinship team has been split into two due to workload pressures. **Action:** JP will update plan and forward to PM by 13.9.21 **Discussion @ Dec DSF meeting** JP has secured additional funding to recruit 8 SW and a new HoS and this was welcomed given demands across Trust. This additional investment should enable more assessments to be completed and greater support to be offered to meet demand. RAG rating to remain at Amber. **Discussion @ March DSF meeting** 70 viability assessments completed in last 6 months. Trust indicated that weekly pressure meetings are taking place to review demand & activity. JP reported that despite staff shortages	

				across service at times between 30-35%. (As of 18/3 this has reduced to 22.2%) progress has been made. In view of overall position at year end RAG is Amber.	
4 Issue: Children with a disability or complex health and lack of regional facilities Trust to provide plans for the three children in temporary accommodation. **Discussion at DSF meeting 16.6.21** Trust have plans in place to progress accommodation needs for 3 children	**Actions:** • Trust to provide Action Plan (31/07/21)	31.7.21	Tracy Magill	Trust had not supplied plan as agreed as they thought this related to individual care planning. PM clarified that HSCB were not requesting individual care plans for 3 children but rather an action plan outlining how Trust would ensure children are in appropriate accommodation. **Action:** agreed that TM will forward action plan to PM by 13.9.21 for review as this was due 31.7.21 **Discussion @ Dec DSF meeting** The Trust had a plan to deal with all 3 children that required Rainbow Lodge (RL) being repurposed. A number of serious concerns	

				were raised by RQIA in relation to RL and Trust have been reviewing governance and monitoring situation on a weekly sometimes daily basis. Accepted that the plan for two children awaiting a move will not take place this year as court assessments/legal challenges ongoing. Agreed to change RAG rating to Red to reflect this. **Discussion @ March DSF meeting** No change to report since last meeting, Trust are challenged by ongoing court process and plans to move child B & C to suitable accommodation. HSCB recognised that the situation is outside Trust control and that plan before court is, according to Trust, in children's best interest. No date for final hearing. Agreed RAG as Amber.	

5 Issue: Early Years 762 Outstanding Inspections **Discussion at DSF meeting 16.6.21** Trust are confident in ensuring compliance	**Actions:** • Trust to provide a capacity and demand action plan, which outlines when Trust will reach compliance (31/07/21)		Tracy Magill	Trust queried if this was still required. **Action:** PM to discuss this with Michaela Glover, HSCB. PM discussed this with MG on 8/9/21, HSCB acknowledge that UL is working with HoS but expect a written action plan detailing what steps Trust are taking to reduce outstanding inspections. **Action:** TM to forward plan to PM by no later than 30/09/21 **Discussion @ Dec DSF meeting** Positive progress made by Trust with support from Una Lernihan. Updated action plan provides greater detail on progress. Agreed that RAG rating to remain at Amber. **Discussion @ March's DSF meeting** The effort to complete 997 outstanding inspections	

				was commended. Trust report that as of 3.3.22 24 outstanding inspections are outstanding. As predicted target will be achieved in year RAG agreed as Green	

Issue	Action Required	By When	Owner	Progress Report	RAG status
Mental Health Issues					
6 Issue: Trust unable to meet demand for Mental Health inpatient beds **Discussion at DSF meeting 16.6.21** Daily patient safety brief in place. Bed management escalation process in place within Trust. Issue further complicated by isolation requirements during covid. Bed pressures across all 5 Trusts. Trust have worked on covid restrictions with a view to improve flow. Trust engaged with Regional Bed Management Network (HSCB lead). Regional Bed Manager Coordinator in post. Trust looking at Crisis & HTT	**Actions:** • Trust to provide Action Plan combining the actions above (31/07/21) to include:	31/7/21 Report sent to M Glover HSCB 3/8/21	Diane Spence	**Progress at 1/3/22** The pressure on mental health acute beds remains challenging. There are specific challenges relating to dementia and learning disability. 50/94 patients in acute mental health beds are detained with complex acuity. Trust also advised that the workforce vacancies in CMHTs due to covid, long term sick and vacancies are having a knock on effect on the ability to see patients, and leads to undue pressure on acute beds.	

programme. Current EoI out for post. Trust undertaking a breakdown of referrals into ED/Crisis Response/CMHT to see where increase/pressures are coming from.				The Bed Capacity co-ordinator (BCC) continues to huddle each day with the regional bed management network to improve flow of beds but the pressure on beds regionally also remains challenging. A Bed Manager is now also in place which will free up the BCC to work solely on bed flow and facilitating discharges. The BCC was carrying both portfolios for a while. Progress report received 3/8/21. This was acknowledged however Caroline and Ciara did not have sight of this. HSCB leads to follow up. 2 months on and level of acuity remains high in line with other Trusts in the region. Bed co-ordinator in post including robust monitoring plan with daily return. Maureen Serplus reported that she will be leaving post	

				and there have been a number of changes to the MH/LD structure. From 1/11/21 Amanda Burgess will take over as AD for professional sw lead for MH and LD. Amanda was in attendance at the meeting, revised structure will follow for ease of reference going forward.	
	• Outcome/progress of review into increase in pressure (period May 2021 and May 2019)	30/06/21	Diane Spence	Facilitation of early discharge and bed co-ordination remain appropriate. There are active plans in place to discharge current LD patients from MH beds. ACTION: Update to be provided at next DSF meeting. Reports of a much improved collaborative system with bed co-ordinator system having clear over sight over challenges.	
Issue	**Action Required**	**By When**	**Owner**	**Progress Report**	**RAG status**
Learning Disability Issues					
7 Issue: Resettlement of patients from Muckamore Abbey to bespoke	**Actions:**		Amanda Burgess,	Verbal up-date re all patients provided at DSF	

placements in the community. The resettlement of patients from Muckamore Abbey remains a priority (8 patients) **Discussion at DSF meeting 16.6.21** Trust advised they have 2 further patients in other units requiring discharge. Trust have met with 7 families to look at resettlement (Trust contacted 20 families in total). There are now only 2 individuals with no discharge plan. In-reach is now open.	• Trust to provide clarity on the discharge plans now in place for 6 patients (31/07/21).		Head of Service ADLT	meeting and followed up by written progress up-date submitted to HSCB, re all patients on 22.10.21. **01/03/22 Update** Gareth Farmer updated there are currently 16 NHSCT inpatients in MAH. 3 individuals have been discharged from the last DSF meeting. (14 inpatients are delayed discharges, none currently in active treatment, 2 of these individuals are in transition/trial leave. 2 major schemes facilitating discharge re NHSCT inpatients, Braefields and Mallusk. Issues remain with progression of discharges to the Mallusk scheme. Meetings ongoing at Director level to progress. Caroline McGonigle commended the Trust for the progress made in supporting effective resettlement of individuals. As there are ongoing issues	

				in respect of the Mallusk scheme it was agreed that the action should remain amber and carry forward into the next reporting period.	
	• The Trust to update HSCB as to progress of remaining 2 patients without discharge plan (Ongoing)			Trust continues to provide regular up-dates at associated meetings and Forums. HSCB noted Trust progress but acknowledged that resettlement of patients requires continual focus to ensure appropriate resettlement continues at pace. Acknowledgement that aligned service providers are experiencing recruitment issues with a potential impact on planned discharge dates. Agreed given progress to date an amber rating is appropriate but should issues/delays impact on resettlement plans, rag status may change to red. Trust to ensure HSCB informed of any pertinent issues. 01/03/22 Update: Gareth Farmer noted there is one	

				inpatient with no confirmed plan. Trust recently appointed a Re-settlement Co-ordinator who will focus on facilitating a plan for this individual. Updates will continue to be provided to HSCB via CIP and RLDODG meetings. Agreed this action will remain amber and carry forward into next reporting period.	

Issue	Action Required	By when	Owner	Progress Report	RAG status
Older People & Adults Issues					
8 Issue: Domiciliary Care Capacity and Demand Due to demographic growth challenges in meeting demand in all areas of the Trust 251 service users do not have a package or a partial package of care. These are spread across all adult services. **Discussion at DSF meeting 16.6.21** Reset-rebuild/reform agenda has Doc Care as a main focus. The Trust are developing a new model of delivery. Further developments include review of eligibility criteria to ensure equity across the system. Risk mitigation steps in place to review unmet need. Reviewed daily. HSCB satisfied with risk management processes in place in relation to care packages and meeting unmet need.	**Actions:** • Trust to share outcome of review of fair access criteria (31/07/21)	31/07/21	Melanie Phillips AD Comm Care & Divisional Lead SW & SC	NHSCT have shared review paper with HSCB Programme Manager outlining the new process established to ensure consistent application of the fair access criteria Final_EGC_DOM_1.3.docx **UPDATE 1.3.22** No discussion as RAG rated GREEN.	
				21.10.21 Unmet Need Figures at 20.10.21 Total service users waiting Domiciliary Care with no existing services = 400 this figure captures service user from Mental Health, Learning Disability, Elder Care and Physical / Sensory Disability. **UPDATE 1.3.22**	

				Discussion re NHSCT figures 24.2.22, total service users waiting dom care with no existing services = 442. Those waiting a partial package =258. Figures include all programmes of care. Recognition that NHSCT had an assurance framework in situ however approx. 10% increase in October position. To be kept under review.	
				Review of Fair Access Criteria Completed – see insert. Shard with HSCB Programme Manager. **UPDATE 1.3.22** No discussion as RAG rated GREEN.	
				New Model of Delivery ▪ The new model of delivery is being finalised with a plan to then pilot in an area for 3 months. ▪ New model aligned to the reform of	

				dom care. CoVID pressures delaying implementation. **UPDATE 1.3.22** Progress made but no timescales for completion, affected by COVID and staff absences. Potentially a pilot in mid-Ulster. NHSCT colleagues advised wanting to tie up with regional model of dom care. To be kept under review.	
	• Trust to update HSCB on actions coming from review (ongoing)	13/09/21	Melanie Phillips AD Comm Care & Divisional Lead SW & SC	NHSCT have shared action log and outcomes following implementation of new consistent process across adult services divisions; see overleaf. NHSCT have also shared a Risk Mitigation Template. Risk Mitigation Template_Unsource **21.10.21 - Improvement Action Plan**	

				▪ Completed – see overleaf. ▪ Closed wokstream as each locality now brings issues into core business. ▪ Risk Mitigation Template used across programmes to manage unmet need. ▪ Elderly care completed an audit of some of their longest waiters. Agreed there was an opportunity to share the template used so process could be replicated across programmes. **Risk Mitigation Template** ▪ Completed – see insert. ▪ Review period dependent on the mitigations and the safety of the client, can be daily with	

				max period of time weekly. ▪ Signed off by SSW and reviewed in supervision. **UPDATE 1.3.22** No discussion as RAG rated GREEN.	
Issue	**Action Required**	**By when**	**Owner**	**Progress Report**	**RAG status**
Physical Disability and Sensory Impairment Issues					
Issue: No issues **Discussion at DSF meeting 16.6.21**	**Actions:**			N/A	
Issue	**Action Required**	**By when**	**Owner**	**Progress Report**	**RAG status**
Acute Issues					
9 Issue: Delayed Discharge • Acquired Brain Injury - Obtaining suitable placements for patients with acquired brain injury continues to be a challenge (5 patients in Antrim Area and 3 patients in Causeway) **Discussion at DSF meeting 16.6.21** ABI - There is a challenge in meeting Trusts' statutory functions in relation	**Actions:** • Trust to provide plan in to outline mitigation process in managing delayed discharge (31/07/21)	31/07/21	Anita White Service Lead Hospital Social Work	Placement requirements are discussed at the Trust Discharge Group. At present each case is considered on an individual basis with significant support from Community Teams to secure the most appropriate placement. **21.10.21 - Obtaining Suitable Placements**	

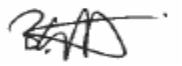
to securing placements. Trust have monitoring process in place with Discharge Group (meet monthly) and intermediate care pathway. No dedicated bed based service in NT. Trust therefore identify commissioned provision on a case by case basis.				This continues to be a challenge in the NHSCT. Measures have been taken to address. ▪ Daily Acute MDT meetings ▪ Discussion at bi-monthly meetings of the Trust Discharge Group which is attended by acute and community staff and across programmes of care ▪ Trust Discharge Group reports by exception to the Trust Risk & Safety Group ▪ Relationship building with IS care homes as to the patients they will accept. **UPDATE 1.3.22** NHSCT continues to progress brain injury patients, case by case basis	

				utilising options for escalation as outlined in Oct 21 e.g.: contact with care homes; raising an expression of interest and consideration of contracts. NHSCT felt a regional approach required. HSCB referenced the Jan 22 retrospective audit completed by Trusts considering those patients who were difficult to discharge. Agreed that the findings from the audit would be reviewed via 21/22 DSF process.	

RAG Rating	
Completed/Confident of Delivery on Actions	
Work in progress and on track for completion within agreed timescales	
Not Complete/ Not on track for completion within agreed timescales	

The above action plan was reviewed at interface meetings with SPPG and Trusts (minimum 3 times yearly). Progress updates were completed after each interface meeting and reviewed by Senior Operational Management Team, SPPG.

This is to confirm that the above Action Plan has been reviewed by the Social Care and Children's Directorate on 06/06/22 and will be signed off at the DSF meeting on 20/06/22. Any outstanding issues requiring further progress will be reviewed at the DSF Meeting with the Northern Trust and these alongside any new issues will be presented in the 2022/23 Action Plan.

Signed:  Date: 20th June 2022

Brendan Whittle, Director of Hospital & Community Care

SEHSCT DSF ACTION PLAN 20201/22 – YEAR END UPDATE MARCH 2022

Programme of Care	Total Number of Issues	Red RAG	Amber RAG	Green RAG
Family and Children	10	0	3	7
Mental Health	2	0	0	2
Learning Disability	2	0	1	1
Older People and Adults	1	0	0	1
Physical Disability	1	0	0	1
Total	**16**	**0**	**4**	**12**

Issue	Action Required	By When	Owner	Progress Update	RAG Status
Family & Childcare Issues					
1 Issue: Insufficient placement provision for children in care At time of reporting, there are 9 children in inappropriate placements. Report required from Trust outlining clear action plan to reduce this. **Update at DSF meeting 14.6.21** Trust to hold a Residential Care Planning Day in June 2021 which will consider how to increase capacity in residential and in availability of foster placement	• Action Plan to be provided by the Trust (31/07/21)	31.7.21	Lorraine Noade	For CwD on the edge of care, further funding being sought to increase short break provision. Business Case completed to secure a second chalet. Further work being progressed to provide short break through fostering.	
	• Scoping exercise currently being undertaken with regards to children under 12, Trust to provide report on outcome of this	29.10.21	David Hamilton and Elaine Somerville	Report and Action Plan is currently being progressed by Trust. 16/12/21 update Paper and review of all the children's homes Report in draft form and will be completed by end Dec 2021 **31/03/22 update** Residential strategy has been completed. This focused on the	

				under 12's action plan in place. 22% of the placements were under 12's. Scoping completed and now taking forward the Action plan	
	• Review of Workforce skill mix/capacity, Trust to provide report on this	31.12.21	Lakewood- Marie Louise Sloan Open Homes – David Hamilton	Lakewood workforce paper completed and submitted to HSCB for review / funding. Open Homes workforce/skill mix paper submitted to HSCB/CSIB and DoH. Further work being progressed regionally to quantify requirements and balance of skill mix.	
2 Issue: Kinship assessments/ unregulated placements The continued increase in demand for kinship placements has been an	• Action Plan to be provided by the Trust	31.7.21	AD Safeguarding Linda McConnell & AD Corporate parenting	Action Plan in place and shared with HSCB. Currently 66 unregulated kinship placements. Robust monitoring system in place to quantify and prioritise assessments, ensure	

influencing factor on the number of unregulated placements within the Trust. There has been an increase by 7 in this reporting period. **Update at DSF meeting 14.6.21** Trust has been working through some of the pressures regarding the increase in kinship placements. Workforce pressures continue to be a significant factor. SE Trust referenced process for assessment of Kinship placements.				timely notifications to HSCB and provide internal oversight. Further consideration being given to overall fostering resource, best and targeted deployment of resources and service reconfiguration. 16/12/21 The Trust have now good robust governance arrangement in place. The Trust completed a review of all unregulated placements within Family and Child Care teams Currently 59 unregulated 16 HSCB notifications and the Trust have progressed these	

				The Trust are running a monthly report and there is governance in place. Concern regarding the lack of foster placements, Kinship assessments take longer to complete **31/03/22 update** Currently 66 unregulated cases These are complex assessments Staffing and workforce pressures due to COVID 29 within CAFT 12 Presented to Director and agreement for placements 37 in Fostering being assessed This is an ongoing pressure however there is robust governance arrangements to	

				address and monitor kinship placements	
3 Issue: Leaving care As at 31.03.21 there are 35 young people are awaiting allocation of a personal advisor. Trust to update on what supports are the young people receiving and what is the action plan to address this **Update at DSF meeting 14.6.21** Workforce vacancies and change in management structure has impacted on availability of Personal Advisors	• Update HSCB on outcome of PSW Safeguarding meeting on 21.06.21 and provide an action plan	1.7.21	David Hamilton	Meeting with Safeguarding team and 16+ team has taken place.	
	• Personal Advisors to be allocated	31.7.21	David Hamilton	A schedule for transition has been developed and a PA will be assigned at point of transfer to ensure continuity of support.	
4 Issue: Development of a strategy to			Lorraine Noade	Substantial Action Plan focusing on Early	

meet present and future needs of children with complex health needs and disability The demand for service provision for children with disabilities continues to rise. At 31st March 2021 there were 189 unallocated cases across the children's disability service. There has been a significant decrease in carer's assessments for parents/ carers of children with a disability, from 101 to 17. **Update at DSF meeting 14.6.21**	• Trust to provide an Action Plan for CwD services to HSCB from Planning Day on 28/04/21 and Residential Planning day in June	29.10.21		Help, Short Breaks, Residential Provision and Transitions is in place. A further workshop took place on 21.06.21 with community teams to determine an action plan to address workforce issues, transition issues etc There is an action plan developed to manage unallocated cases. This is being monitored weekly and reported to Director to determine progress. An IPT has been developed to increase short break provision at Greenhill YMCA to improve access to short breaks for carers. Short break	

Trust has been increasing capacity for short breaks/Lyndsay House. Planning day on28/04/21. Residential planning day in June will also include CwD. Trust continuing to experience significant pressure and are unable to provide require respite due to covid restrictions. PHA guidance required as to when respite facilities can be increase admissions.				provision at YMCA chalet has been increased from 4 nights to 7 nights; a second chalet is now being sought. This is now being completed, currently being drafted Completed early Jan and then will go out for consultation **31/03/22 update** Consultation completed, the increased chalet has been approved The challenge at this juncture is due to staffing the chalet PRAXIS short breaks is now being staffed by HSCT staff. RQIA had reviewed the PRAXIS management of the facility and therefore the HSCT had to take	

				responsibility of another home. Going out to QUB re recruiting staff Little movement re unallocated cases Currently 171 unallocated cases due to COVID absence and workforce challenges Positive progress re Carers assessments currently no waiting list for carers assessments. The HSCT are developing and increasing senior management support for CWD field work teams.	
5 Issue: Unallocated cases There were 287 cases unallocated over	• Trust to provide report on outcome of	1.12.21	Linda McConnell	Currently 273 unallocated cases over 20 days. System and provision	

20 working days at the end of this reporting period. **Update at DSF meeting 14.6.21** Reporting process was changed by the Trust which has impacted on numbers reported. Workforce vacancies have also impacted on unallocated cases. There has been a significant 'spike' in autism referrals to CwD. Trust have provided an Action Plan for Safeguarding and CwD (received by HSCB on 11/06/21)	service wide review		Lorraine Noade in Children's Disability	established within Trust across all CAFTs which through a clinic based system identifies all U/A cases (predominantly in CwD), RAG rates, ensures oversight and close monitoring. Provision in place to deliver an Early Help service/intervention, located within Gateway. Unallocated Cases 32 in Gateway 76 Caft Gateway 135 CWD 322 CASES Unallocated figures will increase due to Sick Leave and workforce pressures	

				CWD – The trust have a plan to address the unallocated cases. The Trust challenge is allocating cases **31/03/22 update** 284 unallocated cases Nov 21- Feb 22 unallocated cases did decrease however this has begun to increase Weekly reporting Unallocated cases is tightly governed Early Help teams has assisted 37% staffing vacancies – The Trust have been working through staffing and hard to fill posts. Initiative with QUB and meeting with students	

				There has been an increase in referrals from schools Response to DOH re work force action plan The Trust are being pro active to address Unallocated cases	
	• Trust to provide action plan on how they are to reduce allocated cases (01/07/21)	1.7.21	Linda McConnell	Action Plan provided to HSCB and is being monitored weekly by Trust Safeguarding and Children's Disability Service	
	• Trust to provide HSCB with a monthly report specifically in relation to unallocated cases	30.06.21	Linda McConnell AD	Monthly unallocated reported to HSCB on monthly basis within 1 to 2 weeks of month end	

6 Issue: Early Years inspection back log 516 early years inspections are overdue **Update at DSF meeting 14.6.21** Covid has impacted significantly on the overdue figure	• Trust to outline clear timelines along with an Action Plan in reducing this figure (31/07/21 and on-going monthly monitoring)	31.7.21 & monthly	Heather Craig/Jason White	Action Plan completed and submitted to HSCB. Trust are working through the backlog. Trust will have caught up in all inspections by March 2022 108 remain outstanding **31/03/22 update** 3 overdue inspections This has been impacted due to COVID and workforce challenges This might increase again due the inspections in year	
7 Issue: Young people requiring hospital admission The Trust has seen an increase in the number of young people from 6 to 18 (28 ASW	• HSCB (Paul Millar & Martina McCafferty) to meet with the Trust (John Hogan & Linda McConnell) to examine this	30.9.21	Paul Miller / Martina McCafferty John Hogan / Linda McConnell	Meeting to take place in October 21 with named leads in Trust / HSCB. 16/12/21 A meeting took place and information received	

assessments in total), seeing a formal admission for assessment to hospital under the Mental Health Order 1986. **Update at DSF meeting 14.6.21** Insufficient beds in Beechcroft necessitated admissions to adult wards. No specific reasons for the increase has been identified	increase in further detail			Action completed	
8 Issue: Explore current provision of Tier 3 & 4 CAMH services by Belfast Trust	Action: • Trust to meet with HSCB Lead (Paul Millar) to discuss current model between SEHSCT and BHSCT re CAMHs provision	**Trust to provide date**	Julie Kilpatrick AD Paul Millar	Meeting to take place in October 21 with named leads in Trust / HSCB. 16/12/21 Work is ongoing Regionally Julie now sits on the AD CAMHS forum.	

				31/03/22 update Meeting has taken place to review CAMHS STEP 1 and 2 Interface meetings with BHSCT re Beechcroft Consultant nurse has been recruited to This will assist in the joint working. This will assist with the EH and Wellbeing strategy. Meeting to take place in October 21 with named leads in Trust / HSCB.	
9 Issue: Decrease in numbers on Child Protection Register March 20 = 373 March 21 = 350 A decrease of 23 (6%) Regionally March 2020 = 2,298 March 2021 = 2,298	**Actions:** • **No action required – included for information only**				

Discussion at DSF meeting 25.6.21 Trust undertook an analysis of thresholds, and were satisfied with decision made.					
10 Issue: Increased numbers of Looked After Children March 2020 = 630 March 2021 = 639 An increase of 9 (I %) Regionally March 2020 = 3,383 March 2021 = 3,530 An increase of 147 (4%) **Discussion at DSF meeting 25.6.21** Trust undertook an analysis of thresholds, and were satisfied with decisions made.	**Actions:** • **No Action required – included for information only**				

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Issue	Action Required	By When	Owner	Progress Report	RAG status
Mental Health Issues					
11 Issue: Mental Capacity Act – Trust not yet fully compliant MCA - Trust has made significant progress, increasing compliance to 91% **Update at DSF meeting 14.6.21** Compliance at time of DSF meeting is now at 95%	• Full compliance in relation to legacy cases by 30/06/21	30.6.21	Margaret O'Kane	Full compliance achieved	
	• Trust is currently progressing an increase in capacity for medical professionals to work on MCA	Trust to provide date	Margaret O'Kane	**Update 11/2/22** Current MCA issues highlighted in SEHSCT MCA Assurance report Jan 22 include; Lack of Medics to complete Assessments Workforce capacity in respect of STDs, MH legacy cases and Trust Panels and additional requirements in relation to Article 15 form 6 Ongoing activity by HSCT to progress Discussion ongoing with Medical Director Small amount of form 6 require action. Frustrations in getting	

				medical sections complete to finalise. Consultants are employed by BHSCT, there will be benefits when SE psychiatrists are recruited. Majority of work is sw task. This must be kept live issue when considering resource and capacity. ACTION: Trust to keep HSCB appraised of any developments.	
	• Trust to provide an update on discussions with Medical Director in relation to MCA	30.6.21	Margaret O'Kane	Update 11/2/22 Discussions take place on a regular basis between both parties.	
12 Issue: Insufficient Mental Health Acute Inpatient beds Trust to take forward: - Recommendations from RQIA Action Plan - Contingency plans for Ward 27.	• Trust to provide updates on Improvement Plan at monthly meetings with the Trusts	Monthly	Damien Brannigan AD M/H Services & DoH	**Update 11.2.22** RQIA actions created a huge amount of work relating to resettlement and 4 work streams were developed. This was queried as part of the action plan as not related to statutory functions.	

- Full engage in bed management network group **Update at DSF meeting 14.6.21** Trust has a robust improvement plan in place. Monitoring and review arrangements are in place with HSCB In relation to Ward 27, the Trust report RQIA observed compassionate care in place. Improvement Notice now in place, with a separate monitoring process in place between Trust and HSCB Directors. Trust advise they have sufficient inpatient beds, and are in a position to, at time, accommodate out of Trust beds.				Clarity re-funding for house 10 needs to be determined. Martina advised that the OBC for House 10 has been approved by HSCB and progress is being made to resettle patients from Ward 27. There is an LD patient currently in house 10 however moving to another facility soon. RQIA improvement notice remains live.	
Issue	**Action Required**	**By When**	**Owner**	**Progress Report**	**RAG status**
Learning Disability Issues					
13 Issue: Mental Capacity Act 33 MCA remain outstanding. Trust to update HSCB on the action plan to complete compliance with MCA **Update at DSF meeting 14.6.21** Agreed action plan to be provided to HSCB	• Action Plan on progress with compliance to be provided to HSCB	31.7.21	Margaret O'Kane	**Up-date at DSF meeting 22/10/21:** Trust confirmed associated Action Plan forwarded to HSCB within required timeframe. All 33 outstanding cases have been completed.	

				11/2/22 Update: Action complete, no further discussion necessary.	
14 Issue: Access to Inpatient Beds for people with a learning disability who present with mental health issues In this reporting period there are 4 people known to LD services who are patients in MH wards. 2 In particular are inappropriately placed due to the severity of their LD **Update at DSF meeting 14.6.21** Trust confirmed issues regarding capacity and pathways. LD & MH services are working collaboratively on a case by case basis. Trust held a workshop looking at mild LD alongside MH issues and when and where it is appropriate to admit.	• SE Trust to work in support Northern Trust to develop inpatient LD facilitate in Holywell Site (30/09/21) Margaret O'Brien Lead	30.9.21	Lyn Preece/Fiona McClean	**Up-date at DSF meeting 22.10.21**: SESHST confirmed currently no service users with a learning disability placed in MH inpatient beds. The Trust has worked with MH colleagues to develop draft flowcharts/pathways to support consistency of practice regarding admissions. Further discussion required with MH colleagues before flowcharts/ pathways can be finalised. Trust to share draft flowcharts with HSCB.	

As with MH inpatient beds, there is a regional approach required in identifying appropriate beds for LD.	• Trust to consider mitigating steps with regards to patient who would otherwise be admitted to Muckamore being admitted to MH facility	31.7.21	Damien Brannigan/ Lyn Preece	**Up-date at DSF meeting 22.10.21**: The Trust is currently working with NHSCT colleagues to develop a three bedded unit in Holywell site to facilitate hospital admission for service users requiring inpatient assessment and treatment. It is anticipated this will enhance provision for service users requiring inpatient admission given the current difficulties accessing beds in MAH. SEHSCT to share draft flowcharts/ pathways with HSCB to support regional discussion/ consideration of appropriate pathways/admissions criteria. HSCB received a draft SEHSCT Pathway for Service Users with a mild/moderate Intellectual Disability presentation and a	

				SEHSCT Pathway for service users with a severe/profound Intellectual Presentation who may require admission to hospital for psychiatric inpatient care on 22.10.21. **Update 11/2/22:** Work by Trust to support 3 bedded unit in Holywell acknowledged. Unit not yet opened. Anticipated unit will open May/June 22. Rag rating agreed as amber.	

Issue	Action Required	By when	Owner	Progress Report	RAG status
Older People & Adults Issues					
15 Issue: No issues	**Actions:** •			**Progress at 9th February 2022:** No actions identified previously. Adult Safeguarding have now established one point of referral for Adult services. This is currently being reviewed. It is noted some	

				staffing challenges due to COVID-19.	
Issue	**Action Required**	**By when**	**Owner**	**Progress Report**	**RAG status**
Physical Disability and Sensory Impairment Issues					
16 Issue: Supervision – Not compliant with supervision policy in one sector (25%) **Update at DSF meeting 14.6.21** Trust have re-audit at the end of July and expect compliance to improve further.	• Trust to update HSCB following the re-audit	31.8.21	Clare McStay/Fiona McClean	Update audit scheduled for end of July. Progress at 11th October 2021: Review of DSF Action Plan with SET confirmed this action is now complete and SET will continue to monitor and ensure compliance with supervision policy In addition PHSD notes they have no outstanding MCA reviews Progress at 10/02/22: Status as above. No further action required.	

RAG Rating	
Completed/Confident of Delivery on Actions	

Work in progress and on track for completion within agreed timescales	
Not Complete/ Not on track for completion within agreed timescales	

The above action plan was reviewed at interface meetings with SPPG and Trusts (minimum 3 times yearly). Progress updates were completed after each interface meeting and reviewed by Senior Operational Management Team, SPPG.

This is to confirm that the above Action Plan has been reviewed by the Social Care and Children's Directorate on 07/06/22 and will be signed off at the DSF meeting on 23/06/22. Any outstanding issues requiring further progress will be reviewed at the DSF Meeting with the South Eastern Trust and these alongside any new issues will be presented in the 2022/23 Action Plan.

Signed  Date 11 July 2022

Brendan Whittle, Director of Hospital & Community Care

2.6 SHSCT DSF ACTION Plan 2021/22 - YEAR END UPDATE MARCH 2022

Programme of Care	Total Number of Issues	Red RAG	Amber RAG	Green RAG
Family and Children	5	0	1	4
Mental Health	2	0	1	1
Learning Disability	3	0	2	1
Older People and Adults	4	0	3	1
Physical Disability / Acute	1	0	1	0
Total	**15**	**0**	**8**	**7**

Issue	Action Required	By When	Owner	Progress Update	RAG Status
Family & Childcare Issues					
1 Issue: Unallocated cases March 2021 = 120 On-going risk associated with unallocated cases in Family Intervention Teams which is directly related to the demand for service and staff capacity Increased numbers of cases including ASD cases requiring further complex, time-intensive intervention following initial assessment Increase in children in the Child Protection Register	Actions: to address workforce issues: 1. Weekly review of vacancies by Directorate Senior Management Team and Heads of Service 2. Challenges with recruitment processes continues to be addressed with BSO and Trust HR 3. Ongoing recruitment campaigns and initiatives with permanent contracts being issued to those covering maternity leave and	Ongoing Ongoing Ongoing	Donna Murphy, AD SHSCT	**Updated: 02.11.21** Trust advise that there are no unallocated cases for Child Protection and LAC. The unallocated figures was 60 at the end of June and have risen to approximately 77 *(return to be quality assured by AD)* at end of October in line with staffing deficits. Trust outlined that they have participated in the regional recruitment exercise but numbers materialising from such are low. There are	

March 2020 – 555 March 2021 – 603 An increase of 9% Regionally March 2020 = 2,298 March 2021 = 2,298 The Trust also advise that changes in unallocated cases are directly linked to vacancies.	long-term sickness to develop a flexible workforce			currently 9 vacancies in CwD and 21% in some FIT teams. Vacancies have been placed on SHSCT Directorate Risk Register and Trust outlined intent to place on Trust Corporate Risk Register. In community paeds 2 locum staff were appointed which has assisted in areas such as SEN etc . While additional funding has been provided across various areas of Children's services for new posts the issue of backfill remains challenging for existing	

				core services/funded posts. **Update 21.03.22** Current unallocated figures are at high levels – 359 (none of which are LAC or CP). The 4 x unallocated CP cases in January are now allocated. This increasing number correlates to ongoing vacancies and workforce issues which are reported to HSCB via monthly return. Concerns remain regarding the significant rise in family support cases remaining unallocated; staff caseloads increasing	

				above normative levels and system pressures / blocks as unable to work cases to point of transfer or closure. The Trust is progressing a number of actions to mitigate these pressures. The DoH led workforce appeal did not assist as 0 staff were available for the Trust's Children's Services however, Trust internal process resulted in 3.5wte for use across the teams. This appeal will be repeated in April.	

				Final year social work students (June graduates) have been offered permanent posts with robust induction and supports in place. All non-front facing social workers are being considered for redeployment to statutory roles (commensurate with their skills and capability). Staff incentives e.g. covid rate payment introduced to progress initial gateway assessments; and for FIT staff to complete short-term work; progression	

				of pathway assessments. Across divisional transfer of cases is now being considered. The directorate wide risk has been escalated to the Trusts corporate risk register and Trust board were informed.	
	4. Improved induction pack aligned to Signs of Safety practice model	Ongoing		Achieved	
	5. Compassion focused staff support sessions provided monthly by clinical psychologists using CFT model (compassion focused therapy)	Ongoing		Achieved	

	6. Formal reflective practice to be introduced for Senior Managers and Front-line Managers	Sept 21		Achieved	
2 Issue: Significant referral pressures across all CAMH Services, including access to inpatient beds in Beechcroft Numbers of children/young people currently on waiting list (as of 11 June 2021 there are 450 young people awaiting CAMHS assessment) Number of children/young people currently waiting on	**Actions:** • Trust to provide plan on how they will utilise additional staff to reduce waiting list and how additional finance has impacted and improved waiting list.	31/07/21	Julie McConville, AD SHSCT	**Updated: 02.11.21** DoH Review in regard to Children's service has confirmed it will now include both Iveagh and Beechcroft. Trust were asked to provide assurance that there were no delayed discharges from Beechcroft and that exit plans were being	

admission/discharge from Beechcroft (as of 11 June, 4 young people from SHSCT were in Beechcroft with 0 on waiting list) **Discussion at DSF meeting 21.6.21** Trust have had additional financial resource allocated, however staffing levels now need to be increased in order to reduce waiting list numbers. Trust are meeting their targets with regards to first appointments. Improvements needed in provision of assessment and ongoing support for young people accessing CAMHS				progressed in terms of all SHSCT young people in the unit. Whilst the Trust report that waiting lists and CAMHS assessments are being managed within stipulated timeframes, there are still concerns noted regarding staffing and vacancies / backfill into posts. **Update 21.03.22** No delayed discharges were reported however, issues were noted in relation to Beechcroft's current inability to accept admissions. One young person was currently being managed in the	

				community with intensive CAMHS support. The reporting to HSCB in relation to these cases and risks for the Trust requires clarification – to be raised with social care commissioning lead for CAMHS. The Trusts were undertaking an exercise to review their usage / occupancy of Beechcroft and benchmarking with other Trusts as it would appear the Trust have lower numbers of young people placed. 298 young people are currently awaiting appointments. Of	

				these, 4 breach the waiting list target but their appointments are scheduled. At SPPG Planning Meeting on 08.06.22 it was agreed that the Trust have made significant improvements and SPPG are satisfied with progress. Rag status therefore changed to Green.	

3 Issue: **Insufficient Placements to meet demand** Trust being required to manage risk in the community for longer period of time than normal due to delays in Court hearings. Increase in demand for placements during the reporting period, specifically in relation to emergency placements and foster placements Looked after Children March 2020 – 562 March 2021 - 591 Increase of 29 (5%) 29 Unregulated Kinship Placements –	**Actions:** • Trust to provide update at midpoint review	Sept 2021	Colm McCafferty AD	**Updated: 02.11.21** Trust update reporting increasing numbers of children coming into care and therefore still significant pressure on securing placements both in terms of family placements and residential. New pressures identified by the Trust include the demand for Bail placements and increased demand for adolescent placements with additional needs / complexity i.e. substance misuse, criminal exploitations, violence and associated severe trauma. This increase in demand is coupled with a drop in the number of fostering	

Discussion at DSF meeting 21.6.21				enquiries across the region. Recruitment remains a priority for short break carers and mainstream fostering. At the end of September the number of unregulated Kinship placements has reduced to 10. The edge of care service is fully operational with all staffing now in place. The Trust report that whilst this is a new	

HSCB satisfied with Trusts response and actions in place to manage unregulated kinship placements. Edge of Care services continue to be developed. The Trust also outline the lack of placements available in the independent sector. The Trust regularly review cases to ensure appropriate threshold decisions both in LAC and CPR cases. Cases appear to be more complex. The Trust welcome the Regional review of Children's services.				service in its infancy there are positive outcomes emerging. SPPG DSF Planning Meeting on 08.06.22 – agreed that the Trust are taking all necessary actions to address this challenging area of work. Rag status changed to Green **Update 21.03.22** Placements remain challenging across the spectrum as well as increasingly complex cases with demand exceeding supply. Local and regional recruitment continues as does supports to	

				carers to maintain their resilience levels. 7 x short-break fostering assessments are ongoing having positively moved through the process of home study and pre-approvals training. At the end of December the number of unregulated Kinship placements has reduced reduction to 5. The Edge of Care Service continues to remain as fully operational and is well embedded. Skill mix has been helpful / positive and there is	

				potential learning ref: delegation of non-statutory social work duties that can increase social work staff capacity.	
4 Issue: 41 LAC Reviews outside timescales **Discussion at DSF meeting 21.6.21** Trust have made significant improvements and reduced the number over the past six months.	**Actions:** • Trust to provide an update on LAC reviews outside timescales	31/07/21	Colm McCafferty, AD	**Updated: 02.11.21** Within the last reporting period the Trust report 26 or 363 reviews being held outside of timeframe but state that there was no impact on case planning and all were rescheduled at the earliest opportunity.	

				Update 21.03.22 The Trust report that the number of LAC Reviews held late are very few in comparison to total numbers held *(DSF data return will confirm),* and any late review is held within 2 weeks of the original date. No adverse impact noted for case planning to date and no reviews were outstanding at month end.	
5 Issue: Children with Disability / Short Breaks	**Actions:** • Trust to provide an action plan/recovery plan outlining clear timeframes	31/07/21		**Updated: 02.11.21** Trust advised that they were working with RQIA and adult services to	

Admissions to Carrickore currently suspended due to care of 2 children in the home. Short break fostering provision has also been reduced due to COVID restrictions and a number of children continue to await a short break placement through this scheme **Discussion at DSF meeting 21.6.21** Trust have been unable to access short breaks in Carrickore for over 2 years. Willowgrove/Oaklands have been asked to increase capacity. This has not translated into increased short breaks due to covid measures. In a Covid secure environment the Trust will be able to upscale facilities. The Trust have also upscaled their short break fostering capacity.	for stepping up short breaks capacity		Colm McCafferty, AD SHSCT	effect a transition as soon as possible but within a defined timeframe set down by RQIA. Action plan re short breaks still outstanding and to send to HSCB Trust indicating that lack of placements for CWD was a regional issue, however, the Courts have clearly determined that the duty to provide placements resides with the Trusts. There was discussion re the mechanisms for planning to enhance provision and need for children's services in SHSCT to engage with	

Trust have put in significant community based supports which has been a very positive contribution and support to families and children.				the Trusts capital planning process in that regard. The Trust report that Short Break Fostering recruitment has had a favourable response to a number of promotion drives with 12 active carers and 7 home studies currently ongoing. **Update 23.03.22** Young person was successfully transitioned to an adult facility. Currently 4 x young people are in placement with another due to reach full capacity. Financial deficit has been raised as cost pressure through recent	

				communication between the Trust and HSCB finance colleagues.	

Issue	Action Required	By When	Owner	Progress Report	RAG status
Mental Health Issues					
6 Issue: Mental Capacity Act (MCA) - there remains concerns about our capacity to meet the demands of the Mental Capacity Act teams are working with higher levels of less experienced staff than in previous years and therefore many social work staff do have the required 2 years' experience with persons who lack capacity.	**Actions:** • Trust will continue to work on to ensure compliance	Ongoing/March 2022	Kathy Lavery	In terms of completion there are 20 outstanding Form 6 reports still required. An additional resource has been put in place to address. There are only 8 legacy level 2 assessments remaining. **Update 25.1.22**	

The increasing numbers of Rule 6 requests has impacted on staff time to focus on legacy DoLS and maintain our target completion date of 31st May. **Discussion at DSF meeting 21.6.21** Trust advise backlog is in regard to completion of Form 6 (this is both MH and LD). There is a dependency on psychiatrists undertaken form 6, sessional Dr's do not have capacity to do this work.				All Mental Health and Memory service phase 1 legacy cases have now been completed Phase 2 = 9 MH / 202 MEM	
	• Trust will continue to liaise closely with the medics to increase capacity	Ongoing/March 2022	Kathy Lavery	The additional work load has impacted on staff. **Year end update** The additional work load has impacted on medical staff and has added to the current pressures of high level of vacancies. MCA sessional doctors have provided support	

				to get the legacy cases completed .	
	• Wider MCA discussions to be undertaken a Regional Group with HSCB/DoH	Ongoing/March 2022	Kathy Lavery	This is subject to ongoing monitoring through the DoH assurance reports and the monthly Strategic advisory Board meetings chaired by HSCB. **Discussion at DSF meeting 22.2.22** Considerable work has been undertaken to complete legacy cases- currently no outstanding legacy cases within MH, 6 within LD. Pressure remains on the system however due to	

				ongoing issues with availability of medics. The assessments required within day centres will also put increased pressure on workforce. However work has commenced to support the workforce in understanding who requires assessment and the process involved which has been a positive development. RAG rating to remain at amber.	
7 Issue: U65's access to assessment and diagnosis with the Specialist Memory Service has been limited	Actions: • Trust to provide terms of reference and provide	30/09/21		ToR Under 65 TF group_sept_21.docx	

Discussion at DSF meeting 21.6.21 Trust to outline pathway open at present and to ensure U65's are accessing the service. Trust confirm that U65's do have access to Psychiatry. There is a review of memory service being undertaken during 2021/22	action plan to HSCB to monitor progress on Task and Finish Group for review of memory service.		Jan McGall, AD MH Services	No further update , Jan was an apology to the meeting. Update: any new referrals for under 65's with a diagnosis of dementia will be automatically allocated to the Memory Service and not POA as was the previous position. We are also working to transfer to Memory Services any individuals under 65 with a diagnosis of dementia and currently on POA caseloads **Update at DSF meeting 22.2.22** Trust advised that there are 9 patients residing in care homes that require	

				migration from POA Services to Memory Services. This will be completed by end March 2022. There are 600 individuals on the Memory Services caseload. Trust to commence a review of community infrastructure in the next few weeks and are hoping to enhance their MDT to include both SLT and Physio support. Current waiting times are 12 weeks but the service is hoping to reduce this to 9 weeks. Service is also progressing with accreditation through Memory Services National Accreditation Programme (MSNAP).	

				RAG rating to remain at Amber until all 9 patients are migrated from POA to Memory Services. SPPG DSF Planning Meeting on 08.06.22 – agreed that there was satisfaction with progress made by the Trust. Rag status changed to Green	
Issue	**Action Required**	**By When**	**Owner**	**Progress Report**	**RAG status**
Learning Disability Issues					
8 Issue: A lack of available community-based accommodation for our young people and adults with disability who require either specialist or a bespoke	**Actions:** • Trust to provide update on actions to increase capacity and meet	30/09/21		Work in progress, 2 carer consultants have been appointed and are now involved in the work stream. Caroline McGonigle will follow up	

arrangement is challenging the delivery of effective care. **Discussion at DSF meeting 21.6.21** Trust have been developing a specialist placement pathway to identify bespoke accommodation for those with complex needs. Regional procurement process is underway. Direct Award process is being utilised to provide timely accommodation The Trust have also developed a specialist team to work alongside Independent Sector to have a specialist service in the community to identify more appropriate accommodation. Regional discussions have looked at how Trusts can pool resources to best meet the needs of those	accommodation needs appropriately		John McEntee, AD SHSCT	a date for discussion with HSCB bed capacity lead. **Update at DSF meeting 22.2.22** Trust continues to develop accommodation in partnership with other agencies. Trust commented on NIHE Strategies, Ending Homelessness Together and Homeless to Home. Monthly accommodation Panel supports forward planning. Difficulties ongoing re securing suitable accommodation for service users with a complex Learning Disability. Trust have developed Specialist	

requiring specialist accommodation, also inc. how to attract independent providers to NI.				Team to work with ISPs . Relates to regional work re CART. Trust developing CARS Team to provide Behaviour Support/Intensive Support 7 days per week 8-1. Project Manager in place. Trust commended for ongoing work, agreed rag rating to remain as amber as this area given continued challenges.	
	• Trust to provide data in terms of demand and capacity	30/09/21	John McEntee, AD SHSCT	This has been provided to HSCB through the Regional procurement group meetings which SHSCT attends and is chaired by HSCB. Ongoing. **Update 25/1/22**	

				Trust continues to work with ISP to develop bespoke schemes and to work with regional partners to plan for and facilitate hospital discharges. No new provider contracts initiated during this period. **Update 22/02/22** Trust continues to work with regional colleagues to support discharge and resettlement. Trust engaged in Regional procurement group to develop a framework for Enhanced Domiciliary Care Provision to support independent living. Rag rating to be retained as amber.	

9 Issue: Adult Safeguarding - Pressures on DAPO's. Issues in adult safeguarding in terms of reduction in JP investigations due to PSNI position to undertake single agency response. **Discussion at DSF meeting 21.6.21** Trust introducing a DAPO 'buddy system' and sharing workload through a rotational of work to ease pressure on staff. Issue regarding single agency PSNI investigations and Joint Protocol matter to be taken to Adult Protection Board, and will not be put on 2021/22 Trust DSF Action Plan	**Actions:** • Trust to introduce a DAPO rotational model (Workshop schedule for June/July). Update to be provided at midyear point	31/07/21	Kathy Lavery	This has been implemented along with specialist DAPO for MHD complex cases – continued drive to increase number of DAPOS **Update 25/2/22** The MHD Directorate have achieved a 15% increase in the number of DAPOs in post and all are working to the new rotational model which is due for review in Feb.	
	• Band 7 Job descriptions to include JP/DAPO role	30/09/21	Kathy Lavery	DAPO rotational model in place. Every band 7 sw must take on DAPO role. Rotation is working very well.	

				Roughly 1 per month per worker. This upskilling of staff has created more confidence and capacity in the workforce. **Update 25/1/22** The MHD Directorate has achieved a 15 % increase to the number of band 7 SW undertaking the DAPO function. The introduction of the rotational model and the increased number of DAPOs has significantly reduced the number of DAPOs referrals undertaken by many of our DAPOs. On average DAPOs will be allocated 6-8 cases per annum.	

	• Trust to outline their training needs analysis for 2021/22	31/08/21	Deborah Hanlon	SSTDT have corporate training programme for 2021/22 which can accommodate demand for initial training as required. CPD is available on a quarterly basis to all staff undertaking protection work Update at SPPG DSF Planning Meeting 08.06.22 – satisfied with progress and actions undertaken by Trust – Rag status changed to Green	
	• Trust to share action plan on Senior oversight of Adult Safeguarding		Kathy Lavery	Trust to share action plan with HSCB Update at SPPG DSF Planning Meeting 08.06.22 – satisfied with progress and actions	

				undertaken by Trust – Rag status changed to Green	
10 Issue: Mental Capacity Act (MCA) - there remains concerns about Trust's capacity to meet the demands of the Mental Capacity Act, teams are working with higher levels of less experienced staff than in previous years and therefore many social work staff do not have the required 2 years experience with persons who lack capacity. **Discussion at DSF meeting 21.6.21** Trust advise backlog is in regard to completion of Form 6 (this is both MH and LD). There is a dependency on psychiatrists undertaking form 6, sessional Dr's do not have capacity to do this work.	**Actions:** • Trust will continue to work on to ensure compliance	Ongoing/March 2022	Kathy Lavery	There are 120 completed on the ground which are waiting on completion of Form 6 to finalise the process. Trust have recruited a sessional doctor who will complete 2 sessions per week with an aim to complete 2/3 form 6's per week. Ideally to meet actions 6 per week would need completed by end of March. **Discussion at DSF meeting 22.2.22** Considerable work has been undertaken to complete legacy cases-	

				currently no outstanding legacy cases within MH, 6 within LD. Pressure remains on the system however due to ongoing issues with availability of medics. The assessments required within day centres will also put increased pressure on workforce. However work has commenced to support the workforce in understanding who requires assessment and the process involved which has been a positive development. RAG rating to remain at amber.	

				Update 25/2/22 There are currently 19 phase 1 LD legacy cases still outstanding however these will be achieved by 31st March.	
	• Trust will continue to liaise closely with the medics to increase capacity	Ongoing/March 2022	Kathy Lavery	**Update re LD 25/1/22** Workload capacity among our MH and LD psychiatrist is currently at crisis point and there is limited capacity to undertake any MCA work. Additional resource is required within the MCA sessional bank to ensure the service can be delivered.	

	• Wider MCA discussions to be undertaken a Regional Group with HSCB/DoH	Ongoing/March 2022	Kathy Lavery	Ongoing	

Issue	Action Required	By when	Owner	Progress Report	RAG status
Older People & Adults Issues					
11 Issue: Annual Reviews outstanding Trust confirmed figures of outstanding annual reviews as follows: **Service Type** — **>1 Year** Residential Home Placement — 137 Nursing Home Placement — 588 Domiciliary Care Package — 1435	**Actions:** • Trust to provide action plan with timeline and trajectory to ensure compliance	31/07/21	Brian Beattie	1. An Action plan has been developed with a trajectory and proposed timeline which will be monitored monthly by the Social Work Managers to determine progress. (attached) 2. The Action plan will be further developed to include Care Home Annual Reviews. 3. A work plan has been developed with Social Workers to provide ring-fenced annual review days to undertake 2 annual reviews per week per WTE.	

Total **2160** **Discussion at DSF meeting 21.6.21** Trust advise this has been a challenge for a number of years. There have been additional pressures due to covid and associated restrictions. Trust have made additional 12.5 additional SW (total now 46 band 6 SW's) and 7 Band 4 care workers to reduce caseload size. This was done pre-covid and therefore Trust did not feel the benefit. The Trust will have to re-visit this investment in additional staff to reduce caseloads and therefore make more time to complete reviews.				4. Recruitment is ongoing a number of posts have been recruited into permanently. 5. The demand to support Service Users is exceeding the capacity within the teams with urgent work taking priority.  Copy of Annual Review Cutting Plan - **Discussion at DSF meeting 29.9.21** At 29.9.21 there are 2,215 outstanding reviews and a plan is in place to complete an average of 48 reviews per week from 9.8.21 to 10.10.22 in order to address this backlog. MCA DOLs assessments are taking priority over non-urgent annual reviews. Trust has progressed with recruitment to some permanent social work posts at risk in order to address maternity leaves and	

				delays in recruitment processes. This remains ongoing. **Update 15/02/2022** **Service Type** / **>1 Year** Residential Home Placement: 147 Nursing Home Placement: 509 Domiciliary Care Package: 1458 **Total: 2114** **Update 23/2/22** Pressures remain with Dec '21-February '22 particularly challenging due to reduced staffing linked to C-19.	

				10% of ICT resource transferred to MCA posts, urgent &MCA work taking priority ie. Safeguarding, hospital discharges, step-down beds and carer breakdown Alongside recruitment to vacancies Trust has proposal with Director for 4 additional Sen Prac posts to cover urgent work in ICT so core work can continue.	
12 Issue: Domiciliary Care 137 outstanding domiciliary care = 841 hrs 55 mins **Discussion at DSF meeting 21.6.21** Trust advise this is an ever changing picture. The range of needs differs significantly. Where there is unmet	**Actions:** Trust to provide action plan to address waiting list to include: • Maximise use of direct payments • Recruitment of more domiciliary care staff	31/07/21	Brian Beattie	1. There is a current plan to ensure rolling monthly, and fortnightly recruitment 2. Trust Communication Team have supported a 5 weeks PR recruitment exercise on social media.3 3. The workforce appeal has been accessed (126 applied to be interviewed	

need the Social work teams have additional work in terms of monitoring and staying in touch with these individuals. There are also challenges with SDS. Trust are continually trying to recruit staff, though there is a constant turnover of staff. Band 4 now in place to assist with moving recruitment forward	• Dynamic assessments of individuals • Increase capacity of independent sector			4. Demand for service is continually exceeding service capacity. 5. Trust Home Care has additional recruitment ongoing through August 2021 which has been supported through a new position Recruitment liaison officer who is scrutinising processes to remove some of the barriers which create commencement delays **Discussion at DSF meeting 29.9.21** Current position is in region of 540 care packages outstanding (related to lack of workforce). This represents approx. 10% of all cases. In addition to the workforce appeal which saw recruitment of approx. 30 staff , Trust has carried out recruitment fairs with small numbers being recruited, however this has resulted in staff	

				transferring from the independent sector. There is also the current issue of handbacks from the independent sector. Trust is hoping that the issue of equity of pay in the independent sector across both jurisdictions can be addressed as this is also an issue which negatively impacts on workforce availability. **Update 23/02/22** Level of unmet need remains as previously reported. Work plan for 2022/23 to review the In –House Model. Rolling recruitment ongoing for Trust DCW's/supporting Regional college Apprenticeship launch in Feb '22/Appointment Nov'21 of Dom Care Recruitment liaison officer to support new care staff /exploring pilot with Health Sector Talent to assist with recruitment/exploration of live monitoring system for In- house Service	

13 Issue: Delayed Hospital discharges - Trust to clarify numbers of individuals affected Delayed Discharge dashboard indicates that in May 2021, 32 patients were a complex delayed discharge > 48hours with unavailability of domiciliary care package as the most common reason for the delay. **Discussion at DSF meeting 21.6.21** Complex discharges are reviewed twice daily in Control room with MDT staff and ICS In reach Co-ordinator There is also a weekly meeting to look at those waiting over 7 days. Community colleagues	**Actions:** • Trust to provide overview/analysis of issues resulting in May delayed discharges	31/07/21	Flo Fegan	HSCB ACTION PLAN REPORT JULY 21 (2). The above attachment is a synopsis of progress update **Update 23/02/22** work continues on implementation of the 3-4 key priorities which are being monitored to evidence impact and outcomes on patient flow and timely discharges from hospital : Discharge before 12 midday / Discharge to Assess & Nurse Facilitated discharge and effective use of care home beds. This continues to be a challenging area of work, for which all	

are invited to this. The main challenge is getting families to take up SDS, very small numbers are taking this up each month.				Directorates are working collaboratively to address.	
	• HSCB/Trust to discuss this and determine if Trusts are taking all necessary actions			**Discussion at DSF meeting 29.9.21** Trust commended on the delayed discharges action plan which includes the 3 key priorities identified in the Regional Discharge Group. Review of the delayed discharges highlighted coding errors with plan for training of ward clerks. The appointment of the B7 HSW at risk for EDP is providing bed days savings as these patients albeit small numbers are being discharged on date declared medically fit. There remains the issue of being able to identify carers for EDP cases. Noted from the audit of May discharges was the number of patients delayed from other	

	• HSCB/Trusts - consideration should be given to establishment of a register of carers for DP recipients			Trusts. SHSCT continue to work with the other Trusts in escalation of these patients. There continues to be difficulties identifying placements for patients with challenging behaviours without a dementia diagnosis. Chief Executive letter for inpatients has been implemented from July 21	
14 Issue: MCA Trust to ensure all legacy DOLs assessments are completed before 31st May 2021. At 30.4.21 the number of outstanding legacy cases was: Care Home Support Team 537 Integrated Care Team 93 Memory Services 43	**Actions:** • Trust will continue to work on to ensure compliance	Ongoing/March 2022		The Phase 1 DOLS legacy cases have been prioritised within ICT. As of 27th July 2021 the figures show that there are 12 legacy Phase 1 cases to complete within ICT. The teams are progressing with these legacy cases and new cases but due to the availability of medical staff to complete form 6 there is a backlog of DOLS applications to be completed.	

Discussion at DSF meeting 21.6.21 Trust advise backlog is in regard to completion of Form 6 (this is both MH and LD). There is a dependency on psychiatrists undertaking form 6, sessional Dr's do not have capacity to do this work.				Staff having the relevant experience to undertake DOLS assessment is also impacting on the teams as with the recent recruitment a number of AYE social workers have been appointed and therefore not eligible to undertake DOLs assessments. In one ICT team, 3 AYE Social Workers will commence in August 2021 which will impact on the completion of DOLs within the team. **Update 23/02/22** outstanding legacy cases : Care Home Support Team – 19 which will be completed by March'22.	

				Further work required to address outstanding legacy cases in day care with most relating to memory. Trust able to access additional medical capacity to complete medical reports 3 bespoke facilitated sessions provided by MCA trainers for ICT Update at SPPG DSF Planning Meeting 08.06.22 – to be followed up with SHSCT 9.6.22 - SHSCT confirmed they have no legacy DOLS to complete - SPPG satisfied with progress and actions undertaken by Trust – Rag status changed to Green	

	• Trust will continue to liaise closely with the medics to increase capacity • Trust to consider if medical capacity would be available in another Trust	Ongoing/March 2022		Ongoing Update at SPPG DSF Planning Meeting 08.06.22 – SPPG satisfied with progress and actions undertaken by Trust – Rag status changed to Green	
	• Wider MCA discussions to be undertaken a Regional Group with HSCB/DoH	Ongoing/March 2022		On-going **Discussion at DSF meeting 29.9.21** Taken from DOH data at August 21: ICT-110 legacy cases outstanding CHST-389 legacy cases outstanding Memory service-53 legacy cases outstanding PD- 5 legacy cases outstanding	

				Trust has diverted significant time over past 6/9 months to complete this work. The delays in securing the medical assessment can result in SWs having to redo the assessment and subject service users to repeat assessment. Update at SPPG DSF Planning Meeting 08.06.22 – SPPG satisfied with progress and actions undertaken by Trust – Rag status changed to Green	

Physical Disability and Sensory Impairment Issues					
15 Issue:					

Lack of Nursing Home beds for Physical Disability service users. No residential care beds for physical disability service users often results in service users being placed in nursing care when residential care would meet their needs. Trust to confirm numbers of individuals affected. Trust to outline what action they are taking/other options they are pursuing to ensure appropriate placements are identified. **Discussion at DSF meeting 21.6.21** Complexity of cases is impacting on securing beds as NH will not accept some complex cases.	**Actions:** • Trust to undertake a 'Look Back' exercise April – June to determine if those with assessed needs are being placed in nursing home beds as opposed to residential	30/08/21	Tracy Rogers	Between April 21 – June 21 – 6 PD service users where placed in NH beds inappropriately. Reasons for admission include lack of appropriate Residential beds, supported living and housing options. **Update 23/02/22** The lack of appropriate bespoke care environments for the younger client with significant needs remains an issue	

MAHI - STM - 097 - 5890

RAG Rating	
Completed/Confident of Delivery on Actions	
Work in progress and on track for completion within agreed timescales	
Not Complete/ Not on track for completion within agreed timescales	

The above action plan was reviewed at interface meetings with SPPG and Trusts (minimum 3 times yearly). Progress updates were completed after each interface meeting and reviewed by Senior Operational Management Team, SPPG.

This is to confirm that the above Action Plan has been reviewed by the Social Care and Children's Directorate on 08/06/22 and will be signed off at the DSF meeting on 22/06/22. Any outstanding issues requiring further progress will be reviewed at the DSF Meeting with the Trust and these alongside any new issues will be presented in the 2022/23 Action Plan.

Signed_____ _____ Date _____

Brendan Whittle, Director of Hospital & Community Care

2.6 WHSCT DSF ACTION Plan 2021/22 - YEAR END UPDATE MARCH 2022

Programme of Care	Total Number of Issues	Red RAG	Amber RAG	Green RAG
Family and Children	14	2	6	6
Mental Health	4	0	2	2
Learning Disability	5	1	3	1
Older People and Adults	3	0	2	1
Physical Disability / Acute	3	0	2	1
Total	**29**	**3**	**15**	**11**

Issue	Action Required	By When	Owner	Progress Update	RAG Status
Family & Childcare Issues					
1 Issue: Foster Care Assessments / Annual Reviews Trust to complete redesign of resource/service. Trust to report on impact of this service improvement. Increase in kinship placements Annual reviews - Trust to ensure compliance, and display an upward trajectory in annual review of foster carers. **Discussion at DSF meeting 28.6.21** 83 Outstanding Annual Reviews 2 Unregulated placements. Trust have scheduled additional panels to completed outstanding reviews.	**Actions:** • Trust to provide trajectory for completion of all outstanding annual reviews	31/07/21	Suzanne Mahon / Catherine McKevitt	Report submitted detailing trajectory for clearing remaining backlog of Foster Carer Annual Reviews. Decrease from 147 @ Sept 20 to 35 @ Sept 21 The annual reviews continue in trajectory downwards with one office – Kinship support team reaching zero. We had for example 17 annual reviews this week which should bring the figure well down so staff are working really hard on this. I have an increase in sickness absence in last few weeks, this in addition to pressures supporting LAC cases I do worry the figures will creep up again but PSW are keeping close eye on this. The sharepoint information is on the system but just not fully operational due to a technical issue but Ruth and admin are working on this.	

				Update – March 2022 70 outstanding reviews - 36 kinship and 43 mainstream annual reviews outstanding. The upward trend is directly related to the increased numbers of kinship carers coming through the system, staff sickness and significant staffing changes which has left posts unfilled for significant periods. The senior management team will continue to monitor these figures. At 11/02/22 there were no unallocated non kinship assessments with 68 assessments across kinship , non kinship and adoption ongoing; there were 22 Kinship assessments waiting to be allocated.	
2 Issue: Capacity to effect compliance in relation to statutory functions within Early Years' Service Trust to update HSCB on progress on remedial action put in place to ensure compliance	**Actions:** • Trust has an action plan in place. HSCB to monitor implementation of the plan at interface meetings throughout the year	Updates at Sep 2021 and March 2022	Suzanne Mahon/Pat Armstrong	By March 2022 target is that all providers will have received a formal inspection. Action plan in progress - next update due at Sept 21 Early Years Management Forum. Total Inspections overdue July 21 – 439 **Update - March 2022**	

Discussion at DSF meeting 28.6.21 522 overdue inspections. HSCB acknowledge the impact of Covid restrictions on inspections. HSCB have submitted an action plan to address this. Since 1st April 104 Inspections have been completed.				The Early Years Team are on target to meet statutory functions in the Southern Sector. However, this will not be the case in the Northern Sector primarily due to staff absence x2 due to prolonged sick leave. Consequently, we had to reframe and focus on those providers significantly out of date and those posing concerns given compliance issues in respect of the standards. As per DOH directive, each provider required one inspection in the two year period 01.03.20 - 31.03.22. Projection is 59 childminders and 24 groups will not have met this requirement by 31.03.22.	
3 Issue: Family Centre waiting list **Discussion at DSF meeting 28.6.21** Trust have been working on review of services and aligning provisions equitably.	**Actions:** • Trust to provide an updated report on progress of Family Centre, including waiting lists	31/08/21	Suzanne Mahon/Bernie Melaugh	There are currently 27 unallocated cases within the 4 Trust Family Centres due to vacant posts which have remained unfilled. Social Work Managers continue to review unallocated cases on a weekly basis and a work stream has been established to do a 'deep-dive' into caseloads, waiting times and referral pathways. Family Support Panel on a weekly basis looks at capacity with external contracted providers to help assist with capacity.	

				Update – March 2022 There are currently 25 unallocated cases within the Trust Family Centres due to vacant posts which have remained unfilled. A work stream has been established to look specifically at waiting lists, however current pressures of unfilled vacant posts and a decision that Family Centre staff will assist with unallocated Looked After Children due to staffing pressures within LAC teams, has impacted on waiting lists and will continue to do so, until the staffing situation stabilises. Social Work Managers will continue to review unallocated cases on a weekly basis and Family Support Panel will also review capacity with external contracted providers to help assist with capacity at weekly meetings. At SPPG Planning Meeting on 13.06.22 it was agreed that the Trust have made significant improvements and SPPG are satisfied with progress. Rag status therefore changed to Green	
4. Issue:					

Children's Disability Services • Increasing pressures on Family support panel due to the pandemic and the complex needs of families • There is increasing pressure on the Community CwD Team's capacity resulting in increasing waiting lists within each area • There is currently a two year waiting list for CwD Psychology services. • 36 Unallocated cases **Discussion at DSF meeting 28.6.21** Trust has completed paper in relation to direct payments. The Trust did feel that the paper reflected some issues and are to update. Trust has engaged with some families, who raised issue with timescales. Staffing – Trust have examined skill mix and feel this is complete.	**Actions:** **Following Papers to be submitted:** • Review of Direct Payment process -Trust to provide updated paper in relation to family support panel	30/09/21	Kevin Duffy/Peter Quinn	**Update – March 2022** The paper re DPs process still being worked on. The FSP workshop is planned for 1/4/22.	
	• Re-design of CwD community services, to include unallocated cases	30/09/21	Kevin Duffy/Peter Quinn	**Update – March 2022** Due to staff sickness and vacancies, the waiting list for SW caseloads (including unallocated and monitoring only cases is over 100). The staffing paper from April 2021 is being revised and will be resubmitted by 31/3/22 to secure additional community supports including additional B7, B6's and B3's.	
	• Update on Psychological services to address capacity issues	30/09/21	Kevin Duffy/Peter Quinn	**Update – March 2022** The Consultant Psychologist post has been interviewed and appointment made. Efforts are being made to secure earliest start.	

Waiting lists – Trust are currently looking at how to reduce waiting list Unallocated cases – Trust feel that when posts are filled this will address the unallocated cases				Funding is being sought to uplift B5 Psychology assistant post to B6 Psychology associate. It is hoped this funding will allow immediate trawl for B6 psychology post	
5 Issue: Unallocated Cases Trust DSF data was inaccurate. HSCB confirmed with the Trust that as of 31 March 2021 there are 76 Unallocated Cases. 28 – Family Support 12 – Gateway 36 – CwD **Discussion at DSF meeting 28.6.21** No unallocated in LAC. Staffing levels have a direct impact on unallocated cases. There are significant staff vacancies currently.	**Actions:** • HSCB to monitor at interface meetings during 2021/22	Updates at DSF interface meetings with the Trust (updates at Sept 21/March 22)	Suzanne Mahon/Cathy Meenan/Mairead McGilloway	There continues to be unallocated due to the number of social work vacancies in FIS. Gateway have a SSWP reviewing all cases waiting initial assessment with 2 designated social workers. Senior managers have approved for a group of band 7 social workers to complete Gateway initial assessments from the unallocated cases list at weekends throughout the month of September. This will be reviewed at the end of September and if required extended for a further four weeks. **Update – March 2022** An action plan to address unallocated in FIS was implemented and as of the end of November the unallocated had reduced to 10 cases.	

				Gateway/FIS – 58 families which equates to 95 children FIS – 3 families and 5 children Gateway – 53 families and 90 children Looked After Children – 18 children – as at 09.03.22 The Trust has the following measures in place to best manage unallocated cases: Triaging; prioritising of cases based on level of settledness / stability; duty system in place to escalate/prioritise where concerns arise; ongoing monitoring by SSWs. As well as offering overtime to current social work staff Family Centre social work staff are being allocated LAC cases to ensure that as a minimum statutory visits are being undertaken. The impact on completion of LAC reviews and care planning was highlighted.	
6 Issue: Statutory Reviews and Case conference Minutes Trust to confirm exact figures of:	**Actions:** • Trust to address and report any regional learning to HSCB	Updates at DSF interface	Suzanne Mahon/Cathy	A plan was put in place from April – December to address outstanding minutes. This continues to be ongoing with progress being made in all areas.	

Outstanding Case Conference minutes Outstanding LAC minutes **Discussion at DSF meeting 28.6.21** This has been a significant challenge to the Trust. They are to link in with other Trusts as to learning and seeking to ensure this is improved.		meetings with the Trust (Progress updates on Action Plan at Sept 21/March 22)	Meenan/Natasha Duddy	October 21 Case Conference (over 15 days) – 127 LAC Minutes not circulated October 21 – 201 Plan was progressed with additional staff covering meetings to allow for backlog of work to be completed which lead to a reduction in uncirculated minutes within LAC teams. 16+ service experienced staff and management vacancies which had an impact in progressing the plan and despite backlog clearing, further minutes were created which meant it did not have the desired impact. To mitigate against this plans were put in place to reduce the number of lac reviews within 16+, which in turn will impact on a reduction of delayed minutes. Discussion has also taken place with other HOS' across Trusts to understand their systems, although they all have different	

				structures some learning has been incorporated into the current plans as noted above. Current number of uncirculated minutes are: 16+ Service 113 at end of October 21 **Update – March 2022** Number of LAC Minutes not circulated within timescale at 28 February 2022 = 219 Number of CPCC Minutes not circulated within timescale at 28 February 2022 = 84 This remains an area of concern with limited progress being made. Despite minutes not being circulated the key decisions are circulated following the meetings.	
7 Issue: Pathway Plans Pathway Needs Assessments Personal advisors 317 Care Leavers	**Actions:** • Trust to provide plan as to how they are to complete all outstanding pathway plans	30/09/21	Suzanne Mahon/Natasha Duddy	Currently there are 17 Eligible young people without a PA and this has been highlighted as an area under resourced There has been a reduction in the number of outstanding pathway plans and pathway	

10 Eligible young people without a PA 45 young people without a pathway play 16 young people without a needs assessments **Discussion at DSF meeting 28.6.21** HSCB are satisfied with allocations of PA's, and report positive progress in Leaving and Aftercare Bereavement and staffing issues have impacted on completion of pathway plans				needs assessments. With current figures sitting at: 28 young people without a pathway plan 7 young people without a needs assessments Staffing issues continues to create a challenge, added to the introduction of an IT system, covid and summer leave. Plan in place to continue to reduce these: • Focus on those YP without a needs assessment and pathway plan – draw up individual action plan with social worker in supervision • Remaining young people – look at most outstanding & prioritise in date order. Set dates in supervision re pathway plan review meetings • Focused training for SW on completing these on Paris IT System. • PP Lac to work with PSW/ SWM on governance of these **Update – March 2022** The reduction in the number of outstanding pathway plans and pathway needs	

				assessments has been hindered by the staffing challenges over the last few months. Although NS 16+ is improving, we currently have one team in 16+ SS at 66% social work vacancy. Figures at 28 February 2022: Total number of young people who do not have a Personal Advisor: 11 Number of young people who do not have an up to date Pathway Plan: 39 Number of young people who do not have a completed Needs Assessment: 18 Number of young people who do not have an allocated Social Worker: 4	

				Plan remains in place and progress is reviewed monthly at Risk Management Meeting: • Focus on those YP without a needs assessment and pathway plan – draw up individual action plan with social worker in supervision • Remaining young people – look at most outstanding & prioritise in date order. Set dates in supervision re pathway plan review meetings • Focused training for SW on completing these on Paris IT System. • PP Lac to work with PSW/ SWM on governance of these	
8 Issue: Children's Autism Service 897 on waiting list, 709 of which are breaches. Children and families are waiting in excess of 13 weeks for an individual post-diagnostic appointment with a social worker.	**Actions:** • Review of Direct Payment process -Trust to provide updated paper in relation to family support panel	30/09/21	Kevin Duffy/Mary McDaid	**Update – March 2022** Paper is due at the end of Feb 22 as outlined above within Children's Disability Services.	

Trust reports the highest and longest wait for Autism Assessments, and the longest waiting time for intervention. A waiting list exists for families who require assessment of need from a social worker as current demand outstrips capacity. There has been a significant increase in the number of approved SDS packages that require ongoing social work management and monitoring and this is increasing year on year. **Discussion at DSF meeting 28.6.21** Waiting lists for assessments – Covid had a significant impact on this and increased demand for services. Trust do not anticipate waiting list for assessments will reduce during 2021/22 Post diagnostic waiting list has decreased.					
	• Impact analysis of the early intervention service and potential impact on waiting list	31/12/21	Kevin Duffy/Mary McDaid	Update – March 2022 The Trust continues to see an increasing demand for diagnostic assessment and ongoing support and intervention both pre and post diagnosis. The current level of demand outstrips the capacity of the team. The Trust has accepted 599 referrals for diagnostic assessment up to month 10 (31.01.22) the team has capacity to complete 420 assessments per year. There are currently 1233 on the assessment waiting list as at 31.01.22 this is an accumulation of demand outstripping capacity year on year for the last 5 years. An external BSO audit has been completed concluding a satisfactory result on the management of ASD assessment waiting lists highlighting that the length of the waiting list is a consequence of demand and capacity issues The early intervention team is now operational. From 1st February 2022, all referrals accepted onto the assessment	

SDS – Covered in CwD issue above Trust have full complement of staff in place and have a new service in place for approx. 6 months.				waiting list will be invited to participate on ongoing support and intervention whilst they await their diagnostic assessment process. The demand for post diagnostic support and intervention remains high. High levels of anxiety, social isolation and carer stress are the key challenges that are presenting. Increase in the number of families requiring assessment for ongoing support. This is placing additional pressure on the Social Work component of the service. The service is also experiencing unprecedented demand for support for crisis cases which involve significant clinical time and leaving less time for routine cases. The service currently has 50% reduction in social work staff due to a number of vacancies from maternity leave/career break which they are having difficulty recruiting into.	
9 Issue: CAMHS Waiting List	**Actions:**			**Update – March 2022**	

• Jan 2021 – waiting list sitting at 270 with 130 in breach • Increase in crisis referrals and admissions to Beechcroft • 16 looked after children on waiting list **Discussion at DSF meeting 28.6.21** Trust report reduction in waiting list and breaches, despite pressure during past year and impact of covid. Again staffing vacancies has also impacted and focus is on crisis intervention. Funding has been secured to bring in additional staff. Tier 2 & 3 expansion is being introduced along with educative service developments. AD CAMHS Regional meetings are now in place and will monitor how regional funding impacts on waiting lists.	• Monitoring of reduction in waiting lists will be undertaken throughout 2021/22	Updates at DSF interface meetings with the Trust (Progress updates on Action Plan at Sept 21/March 22)	Kevin Duffy/Sara McGee	A further waiting list initiative was launched last week whereby 91 YP were offered appointments and 80 were seen. A sustained period with critical staffing had seen figures increase. Waiting List Figures at 28 February 2022 566 30 of these relate to LAC Children	
	• Trust to update on LAC currently on CAMHS waiting list	31/07/21	Kevin Duffy/Sara McGee	**Update – March 2022** All LAC children referred to CAMHS are referred to the Therapeutic Connections Forum and if appropriate is referred to CAMHS and the referral is expedited. Waiting List Figure at 28 February 2022 30 LAC Children	
10 Issue:					

Decrease in numbers on Child Protection Register March 20 = 597 March 21 = 518 An increase of 79 (13%) Regionally March 2020 = 2,298 March 2021 = 2,298 **Discussion at DSF meeting 25.6.21** These figures are in line with regional overview, numbers of CPR are reducing/static and numbers of LAC are increasing. Review of Children's Service is to be commenced in 2021/22. Trust confirms they are content with thresholds regarding CPR and LAC decision making.	**Actions:** • **No actions required – included for record only.**				
11 Issue: Increased numbers of Looked After Children	**Actions:**				

March 2020 = 651 March 2021 = 688 An increase of 37 (6 %) Regionally March 2020 = 3,383 March 2021 = 3,530 An increase of 147 (4%) **Discussion at DSF meeting 25.6.21** These figures are in line with regional overview, numbers of CPR are reducing/static and numbers of LAC are increasing. Review of Children's Service is to be commenced in 2021/22. Trust confirms they are content with thresholds regarding CPR and LAC decision making.	• **No actions required – included for record only.**				
12 Issue: Young people requiring hospital admission – Increases in the number of young people, seeing a formal admission	**Actions:** • **No actions required – included for record only.**				

for assessment to hospital under the Mental Health Order 1986 Detentions under the MHO overall have increased from 33% in 2018 to 52% in 2020 and remained at this level so far in 2021. In 2021 23% of yp were detained at point of admission, a rise of 12% from 2020 **Discussion at DSF meeting 25.6.21** This is noted as a regional issue and there are no specific actions for the Trust.					
13 Issue: Poor uptake of young carers services Think Family practitioners have been reduced in-year. Number of children in need who are young carers: 70. **Discussion at DSF meeting 25.6.21**	**Actions:** • No actions within Children's				

The Trust is looking at Carers assessments across all programmes of care as the figures are not representative of the actual numbers. Task and Finish group has recently commenced. Further detail/actions will be outlined in adults sections.					
14 Issue: Trust not compliant with MCA Trust has not complied with 31 May 2021 timeline. The Trust has provided a remedial action plan, however HSCB are concerned that the Trust will be unable to comply with the revised timescales. **Discussion at DSF meeting 28.6.21** Trust continues to have issue securing medical input. Numerous recruitments for medical staff, despite all efforts. This has presented significant challenge in	**Actions:** • Trust to re-examine their Action Plan in light of the HSCB concerns in meeting their statutory functions to determine if all necessary actions are being taken	31/07/21	Karen Obrien/ Christine McLaughlin	This issue was discussed with the Trust Family and Childcare at DSF review meeting on 9 March 22; Family and Childcare advised that compliance with MCA is not an issue within Childrens Services. Anticipated concerns about potential increase in requirement for MCAs for CwD from education sector has not materialised. At SPPG Planning Meeting on 13.06.22 it was agreed that the Trust have made significant improvements and SPPG are satisfied with progress. Rag status therefore changed to Green	

working toward compliance with legislation. There is challenge to progress the action plan (already submitted to the HSCB) given the difficulties in staffing					

Issue	Action Required	By When	Owner	Progress Report	RAG status
Mental Health Issues					
15 Issue: Offers and updates of Carers Assessments Trust to provide Action Plan outlining how they ensure compliance with DSF	**Actions:** • Task & Finish Group to provide a paper which outlines the projections of demand by Programme of Care	30/09/21	Stephen McLaughlin /Carina Boyle	The team are meeting re this issue this week and will then forward update for attention of Lorna Conn, Programme Manager, HSCB following this. **Update 9/2/22**	

Discussion at DSF meeting 28.6.21 The Trust are looking at Carers assessments across all programmes of care as the figures are not representative of the actual numbers. Task and Finish group has recently commenced. QI work regarding carers conversation wheel was undertaken last year. This had impacted positively in increasing the numbers of assessments offered. There has been a challenge in how 'carers' see themselves and how an 'assessment' is viewed. The QI project informed staff on how to approach this and how they discuss with those accessing the service				Update report is with David Petticrew. MH team will access report for further information.	
	• Trust to provide an action Plan outlining how they will work towards compliance in provision of assessments	30/09/21	Stephen McLaughlin /Carina Boyle	Work remains ongoing to harmonise standards for carers assessments. Awaiting full update as above by way of actions. **Update 9/2/22** As above and good progress made. Use of Carer's Conversation Wheel via QI project. Posters printed to prompt completion of Carer's Assessments.	
	• Trust to provide update on Action Plan	Updates at DSF interface meetings with the Trust (Progress updates on Action Plan at Sept	Stephen McLaughlin /Carina Boyle	Trust to keep HSCB updated re progress.	

		21/March 22)			
16 Issue: Increasing pressure on ASW Rota due to challenges of MH surge, acute bed pressures and out of Trust conveyance **Discussion at DSF meeting 28.6.21** ASW Rota – Trust note continued increase in demand and staffing changes impacts on this service area. Trust advise they anticipate a positive impact coming from ASW rota. Trust to examine model of ASW rota across the Trust, with a view to covering all PoC. Trust are to fund additional 5 ASW places per year. No reported acute bed pressures/out of Trust placements	**Actions:** • Trust to provide detail of the proposal to extend to a single ASW rota to cover all PoC	30/09/21	Darren Strawbridge/Carina Boyle	Quality standards achieved. Rota in place and improved working evidenced. **Update 9/2/22** Improvement in number of staff trained. 3 more staff have joined the rota and have just finished shadowing. This has eased pressure in Southern area of Trust. There are 2 more students currently going through ASW training in this sector. Northern sector has a further 2 trained staff joining rota and additional 2 staff in training.	
	• Trust to provide detail of uncovered hours in April – Sept (inc)	30/09/21	Darren Strawbridge/Carina Boyle	As above	
17 Issue: Trust not compliant with MCA	**Actions:**	31/07/21		Trust taking issue to project board outcome to be provided to board following this.	

Trust have not complied with 31 May 2021 timeline. The Trust has provided a remedial action plan, however HSCB are concerned that the Trust will be unable to comply with the revised timescales. **Discussion at DSF meeting 28.6.21** Trust continue to have issue securing medical input. Numerous recruitments for medical staff, despite all efforts. This has presented significant challenge in working toward compliance with legislation. There is challenge to progress the action plan (already submitted to the HSCB) given the difficulties in staffing	• Trust to re-examine their Action Plan in light of the HSCB concerns in meeting their statutory functions to determine if all necessary actions are being taken		Karen OBrien/Christine McLaughlin	All avenues have been exhausted re securing input form medical staff. Retirees have been targeted to alleviate pressure. **Trust continue to focus on avoiding breaches. Executive team aware – amber** **Update 9/2/22** Legacy cases have all been allocated to Legacy Team with aimed completion end of March 2022. Medic input remains an ongoing issue alongside pressures on community teams. Current pilot in place MCA Teams reaching into community teams aiming to preventing further breaches. Training is considered green. Additional pressure - staff need to be 2 years qualified to complete assessment.	
18 Issue: Adult Safeguarding Referrals	**Actions:** • HSCB to meet with Trust to go through specific	31/08/21		Challenges on-going. Trust to share associated Action Plan with HSCB.	

Western Trust undertake 50% of all AS referrals. Trust to complete analysis of data and referrals thresholds. **Discussion at DSF meeting 28.6.21** Advice and resolution is not recorded formally (35 per month), which has impact on the reported figure. There has been a reduction in AS referrals, and the Trust have arranged a communication plan covering a 6 month period to increase awareness with a view to ensuring appropriate referrals are made. This will launch in July and media campaign will be over a 6 month period.	detail behind the issue and Trust to provide updated response		Valerie Devine/John McCosker	9/2/22 Adult Safeguarding issues resolved.	

Learning Disability Issues					
Issue	**Action Required**	**By when**	**Owner**	**Progress Report**	**RAG status**

19 Issue: Carers Assessment Trust are undertaking a QI project on Carers Conversation Wheel, and have made significant progress in reducing numbers of assessment. There remain significant challenges in identifying appropriate resource. The Trust have advised in DSF report that they are unable to meet their statutory functions in terms of carers assessments. HSCB require the Trust to outline their action plan to address this during 2021/22 **Discussion at DSF meeting 28.6.21** The Trust are looking at Carers assessments across all programmes of care as the figures are not representative of the actual numbers. Task and Finish group has recently commenced. QI work regarding carers	**Actions:** • Task & Finish Group to provide a paper which outlines the projections of demand by Programme of Care;	30/09/21	Stephen McLaughlin /Carina Boyle	Task and Finish Group in respect of Carers Assessments on-going to increase the number of Carer's assessments offered/completed. Trust report progress continues to be made. Associated Action Plan to be submitted to HSCB. **9/2/22 Update** Given progress noted above re Carers' Assessment and use of Carer's Conversation wheel.	
	• Trust to provide an action Plan outlining how they will work towards compliance in provision of assessments	30/09/21	Stephen McLaughlin /Carina Boyle	As above **9/2/22 Update** Trust to keep HSCB updated re progress.	
	• Trust to provide update on Action Plan	Updates at DSF interface	Stephen McLaughlin	Work on-going via Task & Finish Group. Trust to forward associated Action Plan to HSCB.	

conversation wheel was undertaken last year. This had impacted positively in increasing the numbers of assessments offered. There has been a challenge in how 'carers' see themselves and how an 'assessment' is viewed. The QI project informed staff on how to approach this and how they discuss with those accessing the service.		meetings with the Trust (Progress updates on Action Plan at Sept 21/March 22)	/Carina Boyle	**9/2/22 Update** Action plan to be reviewed by HSCB.	
20 Issue: Ralph Close Trust to provide progress report on Action Plan following RQIA inspection December 2020 **Discussion at DSF meeting 28.6.21** Further RQIA inspection in April 2021 and a medication review in	**Actions:** • Trust to provide a progress report on the action plan	31/07/21	Christine McLaughlin	As noted above a Manager from another area was redeployed with positive effect. Permanent Manager position currently being recruited to. Whilst COVID has brought challenges Trust positive re services currently being provided at the facility. Trust to provide progress report re Action Plan to HSCB. **9/2/22 Update**	

June, Trust report these were both positive. Trust are having difficulties in recruiting for a manager. A manager has been deployed from another area.				Trust acknowledged significance of securing permanent manager. Right leadership is paramount to making the right changes. Stressors and pressures related to Covid have impacted on staff and residents. There have been 2 new admissions and a 3rd pending. Transitions were very positive in what was considered very complex scenarios. Action plan remains live and under continuous review, robust plans are in place to monitor. Trust have set up their own internal unannounced inspections which have been positive and will remain in place. Outcomes will be sent to HSCB for information. Clear evidence of QA in place.	
21 Issue: Trust not compliant with MCA Trust have not complied with 31 May 2021 timeline. The Trust has provided a remedial action plan, however HSCB are concerned that the Trust will be unable to comply with the revised timescales. **Discussion at DSF meeting 28.6.21**	**Actions:** • Trust to re-examine their Action Plan in light of the HSCB concerns in meeting their statutory functions to determine if all necessary actions are being taken	31/07/21	Karen OBrien/Christine McLaughlin	Band 7 staff member freed up to complete legacy cases. 2 ASW staff to incorporate MCA activity into role. MCA work continues to present as a significant challenge for the Trust. Trust to share up-dated Action Plan with HSCB. **Update 9/2/22** Legacy cases have all been allocated to Legacy Team with aimed completion end of	

Trust continue to have issue securing medical input. Numerous recruitments for medical staff, despite all efforts. This has presented significant challenge in working toward compliance with legislation. There is challenge to progress the action plan (already submitted to the HSCB) given the difficulties in staffing				March. Medic input remains an ongoing issue alongside pressures on community teams. Current pilot in place MCA Team provide support to community teams aimed at preventing further breaches. Training is considered green. Additional pressure is that staff need to be 2 years qualified to complete assessment.	
22 Issue: Adult Safeguarding Referrals Western Trust undertake 50% of all AS referrals. Trust to complete analysis of data and referrals thresholds. **Discussion at DSF meeting 28.6.21** Advice and resolution is not recorded formally (35 per month), which has impact on the reported figure.	**Actions:** • HSCB to meet with Trust to go through specific detail behind the issue and Trust to provide updated response	31/08/21	Valerie Devine/John McCosker	Challenges in respect of Adult Safeguarding continue. Following an RQIA inspection, 5 potential notices. Cara McLauglin leading project/training re Adult Safeguarding. Trust to share Action Plan with HSCB. Challenges on-going. Trust to share associated Action Plan with HSCB. **Update 9/2/22** Adult Safeguarding issues resolved.	

There has been a reduction in AS referrals, and the Trust have arranged a communication plan covering a 6 month period to increase awareness with a view to ensuring appropriate referrals are made. This will launch in July and media campaign will be over a 6 month period.					
23 As per above issue: **Emerging Issue at DSF meeting 13.10.21** **Lakeview** Challenges in respect of Adult Safeguarding continue. Following an RQIA inspection, 5 potential notices. Cara McLauglin leading project/training re Adult Safeguarding. Trust to share Action Plan with HSCB.				**Update 9/2/22** Noted safeguarding issues across Trust resolved. Specific work within Lakeview to support safeguarding e.g. ongoing training. Trust working to Improvement Plan to address RQIA recommendations following unannounced inspection. Trust have shared Improvement Plan with HSCB and will continue to keep HSCB updated.	

Older People & Adults Issues					
Issue	**Action Required**	**By when**	**Owner**	**Progress Report**	**RAG status**
24 Issue: Carers Trust are undertaking a QI project on Carers Conversation Wheel, and have made significant progress in reducing numbers of assessment. There remain significant challenges in identifying appropriate resource. The Trust have advised in DSF report that they are unable to meet their statutory functions in terms of carers' assessments. HSCB require the Trust to outline their action plan to address this during 2021/22	**Actions:** • Task & Finish Group to provide a paper which outlines the projections of demand by Programme of Care;	30/09/21	Stephen McLaughlin/Carina Boyle	19.10.21 - Task and Finish group continues its work and will provide over-arching paper by end October 2021 **UPDATE 9.2.22** Projections of demand by programme of care, has not yet been completed due to COVID. RAG rating to remain Amber.	
	• Trust to provide an action Plan outlining how they will work towards compliance in provision of assessments	30/09/21	Stephen McLaughlin/Carina Boyle	Action Plan being finalised as part of above work and Trust will submit by end October 2021 **UPDATE 9.2.22** Action Plan provided. Trust has developed a tool for staff. Training Plan for 22/23 in place.	

Discussion at DSF meeting 28.6.21 The Trust are looking at Carers assessments across all programmes of care as the figures are not representative of the actual numbers. Task and Finish group has recently commenced. QI work regarding carers conversation wheel was undertaken last year. This had impacted positively in increasing the numbers of assessments offered. There has been a challenge in how 'carers' see themselves and how an 'assessment' is viewed. The QI project informed staff on how to approach this and how they discuss				Poster now available for use across teams to highlight Carers Ax. Utilising existing baseline data. Further audit.	
	• Trust to provide update on six month plan from T&F group	Updates at DSF interfacemeetings with the Trust (Progress updates on Action	Stephen McLaughlin/Carina Boyle	Update from Task and Finish group to be incorporated into wider over-arching paper, due end October 2021. **<u>UPDATE 9.2.22</u>** As above.	

with those accessing the service		Plan at Sept 21/ March 22)			
25 Issue: Adult Safeguarding Referrals Western Trust undertake 50% of all AS referrals. Trust to complete analysis of data and referrals thresholds. **Discussion at DSF meeting 28.6.21** Advice and resolution is not recorded formally (35 per month), which has impact on the reported figure.	**Actions:** • HSCB to meet with Trust to go through specific detail behind the issue and Trust to provide updated response	31/08/21	Valerie Devine/John McCosker	Meeting between HSCB and WHSCT Adult Safeguarding leads on 20.8.21 to better understand WHSCT processes and regional differences in referral numbers. Impact of Trust Advice and Resolution service noted. Work to improve data quality continues. Trust awareness raising activities are underway with successful conference with keynote speaker 15th September 2021. **UPDATE 9.2.22**	

There has been a reduction in AS referrals, and the Trust have arranged a communication plan covering a 6 month period to increase awareness with a view to ensuring appropriate referrals are made. This will launch in July and media campaign will be over a 6 month period.				No discussion as RAG rated GREEN. HSCB Adult Safeguarding Lead advised (prior to meeting) nfa.	
26 Issue: Trust not compliant with MCA Trust have not complied with 31 May 2021 timeline. The Trust has provided a remedial action plan, however HSCB are concerned that the Trust will be unable to comply with the revised timescales.	**Actions:** • Trust to re-examine their Action Plan in light of the HSCB concerns in meeting their statutory functions to determine if all necessary actions are being taken	31/07/21	Karen OBrien/Christine McLaughlin	Work is on-going. Trust continues to work in context of competing pressures to achieve and maintain compliance with MCA. Recent DOH letter has established this is a legal responsibility for Trusts. Trust contributes to regional MCA oversight group and performance monitoring. **UPDATE 9.2.22**	

Discussion at DSF meeting 28.6.21 Trust continue to have issue securing medical input. Numerous recruitments for medical staff, despite all efforts. This has presented significant challenge in working toward compliance with legislation. There is challenge to progress the action plan (already submitted to the HSCB) given the difficulties in staffing				**Legacy cases** – all outstanding cases have been allocated. Number waiting medical ax. Medical resource limited to cover Legacy, TP and Extensions. Indicative date for completion March 22. **STDA** – Trust advise not delivering. Ongoing issue both in terms of medical involvement and SW resource. SW staffing challenged across Acute and comm. MCA Team focusing on Legacy and Extensions not Acute. Trust highlighted the focus on 'discharge' and recent audits had been a challenge to and focus for SW workforce. Two years qualified stipulation impacts medical availability. **Day Care/Dom Care Legacy -** scoping to be completed end Feb 22. **Training** – RAG rating GREEN across POC.	

Issue	Action Required	By when	Owner	Progress Report	RAG status
Physical Disability and Sensory Impairment Issues					
27 Issue: Carers Assessment Trust are undertaking a QI project on Carers Conversation Wheel, and have made significant progress in reducing numbers of assessment. There remain significant challenges in identifying appropriate resource. The Trust have advised in DSF report that they are unable to meet their statutory functions in terms of carers assessments. HSCB require the Trust to outline their action plan to address this during 2021/22 **Discussion at DSF meeting 28.6.21** PH & SI have seen an increase in uptake.	**Actions:** • Task & Finish Group to provide a paper which outlines the projections of demand by Programme of Care	30/09/21	Stephen McLaughlin /Carina Boyle	Task and Finish group continues its work and will provide over-arching paper by end October 2021 **<u>UPDATE 9.2.22</u>** Projections of demand by programme of care, has not yet been completed due to COVID. RAG rating to remain Amber. HSCB however recognises the progress made by the PDSI programme in terms of offer of assessment and the conversion to completed assessment – see attached  160322_CA_Dashboard_of_Charts_PSD v	

The Trust are looking at Carers assessments across all programmes of care as the figures are not representative of the actual numbers. Task and Finish group has recently commenced. QI work regarding carers conversation wheel was undertaken last year. This had impacted positively in increasing the numbers of assessments offered. There has been a challenge in how 'carers' see themselves and how an 'assessment' is viewed. The QI project informed staff on how to approach this and how they discuss with those accessing the service					
	• Trust to provide an action Plan outlining how they will work towards compliance in provision of assessments	30/09/21	Stephen McLaughlin /Carina Boyle	Action Plan being finalised as part of above work and Trust will submit by end October 2021 **<u>UPDATE 9.2.22</u>** Action Plan provided. Trust has developed a tool for staff. Training Plan for 22/23 in place. Poster now available for use across teams to highlight Carers Ax. Utilising existing baseline data. Further audit.	
	• Trust to provide update on six month plan from T&F group	Updates at DSF interface meetings with the Trust (Progress updates on Action Plan at Sept	Stephen McLaughlin /Carina Boyle	Update from task and Finish group to be incorporated into wider over-arching paper, due end October 2021. **<u>UPDATE 9.2.22</u>** As above	

		21/March 22)			
28 Issue: Trust not compliant with MCA Trust have not complied with 31 May 2021 timeline. The Trust has provided a remedial action plan, however HSCB are concerned that the Trust will be unable to comply with the revised timescales. **Discussion at DSF meeting 28.6.21** Trust continue to have issue securing medical input. Numerous recruitments for medical staff, despite all efforts. This has presented significant challenge in working toward compliance with legislation. There is challenge to progress the action plan (already submitted to the HSCB) given the difficulties in staffing	**Actions:** • Trust to re-examine their Action Plan in light of the HSCB concerns in meeting their statutory functions to determine if all necessary actions are being taken	31/07/21	Karen OBrien/Christine McLaughlin	Work is ongoing. Trust continues to work in context of competing pressures to achieve and maintain compliance with MCA. Recent DOH letter has established this is a legal responsibility for Trusts. Trust contributes to regional MCA oversight group and performance monitoring. **<u>UPDATE 9.2.22</u>** **Legacy cases** – all outstanding cases have been allocated. Number waiting medical ax. Medical resource limited to cover Legacy, TP and Extensions. Indicative date for completion March 22. **MCA Team** focusing on Legacy and Extensions. **Day Care/Dom Care Legacy -** scoping to be completed end Feb 22. **Training** – RAG rating GREEN across POC.	

29 Issue: Adult Safeguarding Referrals Western Trust undertake 50% of all AS referrals. Trust to complete analysis of data and referrals thresholds. **Discussion at DSF meeting 28.6.21** Advice and resolution is not recorded formally (35 per month), which has impact on the reported figure. There has been a reduction in AS referrals, and the Trust have arranged a communication plan covering a 6 month period to increase awareness with a view to ensuring appropriate referrals are made. This will launch in July and media campaign will be over a 6 month period.	**Actions:** • HSCB to meet with Trust to go through specific detail behind the issue and Trust to provide updated response	31/08/21	Valerie Devine/John McCosker	Meeting between HSCB and WHSCT Adult Safeguarding leads on 20.8.21 to better understand WHSCT processes and regional differences in referral numbers. Impact of Trust Advice and Resolution service noted. Work to improve data quality continues. Trust awareness raising activities are underway with successful conference with keynote speaker delivered 15th September 2021. **UPDATE 9.2.22** No discussion as RAG rated GREEN. HSCB Adult Safeguarding Lead advised (prior to meeting) nfa.	

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RAG Rating	
Completed/Confident of Delivery on Actions	
Work in progress and on track for completion within agreed timescales	
Not Complete/ Not on track for completion within agreed timescales	

The above action plan was reviewed at interface meetings with SPPG and Trusts (minimum 3 times yearly). Progress updates were completed after each interface meeting and reviewed by Senior Operational Management Team, SPPG.

This is to confirm that the above Action Plan has been reviewed by the Social Care and Children's Directorate on 13/06/22 and will be signed off at the DSF meeting on 27/06/22. Any outstanding issues requiring further progress will be reviewed at the DSF Meeting with the Western Trust and these alongside any new issues will be presented in the 2022/23 Action Plan.

Signed_____ _____ Date _____

Brendan Whittle, Director of Hospital & Community Care

Belfast Trust Delegated Statutory Functions Monitoring
For Period: 1st April 2014 – 31st March 2015
Actions to be taken forward 1st April 2015 – 31st March 2016

REGIONAL ISSUES

Originating date	Issue	Action	Outcome	Action by	Date completed (if not completed, carry forward)
June 2015	**ASW**				
	• ASW availability particularly OOH	Meeting planned for 26th Nov 2015	Actions agreed and completed	Aidan Murray	January 2016
	• Increasing use of nearest relative consent by GPs	Meeting planned for 26th Nov 2015	Actions agreed and completed	Aidan Murray	January 2016
June 2015	**CARERS**				
	Young carers • Identification of young carers			Tony Rodgers / Aidan Murray	
	• Activity being reported under independent contract arrangements – HSCB to investigate	Returns have been aggregated and sent to Trusts		Tony Rodgers	June 2016
	• Clarification that returns are inclusive of other programme returns for under 18s			Tony Rodgers	

T = Trust to action; B = Board to action

	Carers • Encourage better uptake of carers assessments and increase offers?	Mental health staff to encourage uptake of assessment by young carers To be monitored March 2016		Kevin Keenan	
June 2015	**AUTISM**				
	Significant breaches of waiting time targets for children with Autism			Tony Rodgers	
June 2015	**TRANSITIONS**				
	High cost cases transitioning from children into adults and also adults into older peoples services eg especially in complex medical cases	Regional work to be progressed to look at 10-15 year projections		Fionnuala McAndrew	
June 2015	**FAMILY CENTRES**				
	Review of role and function to address any unintended variations in services provided			Tony Rodgers	
June 2015	**DOMICILIARY CARE**				
	Progress the regional review to address: • Quality to be monitored both in-house and through Independent Sector	The Domiciliary Care Review Report and associated recommendations were approved by the Board in November 2015. Plans for Implementation of the report's		Kevin Keenan	

		recommendations are underway, this will address a range of issues, including service quality, monitoring, workforce and market stability. A 'Task Force' will be established Summer 2016 under the auspices of the DHSSPS 'Review of Adult Social Care' work to address a range of challenges facing domiciliary care and other related services and to progress the recommendations of the review report.			
	• Medicine management to be reviewed	A Business Case is currently being developed by the HSCB to secure the resources required to implement a regional medicines management assessment process by pharmacists. This includes funding to support the provision of Monitored Dosage Systems where required.		Kevin Keenan	
June 2014	**ADULT SAFEGUARDING**				
	Continuing increase in rates of referral exerting pressure on resources within HSC Trusts	Demand/Capacity analysis underway. Timescale for	Demand Capacity exercise now complete	Joyce McKee	February 2016

		completion has slipped to Dec 2015.			
	Social Care training resource being used to provide multi-disciplinary training across HSC Trusts	Issue raised with PHA etc. Engaging with DOIC re training for GPs; dentists; pharmacists and ophthalmologists.		Joyce McKee	
	Inconsistent application of electronic activity records	Challenges remain re running management reports from SOSCARE.	Management reports now available through SOSCARE	Joyce McKee	December 2015
	Reduction in adult safeguarding activity within acute settings	Trust running information sessions for staff in acute settings (across 4 sites) focusing on recognition and response.	Information sessions completed	Joyce McKee	December 2015

LOCAL ISSUES

FAMILY & CHILD CARE PoC

Originating date	Issue	Action	Outcome	Action by	Date completed (if not completed, carry forward)
June 2012	**Looked After Children**				
June 2012/13/14	Placement Issues: Fieldwork approved kinship placements. Belfast continues to have significantly higher proportion of field work approved carers. Trust continues to show high use of independent foster carers. Also higher proportion of kinship at Stage 1and comparatively high number of children placed at home with parents (107 out of NI total of 357) Information raises issues in respect of Trust activity in fostering recruitment and	HSCB and Trust to continue to monitor the situation and identify any necessary actions. September returns show service continues to be under pressure. Trust reports review of fostering almost complete. Trust to provide numbers of carers as part of the adolescent fostering scheme contracted from Barnardo's which will give a more accurate reflection of position (Trust has actually a directly commissioned service). Trust still have 25 identified in inappropriate placements out of regional total of 47. Trust		T	

	rationale for LAC placed at home. Trust identify 10 children in inappropriate placement (ie s/t foster care requiring l/t placement) and an overall total of 19 requiring long term foster home. Breakdown of length of time of waiting not recorded. In addition Trust fostering / adoption recruitment shows no change in levels (3 stranger recruited and only 3 vacancies)	seeking to recruit frontline carers to assist in addressing this issue. To be reviewed when end of year figures received			
June 2015	**Fostering - 10.5.2** BT have 146 kinship carers at Stage 1 and 88 at Stage 2 which is the highest in the region. Trust completed 17 kinship and 25 non-kinship (total 42) assessments. Issue categorised as medium in the Trusts Risk Register	Trust have received some investment and may make some more in-year. They are looking for a more consistent regional approach to assessment. Trust still have a backlog of kinship assessments/unregulated placements. Fieldwork teams now undertaking assessment and anticipate backlog to be dealt with in February/March panels. Also permanent posts being recruited.	Issues regarding kinship as identified show a significant improvement with only 10 vacancies in the total of placements available.		June 2016

		Improvement in end of year figures expected.			
June 2015	**Adoption (Ref 10.6.7 – 10.6.8)** 19 children adopted in the past year, 4 placed in less than 12 months (2 in less than 6 months)	September figures still show issues in relation to adoption activity.			
	BT, one of two Trusts with 5 children freed for adoption but awaiting placement. 11 with best interest decisions where they had not been placed with 7 waiting longer than 6 months.	As above. March 2016 figures to be reviewed to see if additional resource has had an impact.			
	10.3.26 Permanency Panel recommendations have 59 children recommended for adoption as their permanency plan	Trust to clarify use of "other" category in decisions by Permanency Panels.			
	10.6.3 No of prospective adopters waiting assessment, the Trust has 19 waiting (2 for 1year+) and the reason is no social worker available to commence assessment.	Trust advised they have addressed this issue be allocating some additional resource. Trust to provide an additional update. HSCB looking at time management and expectations of number of assessments that should be undertaken.	Number of adopters waiting is significantly reduced.		11.1.16

June 2015	10.3.6: LAC accommodated in hospital for 3 months+, Trust showing 11 out of regional total of 19 (SET 7, other Trusts1 or 0)?	Beechcroft – requires more clarity particularly around CAMHS and notifications that are being made. Trust to provide more detail re LAC accommodated in hospital particularly re Iveagh and Beechcroft. With clarification, issue may be signed off.			
June 2013	**Children with Disability**				
June 2013/14	Autism intervention service – earlier moves	Trust reports continuing breaches of the 13 week target in relation to autism. The Board provided additional short term finance to assist in a resolution however work is ongoing to introduce a revised model in relation to the autism service (the Southern Trust proposal). CSIB are taking this work forward but issue not yet resolved. A new project group has been established and work is ongoing to address this issue		T	

		New project group established and on-going work to address this issue. This is a regional concern and will be reviewed once the end of year figures are available.			
June 2014	**Children in Need**				
	Trust report on use of sponsored Day Care not yet received. Returns showing an increased use and significant higher usage as compared to other Trusts.	Trust review of SDC now included in a wider review by the Trust into Family Support Services with the support from the Beeches. The Trust will provide sufficient information in the end of year report to enable sign off of this issue.		T / B	
June 2015	Trust continues to show significant comparative use of sponsored day care. The guidance was amended and sent out to all Trusts to ensure consistency on the data collection (1.1.12)	As above			
June 2015	**Untoward Events**				
	Untoward Events show detentions by PSNI >4 hours is 242 NI total – BT is 128 (next	Issue feed into regional assessment of this.	The total number of events for the region showed a reduction to 161 with a		June 2016

	highest is SET with 43) involving 39 young people	Can PSNI provide this data? HSCB (JD) to look at this. Figures to be checked but general indications that figures have reduced. This will be reviewed at the end of the year.	total for BHSCT as 51 involving 27 young people. The figures show a sufficient reduction for this issue to be signed off.		
June 2015					
	The Trust have raised an issue regarding recording the age of young people detained under the Mental Health Order which they consider should be removed in order to protect patient confidentiality.		Trust confirmed they have addressed and this will be completed moving forward.		11.1.2016

MENTAL HEALTH & LEARNING DISABILITY - MENTAL HEALTH					
Originating date	**Issue**	**Action**	**Outcome**	**Action by**	**Date completed (if not completed, carry forward)**
June 2014	**Social Care Packages**				
	The programme reports a significant increase in the number of social care packages from last year (section 1.4). Some of this increase may have arisen from resettlement, however numbers seem disproportionate. It is also noted that the numbers for residential and nursing home placements reported in Section 1.4 does not correspond to that reported in 4.2 and 4.3 / 4.4.	Trust to confirm the figures and include the numbers for supported housing and adult placements.	Trust advised that the increased numbers reported was an administrative error. They confirmed that administrative problem was resolved (midyear report for Sept 2014). Corrected figure for year ending 31.4.14 was 163 service users	T	24.11.15
June 2014	**Children Detained Under the Mental Health Order**				
	The Board acknowledges the Trust concern to maintain the confidentiality of individual children detained under the Order, however, given the limited other detail it is unlikely that providing ages would risk identifying individual children.	Trust provide a breakdown of the use of powers in respect of the following age bands; >11 years; 11 -14 years; 14 – 16 years 16 – 17 years? Trust to provide information requested.	Trust advised it has been addressed.	T	25.6.15

MENTAL HEALTH & LEARNING DISABILITY - MENTAL HEALTH					
Originating date	**Issue**	**Action**	**Outcome**	**Action by**	**Date completed (if not completed, carry forward)**
	However it is important to monitor the use of powers for different age groups.				
June 2015	**SW Staffing Levels in AMH**				
	P 97 3.6 - The Trust is reporting that they are 11 Social Workers short of regional recommendation for population size. What action does the Trust plan to take to rebalance skills mix within AMH services?	Trust advised they have been to press to recruit additional social workers to address this issue. There are issues on skill mix and there are steps to encourage AYE into Mental Health services. Trust advised £2.7m recurrently has been removed from MH services since 2012 so this is proving challenging. Trust to advise on progress with recruitment in midyear report.	Review completed and report being finalised for Trust SMT	T	24.11.15
June 2015	**Self Directed Support**				
	P 114 - What action is AMH planning to ensure staff are knowledgeable and competent to support SDS?	Trust advised they have provided additional training for staff expanding on Direct Payments training.	No further action		25.6.15

MENTAL HEALTH & LEARNING DISABILITY - MENTAL HEALTH					
Originating date	**Issue**	**Action**	**Outcome**	**Action by**	**Date completed (if not completed, carry forward)**
		Looking at Day Services and reshaping may make for a more flexible response. Resettlement – recovery, can 'peer support' workers help with this?			
June 2015	**Social Care Placements outside NI**				
	P 117 - Can the Trust please confirm that these are 9 social care placements? (if they are in fact specialist hospital admissions through ECR they should not be reported here)	Trust confirmed that the number reported were hospital placements for treatment and not social care placements outside NI. Trust to amend as confirmed these are ECRs.	Trust confirmed only 2 of the 9 ECRs were social care placements. No further action	T	25.6.15
June 2015	**Young Carers**				
	5.7 - only 2 young carers assessed in year. Also at year end no young carers receiving support? I believed Trust had young carers support contract with C&V. Has this been stopped?	Trust confirmed that it does refer to young carer support groups and other mechanisms to support young carers. It is currently reviewing how it collects activity and outcome data from Contractors to ensure	System in place for recording family carers under 18 years. Monitor for increased reporting 2015/16	T	24.11.15

MENTAL HEALTH & LEARNING DISABILITY - MENTAL HEALTH					
Originating date	**Issue**	**Action**	**Outcome**	**Action by**	**Date completed (if not completed, carry forward)**
		that all carer support is captured and reflected in reporting. Trust to provide update on progress in midyear report.			
June 2015	**Data Issues – Social Care Services**				
	1.4 xiii - 74 RH v sect 4.2 = 61 explain differential 1.4 xiv - 126 NH v 4.3 = 106 explain differential	Trust advised there are 13 self-funding in Residential Homes Trust advised there are 19 self-funders in Nursing Homes	No further action required		25.6.15

MENTAL HEALTH & LEARNING DISABILITY – LEARNING DISABILITY					
Originating date	**Issue**	**Action**	**Outcome**	**Action by**	**Date completed (if not completed, carry forward)**
June 2015	**Baseline for LD Framework Audit**				
	P 131 - The Trust report that their baseline audit data for the LD framework review is not robust. This is of concern as this represents the baseline measure to demonstrate progress against the LD standards framework.	Trust proposed that there was a regional problem with the interpretation of LD standards. The Board advised that this had been discussed with DHSSPS, however there was no appetite at this stage for a major review of the standards.	Agreement on interpretation to be sought through the regional working group.	B / T	25.6.15
June 2015	**MHRT – Communication Request**				
	P 133 - Meeting with MHRT 3.7.14 re issues of timing and communication in relation to tribunals (to safely manage MHRT unexpected discharges). MHRT undertook to consider the Trusts proposals. Trust still awaiting response at time of report. How will this be followed up?	Trust to pursue again with MHRT and request further meeting. Trust to advise HSCB of progress. If no progress, Trust will escalate to HSCB. Trust have a further meeting with MHRT scheduled for Jan 2016		T	

T = Trust to action; B = Board to action

MENTAL HEALTH & LEARNING DISABILITY – LEARNING DISABILITY					
Originating date	**Issue**	**Action**	**Outcome**	**Action by**	**Date completed (if not completed, carry forward)**
June 2015	**Data Issues: Carers and Direct Payments (Section 5)**				
	P162 – 5.4 Please explain 119 & 3?	Trust advised that there was a formatting problem with the document as it would not allow a four figure number to be inserted. The report should read 1193.	HSCB to note and amend for regional report.	B	25.6.15
	P 162 – 5.9a Trust indicate what is being asked is not clear.	HSCB gave an explanation. This is direct payments made to a third party (usually because of capacity issues, and normally using short procedure order); as opposed to 5.10 which is carers receiving a direct payment for their own carers needs. As opposed to 5.10 which is asking about carers receiving a direct payment for their own assessed carers needs. The Trust may wish to review this table in light of the clarification.	Amended figure provided in mid year report No further action required	T	24.11.15

T = Trust to action; B = Board to action

MENTAL HEALTH & LEARNING DISABILITY – LEARNING DISABILITY					
Originating date	**Issue**	**Action**	**Outcome**	**Action by**	**Date completed (if not completed, carry forward)**
June 2015	**Detained Admissions for PoC**				
	P164 - 9.1 a-d RESW have advised that they are unable to give a breakdown of ASW assessments and detained admissions by programme of care.	HSCB advised that RESW are not able to provide a breakdown by PoC. Trust to provide data for OOH admissions for LD PoC asap. RESW have advised that they are unable to provide data for ASW activity out of hours by PoC.	Trust to have internal discussion with RESW to agree resolution.	T	24.11.15
June 2015	**Trust Issue – Deaf Blind?**				
	The PoC were unable to provide detail of information required for section 2.	Trust advised that this information currently relied on manual counting from across a range of teams and services and could not be verified as being accurate.	Trust is reviewing its information systems to produce more accurate data for prevalence of sensory impairment for people with LD.	T	25.6.15
Nov 2015	**Guardianship**				

MENTAL HEALTH & LEARNING DISABILITY – LEARNING DISABILITY					
Originating date	**Issue**	**Action**	**Outcome**	**Action by**	**Date completed (if not completed, carry forward)**
	Correspondence from RQIA sent via DHSSPS in respect of 2 issues contrary to GAIN guidance (initials instead of full signature and time scale between medical and social welfare recommendations)	[redacted]	Trust reported that they have provided advice to staff and that they are assured that their processes for guardianship are robust. No further action required		24.11.15
Nov 2015	**Key Workers for people using Day Services**				
	Not all people using statutory day services have a named key worker from CLDT	Trust to ensure that statutory day services are compliant with Standard 17 "working together" of the Service Framework for Learning Disability (DHSSPS 2013).	Trust reported that every service user has a named team to respond if care needs require review, but there would be a significant resource issue to appoint named key workers and routine review processes.		24.11.15

OLDER PEOPLE AND ADULTS & PHYSICAL DISABILITY AND SENSORY IMPAIRMENT					
Originating date	**Issue**	**Action**	**Outcome**	**Action by**	**Date completed (if not completed, carry forward)**
June 2015	**Risk and Governance**				
June 2015	***Safe and Effective Hospital Discharges*** - Pressure to achieve timely discharge and improve care pathways internally and with other Trusts.	Complex Discharge team established (October 2014) Work to improve information and data systems underway Focus upon team skill mix and strengthening role of hospital SW in Multi-Disciplinary teams. Development of a Community Access Centre (CAC) November 2015 to better support the management of referrals via a single entry point on a 7 day per week basis and improve management of complex discharges. Improved skill mix and staffing complements via planned implementation of the Trust's		T	

OLDER PEOPLE AND ADULTS & PHYSICAL DISABILITY AND SENSORY IMPAIRMENT					
Originating date	**Issue**	**Action**	**Outcome**	**Action by**	**Date completed (if not completed, carry forward)**
		'Modernisation and Workforce Review' report (September 2015) ie an increase in the number of Band 4 social care co-ordinator posts in hospital to assist in the discharge of non-complex cases).			
June 2013	***Compliance with Care Management Reviews*** Difficulty in achieving annual care management reviews due to workforce / other pressures	Review of Care Management role underway and review of team structure. Service re-structuring to focus upon outstanding review work. Development of new care management form; processes streamlined. Implementation of the Trust's 'Modernisation and Workforce Review' planned for 2016 onwards with changes to care management and social work			

OLDER PEOPLE AND ADULTS & PHYSICAL DISABILITY AND SENSORY IMPAIRMENT					
Originating date	**Issue**	**Action**	**Outcome**	**Action by**	**Date completed (if not completed, carry forward)**
		arrangements. Establishment of an 'Older Person's Care and Placement Review Team' to improve performance.			
	Access to Service				
June 2015	***Access to domiciliary care packages and capacity of the Independent Sector to meet demand –*** Including meeting accommodation / other needs of people with complex disability	Streamlining of referral pathway for domiciliary care via single point of access gateway model New procurement of domiciliary care services in Trust planned – first stage underway. The Trust will move forward from its pre-procurement consultation exercise in June 2015 to undertake full tendering for domiciliary care in the 2016-17 Financial Year. A new domiciliary care provider entered the market in Belfast in January 2016.			

OLDER PEOPLE AND ADULTS & PHYSICAL DISABILITY AND SENSORY IMPAIRMENT					
Originating date	**Issue**	**Action**	**Outcome**	**Action by**	**Date completed (if not completed, carry forward)**
		Enhancement of the domiciliary care hourly rate in early 2016 will stimulate the market and increase capacity. The Trust's re-ablement service has been enhanced with the appointment of additional staff to meet demand.			
June 2013	***Carers Assessment and Direct Payments*** Update on Trust activities regarding implementation of regional carers strategy. Priority Area for Trust agreed as: - Hospital Discharge, - Unmet Need, and - Direct Payments to carers.	Hospital Discharge Protocol to be put in place Unmet Need – Trust continue to scope out this issue Direct Payments – see below	Protocol in place	T	23.11.15

OLDER PEOPLE AND ADULTS & PHYSICAL DISABILITY AND SENSORY IMPAIRMENT					
Originating date	**Issue**	**Action**	**Outcome**	**Action by**	**Date completed (if not completed, carry forward)**
June 2015	Increase in number of assessments offered / accepted is required, also evidence of use of **direct payments** in Older Peoples services	Service User engagement has taken place to better understand the user assessment experience and how this can be learnt from and improved. Further workshops in this area planned ie Enhanced engagement and outreach to carers ie 'Planning together, a better future for Belfast carers' workshop, 25th February 2016. Promotion of direct payments will remain as a future target area. Successful completion of Physical and Sensory Disability pilot as part of regional work around innovative short breaks has increased access to innovative short breaks and cash grants.			

OLDER PEOPLE AND ADULTS & PHYSICAL DISABILITY AND SENSORY IMPAIRMENT					
Originating date	**Issue**	**Action**	**Outcome**	**Action by**	**Date completed (if not completed, carry forward)**
	Identification of Unmet Need	Learning/ analysis from the recently completed Trust audit of carer support/ carer assessments is currently underway. Trust continues to scope out unmet need issues.			
June 2014	**Professional Issues**				
	Access to Supervision in Adult Services and related monitoring activity following BSO Audit – Trust response to BSO audit is noted and commended. Further Trust update welcome	Proactive response to BSO audit recommendations Skill mix reviewed to ensure access to appropriate staff for supervision purposes	Audit and reporting mechanism in place for monitoring failure to deliver supervision New supervision template devised	T	25.6.15
June 2014	**Workforce Issues**				
	Social Care Workforce Review and skill mix issues; workforce stability, vacancy controls –	The Trust's draft 'Modernisation and Workforce Review' report has been shared with HSCB for comment. It outlines planned		T	

OLDER PEOPLE AND ADULTS & PHYSICAL DISABILITY AND SENSORY IMPAIRMENT					
Originating date	**Issue**	**Action**	**Outcome**	**Action by**	**Date completed (if not completed, carry forward)**
	Pressure re increasing workload, case complexity, safeguarding referrals (Impact of above on Trust workforce and Trust ability to discharge statutory duties.	changes to social work/social care staffing arrangements and structures, including the re-organisation of the care management function.			
June 2015	**Information and data returns**				
	BSO Internal Audit on Statutory Report data – this is noted in context of improvements in information quality this year and roll out of CIS / PARIS system. Further Trust update welcome.	Review of Trust information systems on-going with move to Paris system Band 7 information officer appointed	Trust data now improved	T	25.6.15
June 2014/15	**Trust Issue - Meeting the Need of People with Alcohol related disabilities within Older People and PSD services (ie ABI, Korsakoff's Syndrome)**				
	Pressure placed upon services by this cohort of users with complex needs. Clients currently located across a number of service areas; Mental Health, Older People, PSD - no	HSCB and Trust representatives met in August 2015 to discuss internal Trust management issues in relation to the above. Issue further discussed at HSCB/Trust DSF interim meeting 23.11.15 and need for whole		T/B	

OLDER PEOPLE AND ADULTS & PHYSICAL DISABILITY AND SENSORY IMPAIRMENT					
Originating date	**Issue**	**Action**	**Outcome**	**Action by**	**Date completed (if not completed, carry forward)**
	agreement regionally or locally how needs can be best met.	system/ care pathway approach identified. HSCB/LCG and Trust have worked together on issue - a database has been populated to scope out the number of relevant cases and associated costs to better support future planning for funding and service development.			

ADULT SAFEGUARDING					
Originating date	**Issue**	**Action**	**Outcome**	**Action by**	**Date completed (if not completed, carry forward)**
June 2015	Human Trafficking victims withdrawing from contact with sources	Ensure that users are all eligible to access public funds	Situation clarified	T	25.6.15
June 2015	Increase in referrals from mental health and lack of trained IO's What action is Trust taking to ensure there is an appropriate number of IO's trained/available within MH services	Trust has described a comprehensive training programme. Number and location of all trained staff identified.	Trust has identified adequate number of staff trained as IOs in Mental Health services.	T	31.01.16
June 2015	Variation in referral rates across Trust localities Trust to clarify possible reasons for variation especially in relation to Carlisle and Beechall localities	Trust to examine possible reasons for variation. To monitor / review at next meeting.		T	

MAHT - STM - 097 - 5962

BHSCT DSF ACTION Plan 2021/22 - YEAR END UPDATE MARCH 2022

Programme of Care	Total Number of Issues	Red RAG	Amber RAG	Green RAG
Family and Children	10	0	8	2
Mental Health	1	0	0	1
Learning Disability	7	3	2	2
Older People and Adults	6	1	2	3
Physical Disability	2	0	0	2
Total	**26**	**4**	**12**	**10**

BHSCT DSF ACTION Plan 2021/22 - YEAR END UPDATE MARCH 2022

Issue	Action Required	By When	Owner	Progress Update	RAG Status
Family & Childcare Issues					
1. Issue: Early Years inspections In order to undertake the 355 outstanding inspection as well as the additional inspections the Trust will follow Departmental and HSCB guidance as it evolves. Due to covid restrictions Trust have only been permitted to undertake one inspection per day, per SW. Trust to provide an Action Plan outlining timeframes to complete backlog (31/07/21) Trust to update HSCB Lead monthly on progress. **Discussion at DSF meeting 25.6.21** Outside of Covid period, the Trust advise the Early Years team have managed their inspection process well. With lifting of restrictions, the team have been able to increase inspections. Backlog now sits at 232. Trust report a trajectory to clear	**Actions:** • Trust to provide an action plan detailing how the remaining backlog will be resolved.	31/07/21	Edel McKenna Co-Director Early years and Safeguarding	**Update 13.12.21** Action plan received on 03.12.21, detailing current position of 47 outstanding inspections which are now allocated and due to be completed within the reporting period. Meetings continue fortnightly with Una Lernihan, Social Care Commissioning Lead to review Covid related issues and pressures and to monitor actions both regional and Trust specific. **Update 14.03.22** Regional meeting forums continue with HoS and Una Lernihan. The remaining backlog assessments have been allocated and are nearing completion.	

backlog by Nov 2021				Action deemed completed.	
	• Trust to clear backlog by November 2021	30/11/21	Edel McKenna Co-Director Early years and Safeguarding	**Update 13.12.21** See above **Update 14.03.22** See above	
2. Issue: Children with a disability - short breaks availability / numbers on child protection register The HSCB notes: • Trust have reported no CWD on the CPR • Trust report the highest number on ASD waiting list • Trust report highest per capita SEN statements • Trust report highest level of Children on high level DLA. • Trust report a decline in number of CWD but increase in pressure in this area HSCB and Trusts are still unaware of the consequences or impact arising from the Girvan case relating to	**Actions:** • Trust to provide Action Plan in relation to the management of Autism waiting list	31/07/21	Sarah Meekin Head of Psychology	**Update 13.12.21** Update required from ASD service. **Update 14.03.22** Deputy Executive Director of Social Work (Eileen McKay) had met with and acquired update from the ADS service. They are projected to deliver on commissioned assessment activity (600 p.a.) following COVID19 restrictions. Diagnostic rate is 95% following triage which would indicate	

Educational application to the MCA and this will need to be kept under review. **Discussion at DSF meeting 25.6.21** Relevant staff from Autism service were not at the meeting and therefore the detail could not be provided Children with short breaks (LD services) – Trust have not met their statutory functions in relation to provision of short breaks. Willow lodge is continued to be paused. Trust have accessed an ECR placement. Unit child is discharged the Trust will be unable to effect short breaks. Trust have plans in place to step up levels of support to other families requiring short breaks, inc. Increase in Social Work support, SDS. Currently 11 children with disability on CPR as of June 2021. The Trust are not able to lift data from Paris and rely on manual lift. The Trust advise they are satisfied with their threshold decisions regarding Child Protection within CwD teams.				appropriate referral and triage processes. BHSCT intervention WL < 13 weeks. Level of demand continues; upward trend is projected at 883 p.a. for 21/22. This is in addition to WL created by historical capacity/demand gap and COVID19 impact.	
	• Trust to provide report to the HSCB outlining mitigations in place in terms of levels of support in absence of short breaks	31/07/21	Edel McKenna Co-Director Early years and Safeguarding	**Update 13.12.21** Action plan update received on 03.12.21. There is acknowledgement of the pressures for families in the community who are struggling with reduced service provision as a result of the pandemic and also the impact of changes to educational programmes / in schools. The Trust	

				advised engagement with relevant families continues; They have been able to step up face to face contact and provide additionality via Community and Voluntary partners. The Trust has also increased self-directed support payments. **Update 14.03.22** Action plan update received 22.03.22 which outlines ongoing use of SDS, Article 18 payments and increased contacts with families through community and voluntary partners. Co-Director advised that mitigations remain in place with short breaks being paused. Two pre-action notices have been received. One concluded without progression to full Judicial Review. The second is more recent	

				– outcome awaited.	
	• Trust to provide action plan outlining how they are re-instating short break capacity by October 2021	31/07/21	Edel McKenna Co-Director Early years and Safeguarding	**Update 13.12.21** Updated action plan received 03.12.21. Challenges remain – Willow Lodge continues to be paused in respect of short-breaks. Care planning continues in relation to the child remaining in Willow Lodge at present; ECR agreed. Use of Forest Lodge is being addressed in consultation with RQIA and some adaptations may be required. Forest Lodge Staff are redeployed to assist with Trusts Covid response. Workforce pressures for both facilities are acknowledged. Staffing recruitment continues for Willow, Forest Lodge and Somerton Rd.	

				Update 14.03.22 The Trust advised that funding for an appropriate single occupancy ECR placement was secured and Article 33 granted for the young person currently in the short breaks facility. This placement offer has since been rescinded due the young person's refusal to move. Alternatives are being sourced. Current situation remains challenging in relation to young person's behaviours and needs being met within the home. Exploration of alternatives (Forest Lodge) to reinstate short-breaks has not been achieved due to workforce pressures. Revised 3 month target has been outlined for moving young person	

				to an appropriate long-term placement and thereafter repairs to the home and return of staff team is required. Revised timeframe - June 22. Action plan update received 22.03.22	
	• Trust to examine their data reporting in relation to CwD to ensure appropriate reporting	30/09/21	Edel McKenna Co-Director Early years and Safeguarding	**Update 13.12.21** Data lifts and PARIS system updates are ongoing. **Update 14.03.22** Previous manual return has been problematic. Children's information manager has established a new reporting system under PARIS. This is fully operational and final testing against quality assurances measures will be completed at end of March. Action deemed	

				complete.	
3. Issue: Personal Advisors 109 young people did not have a personal advisor appointed at 31st March 2021. This is a key role for this group of very vulnerable young people Trust to provide action plan outlining steps/measures taken to ensure all young people have a personal advisor (01/07/21) **Discussion at DSF meeting 25.6.21** HSCB would request an analysis of Leaving Aftercare/SAI's to identify unmet need and the impacts on young people. Trust are reviewing 18+ teams with a view to changing to16+. They are also working with Paris to appropriately identify yp requiring a PA. Trust reviewing case closures monthly which all assists in projecting numbers of yp coming into the service.	**Actions:** • Trust to provide an action plan outlining how they are to reduce this figure (to include: staffing levels, data collection and forecasting)	01/07/21	Kerrylee Weatherall Co-Director Corporate Parenting	**Update 13.12.21** Action plan received and update requested by end January 22 for period to 31.12.21. September's data showed reduction from 109 to 63 young people with no PA appointed. Unfortunately some of the Band 4 staff that were recruited have moved on and the figure is currently 72. The PARIS system review continues to allow for data pulls and trends to be overseen easily. These have been forwarded to the HSCB monthly. The Band 4 Staff in the LAC teams to reduce pressures remain at risk to the Trust as unfunded posts.	

				The 16+ young people assessed as low risk / stable with no SW are being managed through the Trusts duty system. **Update 14.03.22** Action plan update received 11.03.22. Service model review paper, process map and action plan monitoring template received. Unallocated cases figures have fluctuated across previous months in relation to PA support staff which correlates to workforce absences. Recruitment to vacant posts continues.	
	• Plan to outline timeframes and outline projected reduction in waiting list	01/07/21	Kerrylee Weatherall Co-Director Corporate Parenting	**Update 13.12.21** See above update. Closures completed Nov 21 and young people assessed as low risk are managed via the Trusts duty system.	

				Update 14.03.22 Recruitment process ongoing (at short-listing stage). Previous vacancies filled however, some moved to alternative posts and those filled via temporary staff / agency have not provided level of stability the service requires. Overall significant workforce challenges remain. Vacancies and unallocated cases being reported via HSCB monthly returns.	
	• Trust and HSCB to undertake a review of SAI's	Review period 01/09/21 – 30/10/21	Kerrylee Weatherall Co-Director Corporate Parenting	Update 13.12.21 DoH review was completed. Three SAI's have been allocated to an independent consultant for review. Trust plan to further review those YP who are known to Mental Health services and SAIs to be completed.	

				Update 14.03.22 Two independent associates have been identified and are being trained for undertaking this specific role. Triaging of priority cases for immediate learning has been completed. Governance system in place to identify SAIs in timely manner.	
4. Issue: Unallocated cases/Named Social Worker 35 young people did not have a named social worker at 31st March and team members via a duty system were undertaking their statutory visits. This impacts significantly on the development of a meaningful relationship between social worker and young person which is a key support for every looked after child. Unallocated cases at time of DSF meeting June 21: LAC - 17	**Actions:** • Action plan from the Trust to explain how they are ensuring each child looked after has a social worker, receives statutory visits and statutory reviews	31.08.21	Kerrylee Weatherall Co-Director Corporate Parenting	**Update 13.12.21** Action plan received and further updated on 26th Oct 21. Update to be forwarded for period to end Dec 21. The figure in Oct = 60 LAC cases with unallocated SW who are being managed via the Trusts duty system. The Trust reported their unallocated cases across Children's	

CwD – 83 FS – 19 Gateway – 10 Total: 129 (an increase of 13 from March 21) **Discussion at DSF meeting 25.6.21** 2.5 staff were brought in to LAC, current unallocated in LAC this is now 0. FS/Gateway – Trust have been unable to meet their statutory function in allocation of a SW to children. Trust submit monthly returns submitted. Figures above are correct. CwD, 4 SP's allocated from IPT monies. Gateway/FS, there has been an increase since March 2021. Trust report these figures are manageable. No actions identified for unallocated cases.				Services Oct 21: LAC- 60 CwD – 173 FS - 81 Gateway - 60 Monthly returns continue to be submitted to the HSCB in respect of unallocated cases and workforce pressures. The Trust have escalated workforce pressures to their Trust Board and is recorded on the Trusts risk register. A meeting was held in respect of current issues across Children's Services (workforce, unallocated cases, placements, short-breaks, complexity of need etc.) with DoH and HSCB on 28.10.21. **Update 14.03.22** See above mitigations to increase workforce capacity within LAC	

				teams. LAC unallocated numbers are: 124 - end January. 86 - end February. The Trust reported significant workforce challenges with 56% absences across children's disability teams and combined children's services absence of 33% in February. The Trust are noting an increase of referrals across Tier 2 and 3 services which compounds current difficulties. The unallocated cases are noted as follows(end January): LAC- 124 CwD – 273 FS - 131 Gateway - 88 The Trust outlined the governance system in place across Gateway to review and prioritise	

				allocations and further action to bolster FIS teams via transfer of appropriate cases identified staff in family centre. This process is overseen by principal practitioners. A second principal social worker post has been created to strengthen management structure for children with disabilities alongside the previous 4 x B7 Senior Practitioner roles from the unallocated cases transformation funding. Monthly returns continue to be submitted to the HSCB in respect of unallocated cases and workforce pressures.	
5. Issue: Statutory Visits 72 statutory visits did not take place	**Actions:** • Action plan from the Trust to explain how they	31.08.21	Kerrylee Weatherall Co-Director Corporate	**Update 13.12.21** The Trust advise that both statutory visiting	

within the regulatory timescales. **Discussion at DSF meeting 25.6.21** Refer to discussion at Unallocated section	are ensuring each child looked after has a social worker, receives statutory visits and statutory reviews		Parenting	and statutory reviews have been impacted by workforce challenges. The figures for October show that 18 visits and 35 LAC reviews did not take place within timescales. **Update 14.03.22** The Trust report that for January 22, there were 12 statutory visits and 41 statutory reviews that did not take place within timescale. As per the Trusts business continuity plan there has been a move to a blended approach of face to face and virtual visiting. LAC Reviews that have not taken place are re-scheduled within 4 weeks. Using the workforce appeal, an out of hours LAC team (with appropriate governance structure)	

				has been established to cover some unallocated cases. Colleagues across children's teams are undertaking statutory and reviews. The additional LAC team that was created (funded by the Trust at risk), now has a Team Leader via the retire and return scheme. The Senior Management Team meet on a monthly basis to monitor progress, manage risks and target action where necessary.	
6. Issue: Statutory reviews 94 statutory looked after children reviews did not take place within the required timescales. **Discussion at DSF meeting 25.6.21** Refer to discussion at Unallocated section	**Actions:** Action plan from the Trust to explain how they are ensuring each child looked after has a social worker, receives statutory visits and statutory reviews	31.08.21	Kerrylee Weatherall Co-Director Corporate Parenting	**Update 13.12.21** See above. **Update 14.03.22** See above	

7. Issue: Placement Moves for children 117 children experienced a move in placement during the reporting period. **Discussion at DSF meeting 25.6.21** Trust are managing very complex situations, including younger children coming into care. Trust are increasing recruitment, wrap around support, edge of care services. However despite this, the Trust are struggling to manage their looked after population and adequately responding to their needs. HSCB are satisfied with actions being taken by the Trust and therefore do not require this to be taken forward as a specific action. Will be considered as part of the review of LAC services as outlined in 'Unallocated/Stat Visits/Stat Review' above	**Actions:** • **No actions required – included for information only.**			**Update 13.12.21** Currently there are 913 children in care in Belfast Trust. The increase in number of LAC and in fostering breakdowns has been noted by the Trust. Additional support from utilisation of B4 staff (unfunded posts /at risk) and packages of support from Community and Voluntary partners has been put in place E.g. additional timeout with Extern for fragile foster placements (35 families have been in receipt of this service/support) and there is a bid submitted via Covid monitoring process ref: same. Challenges remain and pressures within fostering service have been highlighted. The Trust are reviewing	

				their unallocated fostering placements and vacancies in the fostering team. In addition, LAC TSS pressures also shared with HSCB on 08.12.21 and an escalated meeting with HSCB programme manager has been requested. **Update 14.03.22** Fostering team are seeking to improve capacity to complete assessments utilising sessional staff from the independent sector providers and from internal trawls across existing children's teams for additional hours.	
8. Issue: Iveagh delayed discharges **Discussion at DSF meeting 25.6.21** Operational policy requires review during 2021/22	**Actions:** • Review and amend Operational Procedures to prevent future delayed discharges	30/09/21	Tracy Kennedy Co-Director Adult Learning Disability	**Update 13.12.21** Update to be requested from Adult LD service. Process ongoing with AD CwD group and Independent Review are looking at some of	

				the ongoing issues. Iveagh and Beechcroft are included in DoH regional review of Children's Services. The importance of good working and strengthened links between Adult and Children's services was highlighted in relation to Iveagh. A Judicial review is ongoing regarding 1 x YP in Iveagh at present. **Update 14.03.22** Young person remains in Iveagh and Judicial Review hearing is scheduled. Trus continue to work to navigate the issues presenting. Further update should be sought via DSF meeting for LD Services - (Tracy Kennedy Co-Director Adult Learning Disability).	

9. Issue: Increase in numbers on Child Protection Register March 20 = 251 March 21 = 335 An increase of 84 (33%) Regionally March 2020 = 2,298 March 2021 = 2,298 **Discussion at DSF meeting 25.6.21** Trust undertook an analysis of thresholds, and were satisfied with decision made.	**Actions:** • **No action required – included for information only**			**Update 13.12.21** Trust advise that Child Protection Register figures remain fairly static. As of 10.12.21 the figure was 347. **Update 14.03.22** Current figures are 344. Increase of 9 noted from March 21.	
10 Issue: Increased numbers of Looked After Children March 2020 = 866 March 2021 = 875 An increase of 9 (I %) Regionally March 2020 = 3,383 March 2021 = 3,530 An increase of 147 (4%) **Discussion at DSF meeting 25.6.21** Trust undertook an analysis of thresholds, and were satisfied with decisions made.	**Actions:** • **No Action required – included for information only**			**Update 13.12.21** Trust advise ongoing upward trajectory in respect of LAC figures which is now = 913. Action planning and reporting remains regional issue. Further work ongoing via AD Corporate Parenting Forum and actions agreed from Regional HSCB workshop on 06.08.21. See Issue on Placement	

				Moves above for further detail. **Update 14.03.22** Upward trajectory continues which causes significant demands on teams and regarding care placement availability. The number of looked after children has increased to 946 (8.1% since March 21).	

Issue	Action Required	By When	Owner	Progress Report	RAG status
Mental Health Issues					
11. Issue: Continuing difficulties faced by the ASW service in fulfilling requirements under the Order as detailed in 2.1b • Conveyance difficulties • Significant delays in Out of Trust admissions • Access to on call manager after 5pm for ASW staff. **Discussion at DSF meeting 25.6.21** Trust have adopted a conveyance pilot. There is a protocol in place to	**Actions:** • Trust to update HSCB on governance arrangements with conveyance protocol now in place	Update at each HSCB/Trust interface meeting	Mary O'Brien DSW Mental Health	**Update 3/3/22** Conveyance protocol is in place	
	• Out of Trust admission delay to be raised at Regional Bed Management meeting	Update at each HSCB/Trust interface meeting	Julia Lewis Co-Director of MH	**Update 3/3/22** Actioned and work ongoing within the Regional Bed Capacity Co-ordinator group through daily huddle process	

reduce delays. Trust report this has been a positive development. HSCB note potential learning across Trusts. Out of Trust admissions. There is a delay in accessing Consultants for admissions. Some Trusts have introduced a further layer to admissions (to contact an ASM in order to get in contact with a Consultant). On call manager at 5pm. Trust have arrangements in place, HSCB are satisfied and do not require any further actions carried forward.					

Issue	Action Required	By When	Owner	Progress Update	RAG Status
Learning Disability Issues					
12. Issue: Domiciliary Waiting List There are 12 service users on the waiting list for domiciliary care within Learning disability. This presents a potential risk to service users as the Trust is unable to meet their assessed needs in a timely way. This can also impact on	**Actions:** • Trust to provide an action plan outlining the mitigating measures put in place, to include role of care manager in monitoring unmet need	31/08/21	Magda Keeling, Service Manager	**Update 29.10.21-** • There are currently 11 service users awaiting packages. • The project group introduced time bands which increased flexibility for Providers and enabled them to offer more	

carer stress levels **Discussion at DSF meeting 25.6.21** Currently 15 people on the waiting list. Trust have introduced time bands for care packages and are encouraging uptake of SDS. Cases are kept under review by Care Manager regularly. Needs are re-assessed as part of monitoring process.				packages. The time band is for example, 7am – 8.59am or 9am – 10.59am and if a Provider can offer a call in that time band, for example 7.45am, the call can then be delivered anywhere between 7.15am and 8.15am. • Unmet needs audit is carried out on a monthly basis to ensure that all packages on the Care Bureau Circulation list are still required. • Care Managers check with key workers that packages are still required. • Key workers maintain contact with service users and carers to determine how well they are managing in the absence of a	

				package. Frequency of contact is determined individually but is at least monthly • Key workers offer supports to families, for example, SDS/ Direct Payments, carer assessments etc. • Key workers inform Care Managers when circumstances deteriorate and package needs to be escalated. • Care Managers participate in escalation calls twice weekly to try to prioritise urgent cases. This is sometimes successful, but it is dependent on how many packages are required for hospital discharges and palliative care, which are always	

				prioritised. • Even if packages reach the escalation list, there still continues to be difficulties securing packages, particularly in East Belfast where several providers are in contingency and only able to provide packages to existing urgent calls. **Up-date at DSF meeting 09.12.21:** Trust confirmed considerable work undertaken by project group, flexibility re time band had some positive impact. Currently 11 service users requiring dom packages. Trust continues to work with families to explore direct payments, offer carer's assessments, carer grants, short breaks and explore community and voluntary options as appropriate. Trust to continue to monitor issue. Service users reviewed at	

				least monthly. Rag rating agreed to remain amber. **Update at DSF Meeting 04/03/22:** Rhoda McBride updated that the Trust continue to work with service providers, families, C&V groups in an attempt to resolve this issue. Given the impact of the COVID pandemic, reduction in short breaks and Day Centre attendance, demand for domiciliary care appears to be outstripping supply. However, despite remaining solution focused the situation has exacerbated. Currently 21 service users with a Learning Disability require a domiciliary care package. Service users continue to be reviewed monthly and unmet need continues to be flagged through appropriate channels. Rhoda noted that currently there were severe staffing issues in Community Learning Disability Teams. This issue is on the Trust Risk Register, 4 Team Leaders and 8A	

				staff have left. In MAH two Social Workers also due to retire. Impact on ability to maintain service noted, business continuity plans require consideration. On a positive note a Service Manager has been in post this past three weeks and Team Leader posts have been filled via expression of interest, due to commence post April 2022. It was agreed given the significant increase in service users requiring a domiciliary care package and the staffing issues raised the action is to be rated red and carried forward into the next reporting period. Trust to provide HSCB with regular update on staffing and domiciliary care service provision via LDAD Forum.	
13. Issue: Potential failure to provide people deprived of their liberty with adequate legal safeguards Compliance date set at December 2021. **Discussion at DSF meeting 25.6.21**	**Actions:** • Trust to provide monthly update on compliance at each interface meeting with HSCB	Monthly updates	Steph Kerr (Trust MCA Lead)	Updates provided through Mary O'Brien in MH via the interface meetings with HSCB. **Up-date at DSF meeting 09.12.21** HSCB contacted Trust	

Trust have reviewed case loads and met with MCA panel in terms of thresholds for DoLs. Central MCA team in BT has appointed 10 additional SP to assist other teams with legacy work. LD has provided a list of legacy cases to the central team.				yesterday to confirm level of MCA funding available. Trust had requested additional funding and consider available funding will impact on activity levels from 1st April 22. Lorna Conn noted HSCB could move to funding allocation re original funding figures pending response at Senior Level in Trust. Trust to provide response to HSCB. Rag rating agreed to remain as amber.	
14. Issue: Accommodation needs for those being discharged from Muckamore Abbey Hospital • Trust to provide Resettlement Plan **Discussion at DSF meeting 25.6.21** Trust confirm they have a resettlement plan in place for 15 service user, there is 1 service user without a plan. Monthly meetings with the HSCB where updates are given. The Trust currently do not have a timeframe for the 1 service	Actions: • Trust to submit Resettlement Plan to HSCB for 15 service user	31/07/21	Magda Keeling, Service Manager	**Update 31.10.21** A summary document setting out the resettlement options for the BHSCT patients in Muckamore Abbey Hospital is enclosed with the updated position as of 31.10.21. **Update at DSF meeting 09.12.21:** Resettlement Summary document submitted to HSCB prior to meeting. Discussion re specific arrangements for patients. BT patient discharged on trial	

user without a plan.				leave/resettlement on 08.11.21 as planned. 1 patient currently without a plan, Trust to progress discharge plan. Discharges anticipated within coming months. Significant number of discharges dependent on business cases e.g. forensic, on-site, Minnowburn which to date have been slow to progress. It was noted that a number of patients have discharged on trial resettlement/article 15, with the potential for beds to be required in the event of resettlement breaking down. DOJ recently requested patient to return to MAH. Consideration required re enhanced working with DoJ, DoH & Trust to support resettlement. Rating therefore agreed as amber. **Update at DSF Meeting 04/03/22:** Rhoda McBride updated that currently 16 BHSCT service users, 14 inpatient in MAH and two on trial leave. Rhoda noted	

				two of these 14 individuals were admitted recently and require a confirmed plan. Rhoda McBride noted recent difficulties re service user being returned to hospital via DOJ. Caroline McGonigle noted regular updates are provided at CIP and RLDODG meetings but progress is required re discharges, particularly given the ongoing pressure for beds. Rhoda noted ongoing pressure re beds and particular difficulty/ risk this places on Community Learning Disability Teams, issues noted in Early alert. Rhoda keen to be involved in Workshop planned April to look at regional admissions criteria to support bed flow. It was agreed given the issues noted this action should be red and carried forward into the next reporting period.	
	• Trust to confirm plan for remaining service user	30/09/21	Magda Keeling, Service	**Update 11.10.21-** There is currently no confirmed plan identified.	

			Manager	However the Trust are exploring a possible option with Praxis in South Belfast. **Update at DSF meeting 09.12.21**: Praxis not considered a suitable resettlement option so this service user currently still has no discharge plan. Trust to progress discharge plan. Trust held accommodation workshop this week in attempt to attract potential service providers to support the resettlement agenda as a whole. As still no plan in place for this patient, rating therefore agreed as red. Lorna Conn confirmed this issue to be escalated to Brendan Whittle, HSCB SCCD Director. **Update at DSF meeting 04/03/22:** Caroline McGonigle noted the last CIP report for BHSCT indicated there was no plan for 1 individual. Rhoda McBride noted that she did not have an update on individual service users but given the difficulties	

				discussed re service provision it was agreed this action should remain red and carry through into next reporting period.	
	• Trust to provide a timeline for offsite business cases	31/07/21	Tracy Kennedy, Co Director	A summary document setting out the resettlement options for the BHSCT patients in Muckamore Abbey Hospital is enclosed, which includes timeframes in respect of business cases. **Update 31.10.21** • In relation to the Off site business cases • Lanthorne – was presented & passed at the September Strategic Advisory Board, with reprovision for 5 people. The work is likely to start January 2022 • Minnowburn – Capital Redevelopment advised the site is now "live" for other public organisations	

				to express interest (i.e. NIHE). Capital business case presented at September SAB & agreed in principle, however NIHE do have concerns re: value for money / costs (5 tenants) • Forensic – no site identified as yet. MDT in MAH have expressed concerns that the model that passed in 2019 is no longer suitable for the identified tenants – further update are being sought. • The Cairns – capital redevelopment have been approached for an update on the valuation of this site before we could propose further LD accommodation. This would then need to go through	

				the same process as Minnowburn. **Up-date at DSF meeting 09.12.21:** Trust confirmed Lanthorne relates to community provision rather than resettlement from MAH. Minnowburn- Site currently going through public disposal process. Trust has submitted all relevant paperwork and awaiting an outcome re same. If site secured BHSCT will have to staff service. Building work (new build) required, initial indications re completion date 2023. Forensic: Triangle agreed housing provider. Number of potential sites recently identified but consideration required re their suitability e.g. proximity to schools/ urban area. Cairns ruled out as not suitable. Lorna Conn HSCB noted that lack of progress re business cases would be escalated to HSCB SCCD Director Brendan Whittle. Rag rating agreed to remain	

				red. **Update at DSF Meeting 04/03/22:** Rhoda McBride noted in terms of business cases ongoing work is required. Minnowburn Site currently going through land disposal process. Capital and revenue funding require consideration and will go through relevant processes. Further work required in respect of the Forensic Business Case. Trust to continue to update HSCB re CIP and RLDODG meetings. It was agreed that this action will remain red and be carried through into the next reporting period.	
	• Trust to provide timeline for submission of onsite proposal	31/08/21	Tracy Kennedy, Co-Director	**Update 29.10.21** • There are 2 resettlement options • a. New rebuild at a cost of £3.8m or b.Refurbishment at a cost of £1.5m • Refurbuishment would either be at the old football pitch or at the back	

				of the site which would entail some demolition. • A feasibility study is needed and capital development indicated this would take 3 months to complete albeit could not confirm when the completion timeline was for this and indicated this would be confirmed at the next meeting. • There is an understanding that the number of people that would be accommodated would up to a maximum of 5. • SET are in discussions re another potential person but this has not been agreed and therefore this would impact on the building brief.	

				Update at DSF meeting 09.12.21: Feasibility Study currently being underway by Capital Development, to be completed Jan 22. Trust confirmed it is important for environment to be positive for patients. If new build needed planning permission may have lapsed. Lorna Conn HSCB advised the lack of progress required escalation to HSCB SCCD Director Brendan Whittle. Rag rating agreed to remain as red. **Update at DSF meeting 04/03/22**: Rhoda McBride updated meetings continue to be chaired by the MHID Director. Caroline McGonigle noted the Feasibility Study has been delayed, now due for completion early March. Numbers for the scheme are being finalised. It was agreed this action remains red due to the delays in process and is to be carried forward into the next reporting period.	

15. Issue: MAH admissions The Service Area continues to struggle to make admission beds available as required most significantly including detained admissions. There have been no admissions in the last financial year. **Discussion at DSF meeting 25.6.21** HSCB notes a rise in the numbers of people with LD being admitted to MH wards. Trust to cross reference across MH/LD and across Trusts.	**Actions:** HSCB require the Trust to provide a plan outlining the following: • Provide detail regarding the numbers of requests for admission • Outline their process for admission for HSCB consideration (Regionally) • Trust to identify the number of discharges over the previous 6 month period • Trust to provide projections of number of discharges over next 6 month period • Trust to confirm when they will be receiving admissions	31/07/21	Owen Lambert, service manager	• Information on the number of requests for admission made to Muckamore Abbey Hospital in the period 1 April 2020 to 31 May 2021 has been provided. In summary, there were 8 requests made by WHSCT, NHSCT and SEHSCT. No requests were made by BHSCT community teams. **Update as of 31.10.21** • There have been no requests from other Trusts over the past 6 months. There have been 2 BHSCT admissions to MAH- 1 in Sept and 1 in Oct • The Trust would recommend the regional implementation of Care and Treatment Reviews and a Blue Light Protocol which has been implemented by	

				NHS England as a key part of its approach to early intervention and reducing inappropriate admissions. Two documents from NHS England are enclosed. • In the last six months there were 3 discharges from Muckamore Abbey Hospital. **Update 31.10.21** • In the last 6 months there have been 3 full discharges – 2 from BHSCT and 1 from NHSCT. • Resettlement plans across Trusts would indicate the potential for 4 discharges to be achieved in the next six months. **Update 31.10.21** • There is a potential for 5 discharges to be achieved within the next 6 months– 1 BHSCT. 4 NHSCT.	

				• HSCB colleagues are aware of the proposal to open 3 assessment and treatment beds for learning disability services in NHSCT. The proposal put forward by BHSCT to reopen a small number of assessment and treatment beds in Muckamore Abbey Hospital remains paused due to ongoing staffing challenges and slippage in some resettlement dates. **Up-date DSF meeting 09.12.21**: Trust confirmed until a number of patients are resettled, given current staffing issues MAH cannot accept admissions. Impact on region noted given MAH is the regional facility, particular impact on individuals requiring a forensic inpatient bed. Trust monitor requests for admission. Lorna Conn requested this must continue. Consideration required re regional	

				admissions criteria and associated pathways, work commenced in recent T&F group led by HSCB. Trust to forward to HSCB the internal processes to manage admissions. Trust submitted two documents referenced above re implementation of Care and Treatment Reviews and a Blue Light Protocol to HSCB. Trust to continue to monitor requests for admissions. Rag rating agreed to remain amber. **Update at DSF meeting 04/03/22:** Rhoda McBride updated since the last meeting there had been two BHSCT admissions to MAH. Caroline enquired how many requests for admissions had been made to MAH. Rhoda agreed to submit this information to HSCB. The importance of this data was noted in terms of determining service demand. In terms of discharges Rhoda updated since the DSF meeting in December 2021 there has	

				been 2 full discharges (1 NHSCT and I recent SEHSCT discharge). Currently 2 BHSCT on trial/article 15 leave and 2 NHSCT recently commenced transition/trial leave). Although there has been some discharges progressed, given the ongoing issues noted re accessing beds and facilitating discharges, it was agreed that the action should be rag rated as red and carried forward into the next reporting period.	
16. Issue: Safeguarding concerns regarding Shannon/Trench Park and Annadale RQIA report Dec 2020, outlines concerns relating to lack of safeguarding training/staff knowledge of safeguarding/referral process HSCB require the Trust to provide action plan to address recommendations from the RQIA report	Actions: • Report on addressing concerns regarding recording of restrictive practices in Trenchpark and Annadale	31/07/21	Aisling Curran, Service Manager	Action plans in respect of the RQIA Inspections of Trench Park and Annadale are enclosed. **Update 31.10.21** • In relation to Annadale as follows- • All staff have received adult safeguarding training and Mapa training • Any restraint used	

Discussion at DSF meeting 25.6.21 Trenchpark/Annadale – Concerns regarding recording of restrictive practices. Shannon – a number of concerns in relation to safeguarding				is clearly recorded on Datix. • There has been work undertaken with the Behaviour Support Team and Psychology Department in relation to the PBS plan and care plans • Staff have received training which is regularly reviewed and updated to ensure everyone is aware of how to best support the service user to minimise the need for restraint. • There are however ongoing challenges due to staffing predominantly within the core team at Annadale, in terms of sickness , recruiting new staff and lack of band 5 cover, leaving some shifts short. This has also had an impact on	

				facilitating training. • There has been successful recruitment in relation to band 3 staff and currently the service area is shortlisting for the B5 posts. • There was a recent inspection on the 14/10/21 and the inspector was satisfied all actions from last QIP had been completed except the staffing levels as outlined above. • Update in relation to Trench as follows- • In relation to issues identified in RQIA inspection in 2020 relating to safeguarding and DOLS have been addressed and accepted by RQIA	

	• Trust to complete action plan on recommendations from RQIA report regarding Shannon	01/07/21		**Up-date at DSF meeting on 09.12.21** HSCB confirmed up-dates noted in Action Plan had not been received by HSCB. Trust advised these had been forwarded from Carol Diffin to Brendan Whittle. Trust forwarded Trench Park Action Plan, & Annadale Action Plan to HSCB on 09.12.21. Moving forward it was agreed Trust to forward information regarding MH Services to Martina McCafferty HSCB. Information relating to LD Services to be sent to Caroline McGonigle, HSCB. Up-date provided re Shannon. Work conducted in MAH rolled out in MH. Considering deep dive into community teams and roll out to Beechcroft in New Year. Strengthening of systems, role clarity and audit noted. Trust to consider opportunity to scale up and spread. Action plans re Shannon to be forwarded to HSCB.	

17. Issue: Learning Disability Adult Safeguarding Workforce Pressures Trust outlines a range of issues regarding low numbers of DAPOs/ I/Os; diversion of ASG resource to MAH with corresponding gaps in community; business support and admin vacancies exacerbating pressures on staff; staff under pressure with demand outstripping ASG capacity. Trust to provide HSCB with assurances that its Adult Safeguarding service is working effectively and that investigations and related work are undertaken in a timely manner? Trust to provide an outline of the Governance Assurance process. **Discussion at DSF meeting 25.6.21** HSCB outlined concerns as outlined above. Trust have undertaken a review of the numbers of DAPO's in place and are finalising a paper to request additional resource into LD. Divisional SW also requires additional support to undertake role.	**Actions:** • Trust to undertake an internal review of the effectiveness of safeguarding services and report back to HSCB	30/09/21	Mark Johnston, ASG Lead	**Update 31.10.21** • During July the DOH completed an audit into ASG in MAH and this was followed by an RQIA inspection into MAH in July/August. • Unfortunately the completion of this audit has been delayed due to staff having to focus on these other two processes and also due to challenges with staffing levels. As we are also still awaiting the completion of the RQIA inspection report the EDSW, Carol Diffin has requested an extension until the end of November for the Trust to complete this. This will also allow us to take account of the findings of the	

				other two pieces of work that have been carried out by DOH and RQIA. **Up-date at DSF meeting 09.12.21:** Trust to forward audit findings to HSCB. IPT for LD Principal Practitioner to provide professional support to Divisional Social Worker. **Update at DSF meeting 04/03/22:** Caroline McGonigle thanked Rhoda McBride for forwarding the Action Plan to HSCB. Rhoda updated that given the inquiry, thresholds for safeguarding in MAH meant all staff incidents reported in respect of service users were considered under safeguarding. CCTV footage is viewed in any safeguardinginvestigation ensuring a robust though slower process. Rhoda stated she had devised a series of Escalation Forms and Aide Memoirs to assist in respect of safeguarding. Ciara Rooney facilitating bespoke training. As noted	

				in Action Plan ongoing work required. Rhoda and newly appointed Service Manager Colette Johnson intend to revisit Action Plan and ensure it takes cognisance of audit findings and any other recommendations. Rhoda to send updated action plan to Caroline McGonigle in HSCB.	
18. Issue: Iveagh delayed discharges **Discussion at DSF meeting 25.6.21** Operational policy requires review during 2021/22	**Actions:** • Review and amend Operational Procedures to prevent future delayed discharges	30/09/21	Michael McBride, ASM Iveagh	**Update 11.10.21**- The Operational policy for Iveagh was updated in July 2021- please see attached. **Up-date at DSF meeting 09.12.21** MHLD HSCB Programme Representatives agreed to share Iveagh Operational Policy with HSCB Children's Services Colleagues for review.	

Older People & Adults Issues					
Issue	**Action Required**	**By when**	**Owner**	**Progress Report**	**RAG status**
19. Issue: Domiciliary Care Provision – Unmet need	**Actions:** • Trust to share the review		Natalie	**Discussion at DSF meeting 6.10.21** Level of unmet need	

31 March 2021, 278 service users were awaiting care packages, this equated to 1588.75hrs. This represents a significant risk to service users and carers, in terms of unmet assessed need and additional carer stress **Discussion at DSF meeting 25.6.21** Trust report situation has deteriorated, and numbers of unmet need has risen. Significant rise in attendance at ED over recent months. People on waiting lists for medical intervention, and impact on their health needs. People are also much more reluctant to go into care homes as a result of Covid attention in this area. Steps Trust are taking: Increase capacity within Homecare service Weekly review of unmet need Structural changes, modernisation of homecare. New model proposal is almost near completion. Increasing Band 3 staff to increase capacity.	undertake within the service area, including identification of skill mix	31/08/21	Magee Co-Director ACOPS	continues to be a significant issue, current position is 695(387 new) outstanding packages totalling 5, 326hrs. Trust has achieved 8% increase in uptake of Direct Payments. Domiciliary Care Action Plan in place to address in-house and independent sector capacity. **Update 2/3/22** Current unmet need is 873 clients requiring 6,106.25hrs with all cases (including transfers from reablement) subject to weekly review. West Belfast Direct Payments project ongoing. Acknowledgement this is a regional issue which has HSCB and DOH input.	

	• Trust to share outcome of review to utilise/increase use of direct payment	30/09/21	Natalie Magee Co-Director ACOPS		
20. Issue: Mental Capacity Act The inability of Older People's Services to meet full compliance by 31st May 2021 **Discussion at DSF meeting 25.6.21** Trust have reviewed case loads and met with MCA panel in terms of thresholds for DoLs. Central MCA team in BT has appointed 10 additional SP to assist other teams with legacy work. OPPC has provided a list of legacy cases to the central team. There is fortnightly updates to the Trust Exec team with regards to compliance.	**Actions:** • Trust to provide monthly update on compliance at each interface meeting with HSCB		Director of ACOPs supported by Co-Director of MH	**Discussion at DSF meeting 6.10.21** At 31 August 21 there were 84 outstanding DOLs legacy cases, these have now been completed	

21. Issue: Annual reviews Trust report approx. 5,500 face to face reviews require completion. The service areas have significant non-compliance in relation to statutory annual reviews for both care home and domiciliary settings. **Discussion at DSF meeting 25.6.21** Trust report they are going to be compliant by December 2021. HSCB expressed concern as to the Trust's ability to meet this timeline.	**Actions:** • Trust to provide outline of timeframe to ensure compliance – updated on a monthly basis	31/07/21 Updates then monthly	Natalie Magee Co-Director ACOPS / Tracy Reid DSW Community & Hospital Adult Community & Older Peoples Services	**Discussion at DSF meeting 6.10.21** There is acknowledgment that within OP services , there remains a very significant risk of non-compliance by March 22. CREST & CSW action plans in place with set target number of monthly reviews. All cases are rag rated and prioritised in line with level of risk. Workforce review submitted to Senior Management. **Update 2/3/22** Acknowledgement of non-compliance by March '22. CSW projected 51% compliance & CREST projected 57% compliance by Mar'22. Impact of C-19 acknowledged. CSW and CREST action plans in place with set targets for number of	

				completed reviews by practitioner. Successful period of recruitment into CREST bringing potentially 7 additional staff by June'22(5 additional already in place). Staffing review planned for CSW to include caseload weighting & skill mix.	
22. Issue: Historical Case Closures in Hospital Social Work Data indicates 3,824 cases not closed. Target date for closure of 1st August 2021 This presents a significant risk to Trust assurance processes and delays in recording and closures can impact on timely information sharing. **Discussion at DSF meeting 25.6.21** Trust are working on this, and have an action plan in place. They request an extension to target date to 31/08/21	**Actions:** • Trust to provide update	01/09/21	Natalie Magee Co-Director ACOPS / Tracy Reid DSW Community & Hospital Adult Community & Older Peoples Services	**Discussion at DSF meeting 6.10.21** Outstanding Case Closures now at 2680 as of 20/9/21.Target set of a minimum of 900 per month to achieve full compliance by 30 November 2021. Staffing has stabilised (particularly RVH and MIH). HSW action plan in place **Update 2.3.22** Approx. 2,000 cases require closure with plan in place for weekly review of staff	

				caseloads. Trust hopeful for full compliance by end March'22. RAG rating to remain as amber in acknowledgement this may be a challenging target to achieve. **Update 1.6.22** This issue to be taken forward in another forum as per B Whittle.	
23. Issue: Inappropriate Referrals to Adult Protection Gateway Team (APGT) 242 of the 1121 referrals (21%) made to APGT (Older People and Physical Disability services) are screened out as inappropriate with no category of abuse noted. Given the resource implications of this, can the Trust provide information on actions taken to improve the referral pathway and related data? **Discussion at DSF meeting 25.6.21** Action Plan in place, which addresses pathways and development of central team. Important to identify if there high levels of inappropriate referrals which should be signposted	**Actions:** • Trust to provide analysis report on data and activity levels.	31/08/21	Natalie Magee Co-Director ACOPS / Tracy Reid DSW Community & Hospital Adult Community & Older Peoples Services	**Discussion at DSF meeting 6.10.21** Analysis report indicates that for 2020/21 45% of referrals were screened out as inappropriate for APGT. These referrals were largely welfare concerns with PSNI being the main referral agent. Analysis revealed there is significant misunderstanding across the Trust and beyond as to the role and remit of the APGT. Training is ongoing within the Trust and to	

to other areas, in order to increase capacity to Gateway service. An additional resource has been brought in which has provided an analysis of pathways.				Care Homes (AS Champions training). Review of arrangements for the management of Adult Protection referrals and required resource, is being led by Executive Director of Social Work. **Update 2/3/22** Trust acknowledges this continues to be an issue. CREST and APGT have agreed care home reporting to come to key workers , not APGT. Work ongoing via Exec Dir of SW on external reporting with acknowledgement that universal agreement on thresholds is a key issue. Trust to give consideration to adoption of multiagency forum for welfare concerns.	
24. Issue: Adult Protection - Learning and Actions from Level 2 SAI	**Actions:** • Agreed that HSCB will link with DRO to clarify if	31/07/21	Tracy Reid DSW	**Discussion at DSF meeting 6.10.21** HSCB has now received the SAI action plan with	

Significant shortcomings in Trust Adult Safeguarding services were identified in respect of a vulnerable adult and a subsequent Court ruling that Trust should initiate an SAI review because of a range of serious failures. Trust to update on its action plan to address these issues with timeframe for completion? **Discussion at DSF meeting 25.6.21** Trust have an action plan in place and had not forwarded to HSCB. They have also met with DRO and updated the plan.	there is an issue in relation to statutory functions. If so, this will be escalated to the Director, SCCD to Exec Director of the Trust.		Community & Hospital Adult Community & Older Peoples Services	all recommendations completed, providing HSCB with the necessary assurances. Interim AS Manager has facilitated a session with Trust APGT and Care Home managers and the learning from the case has been presented to Trust Adult Safeguarding committee and to Service Managers and the Collective Leadership Team across Adult Community Older Peoples Service. Shared Learning Letter to be redacted to ensure client confidentiality Learning to be shared across all IO and DAPO staff and incorporated into all future IO/DAPO and Joint Protocol training.	

Issue	Action Required	By when	Owner	Progress Report	RAG status
Physical Disability and Sensory Impairment Issues					
25. Issue: Mental Capacity Act 65 Legacy cases As stated above the service area continues to work through outstanding legacy MCA cases, which have had a significant impact upon staff within PSD Care Management. Whilst the service area has made good progress and continues to work towards completion by 31 May 2021, this increasingly complex work involves significant professional time without additional investment **Discussion at DSF meeting 25.6.21** Trust have reviewed case loads and met with MCA panel in terms of thresholds for DoLs. Central MCA team in BT has appointed 10 additional SP to assist other teams with legacy work. PDSI has provided a list of legacy cases to the central team. There is fortnightly updates to the Trust Exec team with regards to compliance.	**Actions:** • Trust to provide monthly update on compliance at each interface meeting with HSCB		Director of ACOPS supported by Co-Director MH	**Discussion at DSF meeting 6.10.21** The outstanding 65 Legacy cases have now been completed.	

BHSCT DSF ACTION Plan 2021/22 - YEAR END UPDATE MARCH 2022

26. Issue: Care Home Annual Reviews 283 Reviews outstanding **Discussion at DSF meeting 25.6.21** Trust report they are going to be compliant by December 2021. HSCB expressed concern as to the Trust's ability to meet this timeline	**Actions:** • Trust to provide outline of timeframe to ensure compliance – updated on a monthly basis	31/07/21 Updates then monthly	Natalie Magee Co-Director ACOPS /Tracy Reid DSW Community & Hospital Adult Community & Older Peoples Services	**Discussion at DSF meeting 6.10.21** 183 outstanding reviews at 24/9/21. PD care management action plan in place with target of 57 reviews per month for compliance by December 21. Sensory Social work team to commence undertaking of reviews. **Update 2/3/22** All outstanding reviews have now been completed.	

RAG Rating	
Completed/Confident of Delivery on Actions	
Work in progress and on track for completion within agreed timescales	
Not Complete/ Not on track for completion within agreed timescales	

The above action plan was reviewed at interface meetings with SPPG and Trusts (minimum 3 times yearly). Progress updates were completed after each interface meeting and reviewed by Senior Operational Management Team, SPPG.

BHSCT DSF ACTION Plan 2021/22 - YEAR END UPDATE MARCH 2022

This is to confirm that the above Action Plan has been reviewed by the Social Care and Children's Directorate on 01/06/22 and will be signed off at the DSF meeting on 16/06/22. Any outstanding issues requiring further progress will be reviewed at the DSF Meeting with the Belfast Trust and these alongside any new issues will be presented in the 2022/23 Action Plan.

Signed:  Date: 22nd June 2022

Brendan Whittle, Director of Hospital & Community Care

Governance Arrangements for Management of Local DSF Action Plans (section 2.6 & 2.7 in DSF report)

- Director, SCCD to forward Action Plan to Trust Executive Director (March)

- Trust submit DSF Reports (May)

- Social Care Leads to hold pre-meetings with the Trust to discuss report and action plans

- Each Programme of Care review Trust Reports and Action Plans and agree on priority areas

- DSF Planning Meetings held in advance of Trust DSF Meetings to agree agenda and priority areas for discussion (meetings will be scheduled for one week before each DSF Trust meeting). Attendance at Planning meetings:
  - Director of SCCD
  - Deputy Director of SCCD
  - Programme Manager
  - Head of Governance
  - Business Manager, Governance Team
  - Social Care Lead (nominated lead for each Trust/Programme of Care)

- Identified Lead for each Trust area:

	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
OP&AS	Ruth	Ann Marie	Jane		Roisin
MH&LD	Caroline	Julie	Ciara	Joy	Martina
Children	Fiona / Max	Paul		Max / Fiona	Pamela

- Trust DSF Meetings (June)

- Local DSF Action Plans issued to Directorate and Trust by the Governance Team following the DSF meetings in June

- Leads to meet with Trusts 3 times a year as a minimum requirement Leads should take into consideration key update points during the year
  - May (DSF Report submission and preparation for June DSF meetings)
  - September/October (Mid-Year Reporting, including 6 month Action Plan updates)
  - Feb/March (End of Year Report, including Action Plan updates)

	OP&AS (insert dates of meetings)	MH&LD (insert dates of meetings)	Children's (insert dates of meetings)
BHSCT	2nd June 21 – 10am	14th June 21 – 12md	9 June 21 – 2pm
	6th October 21 – 10am	5th Oct - 10am	8th Sept 21 – 2pm
	2nd March 22 – 10am	4th Mar - 10am	13th Dec 21 – 10am
			14th March 21 – 10am
NHSCT	27th May 21 - TBC	27th May 21 – 9.30am	7th June 21– 2pm
	21st October 21 – 10am	14th October 21 – 10am	6th Sept 21– 2pm
	17th Feb 22 – 10am	17th Feb 22 – 10am	13th Dec 21– 2pm
			14th March 22 – 2pm
SEHSCT	7th June 21 – 10am	4th June 21 – 2pm	3rd June 21 – 10.30am
	22nd Sept 21 – 2pm	24th Sept - 10am	19th Sept 21 – 3pm
	9th Feb 22 – 10am	11th Feb - 10am	24th March 22 – 2pm
SHSCT	24th May 21 – 10am	3rd June 21 – 3.30pm	25th May 21
	29th Sept 21 – 10am	28th Sept - 10am	2nd November 2021
	23rd Feb 22 – 10am	22nd Feb - 10am	
WHSCT	26th May 21 - 10.30am	8th June 21 – 11am	9th June 2021 - 2pm
	19th Oct 21 – 10.30am	13th Oct - 10am	8th Sept 2021 - 10am
	9th Feb 22 – pm	9th Feb – 2pm	6th Dec 2021 - 10am
			9th March 21 @10am

- Leads to collate information and update the action plan every 6 months including a RAG rating against each action (31st March and 30th September)

- Local Action Plans to be a standing agenda item at Team meetings quarterly/monthly

- Updated Action Plans to be quality assured by Governance Team (March & October)

- Programme Heads to bring updated Action Plans to senior operational team for sign off at each 6 month point (March & October)

- Director, SCCD to forward to Trust Executive Directors every 6 months (March and October)

Process for Regional DSF Action Plan

- Regional DSF Action Plan to be drawn up following June meetings with Trusts including RAG rating - Senior Operational Management Team/Governance Team

- Regional Action Plan to be discussed by Director / Deputy Director and Programme Heads at Consultation meetings (quarterly)

- Regional Action Plan to be discussed at the Senior Team monthly/quarterly

- Regional Action Plan to be on each Programme team meeting agenda monthly/quarterly

- Regional DSF Action Plan to be updated every 6 months by relevant Programme Manager and signed off at the Senior Team meeting (March & October)

- Director / Deputy Director to forward Regional DSF Action Plan to Trust Executive Directors every 6 months (March and October)

- Director / Deputy Director to forward Regional DSF Action Plan to DoH along with the DSF Overview Report and Statistical Report in September following approval at the Board meeting

- The Regional DSF Action Plan is HSCB led and updated by the Director. It is included in each Trusts' DSF Report for information, and does not require any updates from the Trusts when submitting DSF Report.

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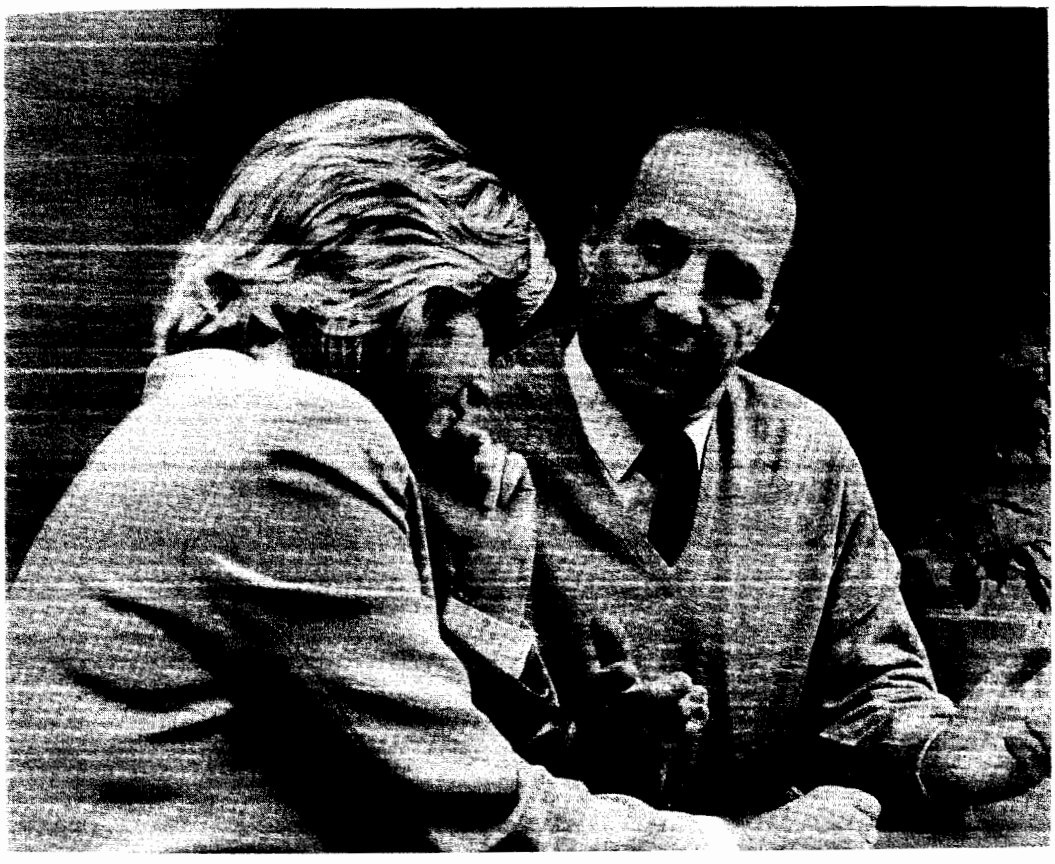
BW/59

The Northern Ireland Health and Personal Social Services

Complaints

Listening...Acting...Improving

Guidance on Implementation of the HPSS Complaints Procedure



March 1996

HPSS Executive

Guidance on Implementation of the HPSS Complaints Procedure

Contents

Appendices

1.1 *Being Heard*, the report on NHS complaints procedures by a Review Committee, chaired by Professor Alan Wilson, Vice Chancellor of Leeds University, was published in May 1994.

1.2 The health services in Northern Ireland were included within the remit of the review. Complaints procedures for community care and child care, which are the responsibility of local authorities in Great Britain, were outside the scope of the review.

1.3 Following formal public consultation on the conclusions and recommendations of the Review Committee, the HPSS Executive published *Acting on Complaints*, its revised policy and proposals for a new unified HPSS complaints procedure, in March 1995. Complaints on child care will **not** be incorporated within the new procedure but will be dealt with under the procedures in the *Children (Northern Ireland) Order 1995*.

1.4 Nationally, the NHS Executive took forward the initial work in developing guidance on implementation of the new procedure. In Northern Ireland, the HPSS Executive set up a Steering Group to take account of the decisions which have been emerging nationally and, in turn, to produce guidance and oversee implementation. The Steering Group comprised representatives from the professions, Health and Social Services Boards and Trusts, Health and Social Services Councils and other key interests.

1.5 Interim Guidance was published in December 1995.

2 Purpose of the Guidance

2.1 This Guidance complements the Directions and Regulations (see paragraphs 4.1 and 4.2) which provide the statutory and therefore the mandatory framework of the complaints procedure. Implementation will be on 1 April 1996. It aims to provide advice for those tackling the practical details of how the policy objectives of *Acting on Complaints* are to be achieved. It updates the earlier advice contained in the Interim Guidance.

2.2 The Guidance is not designed to be all-embracing. Trusts and Boards, and Family Health Service (FHS) practitioners are expected to design and operate their complaints procedure within the spirit of the Guidance, while adhering to the legal requirements of the appropriate Directions and Regulations. It is recognised that the size and complexity of the various organisations will result in different models emerging for the management of complaints. It is hoped that in due course different experiences will be exchanged so that lessons can be learnt.

3 Policy Objectives MAHI - STM - 097 - 6029

3.1 The outcome of the formal consultation on *Being Heard* revealed broad agreement on the objectives for change that had been outlined by the Review Committee. The key objectives for introducing the new procedure remain:

- ease of access for patients and clients;
- a simplified procedure, with common features;
- separation of complaints from disciplinary procedures;
- more rapid, open processes, with an emphasis on early resolution;
- fairness for staff and complainants alike;
- an approach which is honest, thorough, and with the prime aim of resolving the problem and satisfying complainants concerns; and
- making it easier to learn from complaints, in order to improve services and standards.

3.2 The Department is committed to achieving all these objectives. They are a key part of the programme of action flowing from the Charter for Patients and Clients.

3.3 Great emphasis is placed on resolving complaints as quickly as possible. This may be through an immediate informal response by a front-line member of staff or practitioner, or by subsequent investigation and conciliation by staff who are empowered to deal with complaints in an open and non-defensive way. Boards, Trusts and FHS practitioners are therefore urged to concentrate on developing the awareness of front-line staff to the value of satisfying complainants early on, and to establish protocols for an open, positive response to complaints. The successful handling of Local Resolution is the key to the success of the new procedure.

Legal Framework

4.1 The following Directions are being made to implement the new complaints procedure:

- Directions to Health and Social Services Boards on Procedures for Dealing with Complaints about Family Health Services Practitioners;
- Directions to Health and Social Services Trusts and Boards on HPSS Complaints Procedures;
- Directions to Health and Social Services Boards on Miscellaneous Matters Concerning Complaints.

4.2 The following Regulations are being made and will affect the implementation of the new complaints procedure:

- The General Medical and Pharmaceutical Services (Amendment) Regulations (NI) 1996;
- The General Dental Services (Amendment) Regulations (NI) 1996;
- The General Ophthalmic Services (Amendment) Regulations (NI) 1996;
- The Health and Personal Social Services (Fundholding Practices) Amendment Regulations (NI) 1996;

Access to Health and Social Services Records

4.3 Any patient who has a complaint about any aspect of an application to obtain access to health records under the *Access to Health Records (Northern Ireland) Order 1993* may now make a complaint under this complaints procedure **as an alternative** to making an application to the courts. Patients still have the right to take matters to a court if they remain dissatisfied with the outcome of an investigation. Where the complaint relates to a decision to withhold access to all or part of the record the panel's role is to advise the record holder of their opinion. It remains the responsibility of the record holder to decide whether access should be granted. Care must be taken to ensure that in reporting the outcome of an investigation into a complaint about access to health records, the patient does not obtain information to which he or she is not entitled under the Order. This is particularly important when access has been denied on the grounds that it would cause serious harm to the physical or mental health of the patient or any other individual; or the information relates to or was provided by a third party who could be identified from that information and who had not consented to its disclosure.

4.4 Where the patient has sought access to his/her health records without the formality of an application under the Order, any complaint should be dealt with in the same way as if a formal application had been made. Access to health records compiled before 30 May 1994 (other than on computer) is at the discretion of the record holder, having regard to the fact that such records were not compiled in the expectation that they would be disclosed to the patient. This is an additional factor to bear in mind when considering whether to grant access to such records. It remains current policy that patients should be allowed to see what is written about them in their health record whenever possible. Complaints records should be kept separate from health records, subject to the need to record any information which is strictly relevant to the patient's health in their health records.

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4.5 The new complaints procedure will also subsume the complaints procedure for access to social services records. Access to social services records is currently provided for under Departmental circular *Client's Access to Non-computerised Personal Social Services Records About Themselves (HSS SP1/87)*, and *The Access to Personal Files and Medical Reports (Northern Ireland) Order 1991*. Legislation to give clients access to social services records, similar to that given to patients under the Access to Health Records Order, has been enacted but is awaiting implementation.

Confidentiality

4.6 The use of the patient's/client's personal information to investigate a complaint is a purpose for which it is not necessary to obtain the patient's/client's express consent. Care must be taken at all times throughout the complaints procedure to ensure that any information disclosed about the patient/client is confined to that which is relevant to the investigation of the complaint, and only disclosed to those people who have a demonstrable need to know it for the purpose of investigating the complaint. Even so, it is good practice to explain to the complainant that information from his or her health or social services records may need to be disclosed to the complaints officer, clinical assessors, and panel members. If the patient/client objects the effect on the investigation will need to be explained. The patient's/client's wishes should always be respected, unless there is an overriding public interest in continuing with the matter.

4.7 Where a complaint is made on behalf of a patient/client who has not authorised someone to act for him or her (*see paragraph 5.10*) care must be taken not to disclose personal health or social services information to the complainant, unless the patient has expressly consented to its disclosure.

4.8 The duty of confidence applies equally to third parties who have given information or who are referred to in the patient's/client's records. Particular care must be taken where their records contain information provided in confidence, by, or about a third party who is not a health or social services professional. Only that information which is relevant to the complaint should be considered for disclosure and then only to those within the HPSS who have a demonstrable need to know it in connection with the investigation. It must not be disclosed to the patient/client unless the person who provided the information has expressly consented to the disclosure.

4.9 Disclosure of information provided by a third party **outside** the HPSS also requires the express consent of the third party. If the third party objects then it can only be disclosed where there is an overriding public interest in doing so.

4.10 Draft guidance on '*The Protection and Use of Public Information*' is due to be issued shortly for consultation.

Use of Anonymised Information

4.11 Where anonymised information about patients/clients and/or third parties would suffice, identifiable information should be omitted. Anonymisation does not of itself remove the legal duty of confidence but, where all reasonable steps have been taken to ensure that the recipient is unable to trace the patient/client and third party identity, it may be passed on for a justifiable purpose. Where a patient/client or third party has expressly refused permission for the use of information, then it can only be used where there is overriding public interest in doing so.

4.12 Complaints about non-disclosure of other information which may be requested should not be dealt with under the HPSS complaints procedure. Such requests should be considered under the proposed Code of Practice on Openness in the HPSS. Draft guidance on the Code of Practice on Openness will be issued for consultation by the HPSS Executive shortly.

4.13 Where part of a complaint about services is that information has been refused - maybe in pursuit of the original complaint - and provided the Chief Executive has been given the opportunity first to review the circumstances, complainants should be advised of their right to pursue this aspect separately with the NI Commissioner for Complaints (the Commissioner). They should not have to wait for the outcome of investigations into the rest of the complaint.

Complaints about Purchasing

4.14 Boards will **not** be involved in resolving complaints about services provided by Trusts. There will, however, need to be both Local Resolution and Independent Review arrangements for dealing with complaints about purchasing decisions by Boards or GP Fundholders, and services for HPSS patients/clients purchased from the independent sector by Trusts, Boards or GP Fundholders. Boards will also need to have in place arrangements to deal with complaints about their administrative functions, particularly in relation to providing family health services. While most of this guidance is focused on complaints against Trusts and family health services practitioners, as these constitute the vast majority of complaints, similar mandatory provisions and guidance will apply to complaints about purchasing decisions and about services purchased from the independent sector. (*See Section 9 - Complaints about Purchasing.*)

Mixed Sector Complaints

4.15 Where a complaint involves more than one HPSS provider or one or more other body, such as a purchaser, there should be full cooperation in seeking to resolve the complaint through each body's local complaints procedure. Where a complaint is solely concerned with services provided by another provider or a body outside the HPSS, the complaint should be referred to the Complaints Officer. The officer should ensure that it is passed immediately to the correct body, after consulting with the complainant and provided that the complainant wishes this to be done. The complainant and the body concerned should both then be formally advised in writing.

4.16 In cases of mixed complaints relating to the actions of two HPSS bodies - for example two Trusts, or a FHS practitioner and a Trust - where a complainant wishes to pursue related complaints to Independent Review and is content with the arrangement, the convenors involved should liaise with the aim of establishing close cooperation with the respective bodies. While, legally, separate panels would need to be established, they may nonetheless comprise the same panel chairman, and in some cases the same third panel member. The chairman could establish close working arrangements for the two or more panels - possibly meeting in the same place and on the same day. While each panel would make its own separate report the chairmen may be able to ensure commonality of findings and that appropriate advice was given, possibly by the same assessors.

4.17 It is important to recognise that the review procedure for continuing care is not a complaints procedure. If a complainant decides instead to complain directly to the Commissioner, he will have discretion to waive the normal requirement that, before there is an investigation by the Commissioner, the HPSS complaints procedure should have been exhausted. As with all complaints, the Commissioner will need to be convinced that there are prima facie grounds for an investigation related to hardship or injustice.

4.18 The fact that a death has been referred to the Coroner's Office does not mean that all investigations into a complaint need to be suspended. It is important for the Trust or FHS practitioner to initiate proper investigations regardless of the Coroner's inquiries, and where necessary to extend these investigations if the Coroner so requests.

Private Pay Beds

4.19 The complaints procedure will cover any complaint made about the Trust's staff or facilities relating to care in private pay beds, but not to the private medical care provided by the consultant outside his HPSS contract. The procedure applies in similar fashion to any private places provided in residential homes operated by Trusts.

Note: Some sections of the Interim Guidance are reproduced in ***bold/italics*** indicating ***mandatory requirements*** of the new procedure, most of which will be established in ***Directions and Regulations*** (*see paragraphs 4.1 - 4.2*). Other mandatory requirements arise from existing legislation and/or common law.

Formal Procedure

5.1 ***Trusts, Boards and FHS practitioners must establish a complaints procedure and take steps to publicise the arrangements.***

5.2 It will be a requirement for all Trusts/Boards to have a formally adopted written complaints procedure for complaints against themselves.

5.3 FHS practitioners will be required to establish and operate a Board approved complaints procedure within their practices. This applies to all individuals, and public or private companies who appear on the Board's list of contractors and practitioners undertaking to provide family health services.

Grievance Procedure

5.4 It is important to recognise that the HPSS complaints procedure is designed to address patients and clients complaints, not staff grievances, which will continue to be handled separately. Local procedures will also cover more general grievances. Disputes on contractual matters between Boards and FHS practitioners should not be handled through the complaints procedure. Staff of Boards and Trusts may complain about the way they have been dealt with under the complaints procedure and, provided they have exhausted the local grievance procedure, may complain to the Commissioner for Complaints. FHS practitioners may complain to the Commissioner about the way they have been dealt with under the complaints procedure.

Publicity

5.5 ***Trusts, and Boards must ensure well publicised advice is available to all users of their services, visitors, staff, and their local HSS Council, about:***

- ***the arrangements for dealing with Local Resolution and the Independent Review of complaints;***
- ***how to refer a complaint to the Complaints Officer or the Chief Executive;***
- ***how to make a request for an Independent Review panel;***
- ***under what circumstances a complainant may approach a Board with a complaint about a FHS practitioner;***
- ***the role of the HSS Council in giving individuals advice and support on making complaints;***
- ***the right to complain, and the means of making a complaint to the Commissioner.***

(*See paragraph 6.14 for FHS practitioners.*)

Trusts and Boards

5.6 ***Complainants will be existing or former users of a Trust's or Board's services and facilities. People may complain on behalf of existing or former patient's/clients provided they have their consent. If the patient/client is unable to act then consent is not needed. Where the Complaints Officer, or Convenor at the Independent Review stage, does not accept the person as a suitable representative of a patient/client who is unable to give consent, they may refuse to deal with the representative, and may nominate another person to act on the patient's/client's behalf.***

Family Health Services Practitioners

5.7 ***Complainants will be existing or former patients of a practitioner who has arrangements with a Board to provide family health services. Complaints may be made on behalf of existing or former patients by anyone who has the patient's consent. If the patient is unable to act then consent is not needed. Where the Board's Complaints Officer, or the Board's Convenor at the Independent Review stage does not accept the person as a suitable representative, they may refuse to deal with the representative, and may nominate another person to act on the patient's behalf.***

5.8 Complaints can be made about the purchase or provision of any services, treatment and care for a patient/client. A person who has been refused any services, treatment and care can also complain under the complaints procedure.

5.9 A FHS practitioner may also complain to the Board about a patient. In the event of a complaint being made by a FHS practitioner about a patient, the Complaints Officer from the Board will make a written report to the practitioners with a copy, if appropriate, sent to the complainant.

5.10 The question of whether a complainant is suitable to represent a patient/client who is unable to give consent depends in particular on the need to respect the confidentiality of the patient/client, and to any known wishes expressed by the patient/client that information should not be disclosed to third parties.

5.11 Trusts, Boards and FHS practitioners should, as a matter of good practice, ensure that they deal sensitively and effectively with complaints by visitors, contractors and other users of their facilities.

Time Limits on Initiating Complaints

5.12 ***Normally a complaint should be made:***

- ***within six months of the incident that caused the problem, or***
- ***within six months of the date of discovering the problem, provided that this is within twelve months of the incident.***

There is discretion to extend this time limit where it would be unreasonable for the complaint to have been made earlier; and where it is still possible to investigate the facts of the case.

5.13 A complaint should be made as soon as possible after an event. The discretion to vary the time limit should be used flexibly, and with sensitivity. Wherever possible the complainant's concerns should be addressed, while remaining scrupulously fair to staff. An example of where discretion should be exercised in favour of extending the time limit would be where the complainant has suffered particular distress or trauma which prevented them from making their complaint at an earlier stage.

5.14 When a complaint is made outside of the time limit the Complaints Officer or

appropriate FHS practitioner will be responsible for considering an extension of the time limit.

5.15 If the discretionary extension of the time limit is rejected by the Complaints Officer then the procedure will be as follows:

- the complainant may complain about the refusal to exercise discretion to waive the time limits;
- if the refusal is maintained, the complainant may request the convenor to consider setting up a panel for Independent Review of the complaint about refusal to waive the time limit: the normal requirements as to convening decisions will apply - including the time limit for a convening request;
- the convenor may then decide to take no further action; or
- to refer the complaint back for Local Resolution, or
- to set up a panel to consider the complaint.

5.16 If the convenor decides to refer the complaint about the time limit back to the Trust/Board, the Complaints Officer - or Chief Executive if it is referred specifically to him/her - should review very carefully the decision not to accept the complaint in the light of the convenor's conclusion that further action through Local Resolution is possible.

5.17 If the Convenor rejects the request, then the complainant has the right to complain to the Commissioner for Complaints.

Complaints Officer

5.18 ***The Trust/Board must have a designated Complaints Officer, who is readily accessible to the public.*** The prime role of the Complaints Officer is to oversee the complaints procedure. The detailed role and functions should be decided by the Trust or Board. The functions of the Complaints Officer may be performed personally, or by a person authorised by the Trust/Board to act on his/her behalf.

5.19 The Complaints Officer may be:

- the Chief Executive,
- a senior manager reporting directly to the Chief Executive; or
- particularly in large Trusts a senior manager reporting to the Chief Executive through a Director, but with personal access to the Chief Executive when appropriate.

While it is not essential for the title to be used, it is nevertheless important that the person with the role of Complaints Officer should be easily identifiable to the public and staff alike. (*See paragraph 5.21 for equivalent role for FHS practices.*)

5.20 It is for the Trust and Board to decide on the Complaints Officer's exact role. This may be either to investigate or advise, or both. He/she will need access to all relevant records which are essential for the investigation of a complaint referred to him/her. He/she should also be able to investigate and resolve complaints under the Local Resolution process where the complainant does not wish to raise their concerns with the people directly involved with their care, or where front-line staff are unable to deal with the complaint. The Complaints Officer should also provide support and help to staff who respond to complaints.

5.21 *FHS practices must nominate one person to administer the complaints procedure and to identify that person to patients.*

5.22 FHS practices will decide who is most appropriate to be responsible for the practice complaints procedure, together with an alternative to act if this person is the subject of the complaint. Complainants may be unhappy at the prospect of having their complaint dealt with by someone who is already involved in their care and who may be the subject of the complaint. If contacted by a complainant, the Board should be ready to provide assistance to both the complainant and the practitioner to resolve the complaint at practice level, bearing in mind the Board may become formally involved if the decision is made to proceed to Independent Review. (*See paragraphs 6.15 and 6.16.*)

Role of Health and Social Services Councils

5.23 The staff of Health and Social Services Councils have a very important role in assisting complainants at each stage of the process in both the hospital and community services, and family health services. Trust and Board Chief Executives should ensure that advice on how to contact the local HSS Council for assistance in making a complaint is well publicised, and that HSS Councils are fully aware of the complaints procedures in operation.

Appointment of Convenor

5.24 ***The Board must appoint at least one person to act in the role of convenor, who may not be one of its own employees. At least one of the persons appointed must be a non-executive director of the Board.***

5.25 The convenor will consider requests by complainants for Independent Review panels to be set up. The discretion to appoint more than one non-executive director to this function allows the role to be shared, and a successor or understudy to be trained. It also provides for the possibility of an alternate convenor to represent the Board on the panel, if it is established. This will also relieve pressure on the original convenor who may be involved in more than one convening request. The concept of a 'lead' convenor, or 'convenor's office', may be useful. The convenor will need support staff. In organising this the Board will need to demonstrate impartiality, for example, where the remaining grievance relates in some way to the handling of the complaint during Local Resolution. (*See paragraph 8.47.*)

5.26 Convenors may be appointed from any of the non-executive directors, although chairmen are not recommended to take on this role other than in exceptional circumstances. Convenors will be indemnified for this duty in the same way as for their other non-executive director duties.

5.27 Boards should be sensitive to concerns about bias and the appointment of practising clinicians, or recently retired HPSS staff, should be exceptional. The convenor should be fully appraised of guidance and issues relating to their role. Boards may wish to appoint additional people on a 'consultancy' basis, specifically to act as convenors. People appointed to take on this task may act in the role of convenor, including serving on the panel. Their terms of appointment by the Board should ensure that their role is explicit and they have appropriate indemnity cover. (*See paragraph - 8.48.*)

5.28 It is suggested that appointments be for an initial period of at least two years, but where more than one convenor is designated, the appointments might be staggered.

Separation of Complaints and Disciplinary Procedures

5.29 *The complaints procedure must be kept separate from disciplinary procedures.*

5.30 Policy is firm on the need for the new complaints procedure to be concerned **only** with resolving complaints and **not** with investigating disciplinary matters. The purpose of the complaints procedure is **not** to apportion blame amongst staff. It is to investigate complaints to the satisfaction of complainants (while being scrupulously fair to staff) and to learn any lessons for improvements in service delivery. Inevitably some complaints will reveal information about serious matters which indicate a need for disciplinary investigation.

5.31 In hospital and community/ambulance services, a case for considering disciplinary action can be suggested at any point during the complaints procedure. Consideration on whether or not disciplinary action is warranted is, however, a separate matter for management outside the complaints procedure and must be subject to a separate process of investigation.

Trusts/Boards

5.32 In the case of Trusts/Boards, papers that have accumulated during the investigation of the complaint may be passed to the appropriate person in the Trust/Board who will be considering the need for a disciplinary or other form of investigation (*see paragraph 5.35 for other relevant forms of investigation*). The papers can be made available for a disciplinary investigation.

FHS Practitioners

5.33 In the case of family health services, the Service Committee procedure will not be used to investigate complaints made on or after 1 April 1996. Formal complaints already under investigation before that date will be completed under the service committee procedures. From 1 April 1996 complaints will be investigated using the new procedure and the need for local disciplinary action will only be considered after the handling of a complaint has been concluded. Only if action is necessary to protect patients, for example, involving the police, professional registration body, or the HPSS Tribunal, will disciplinary action interrupt the handling of a family health services complaint.

5.34 Information gathered as part of the Local Resolution process by the practitioner belongs to the practice. The information will be kept separate from the patient's health record. Therefore the Board has no right of access to it. The Commissioner for Complaints does, however, have wide-ranging powers which can be used, if necessary, to require the production of information and documents.

Hospital and Community Health Services

5.35 ***If any complaint received by a member or employee of a Trust/Board indicates a possible need for referral to:***

i ***an investigation under the disciplinary procedure;***

ii ***one of the professional regulatory bodies; or***

iii ***an independent inquiry into a serious incident under Article 54 of the Health and Personal Social Services (Northern Ireland) Order 1972;***

iv ***an investigation of a criminal offence.***

the person in receipt of the complaint should immediately pass the relevant information to the Complaints Officer. The officer will pass it on to a suitable person who can make a decision on whether or not to initiate such action. This referral may be made at any point during any stage of the complaints procedure.

Neither the Complaints Officer nor the convenor shall be responsible for deciding whether or not to initiate any of the action referred to in the above paragraph and they should refer such circumstances to the person designated in the Trust/Board for dealing with such matters.

Whenever these circumstances arise, a full report of the investigation thus far should be made available to the complainant.

The complaints procedure will not deal with matters relating to that part of the complaint which is currently the subject of disciplinary investigation. If action is initiated under i or ii above, the complainant should be advised accordingly. Where there are other matters raised in the complaint which do not relate to disciplinary investigation appropriate action should then be pursued under the complaints procedure.

If any action is initiated under iii or iv above, the complaints procedure should be similarly modified until such action is concluded.

When any action as set out above has been concluded, that part of the original complaint which has been referred to a different procedure should only recommence where there are matters in the complaint which have not been dealt with through that action.

5.36 When a decision is made to embark upon a disciplinary investigation, the processing of the complaints procedure ceases in respect of all matters that are the subject of disciplinary proceedings. There may well be other aspects of the original complaint not covered by the disciplinary inquiry which will continue to be investigated. It is essential for the person handling the complaint to make clear to the complainant that a disciplinary inquiry is now under way, particularly if the complainant is likely to be asked to take part in this process.

5.37 If there are no outstanding issues from the original complaint to be investigated the complainant should be advised that no further action will be taken, other than that taken through the disciplinary procedure.

5.38 The complainant may well ask at this point to be informed of the outcome of the disciplinary inquiry. A judgement will need to be made on how to reassure the complainant that the matter complained about has been dealt with seriously and satisfactorily, while protecting the confidentiality of the member of staff.

5.39 The guiding principle should be that, when the disciplinary procedure is invoked, the complainant receives the same consideration and level of information as if the matter had been dealt with through the complaints procedure. The complainant should be able to understand what happened, why it happened, and what action has been taken as a consequence to ensure that it does not happen again. The complainant should be informed in general terms of any disciplinary sanction imposed on any staff member.

5.40 It is most important that the complainant is satisfied with the action being taken by the Trust/Board. If a referral for disciplinary investigation has been made during the period of Local Resolution then this part of the complaints procedure should be rounded off with a formal written explanation of the action taken by the Trust/Board. Where the referral is made later during the Independent Review process, then a similar written explanation needs to be given on completion. Within the context of the complaints procedure, the overall consideration must be that, even if the investigation has been moved into the disciplinary procedure, the complainant is not left dissatisfied, and feeling that their grievance has only been partially dealt with.

5.41 A similar approach will need to be adopted in a case which has indicated the need for a referral to one of the professional regulatory bodies. A Trust/Board has no control over what then happens and over what period. The complainant should be informed of this decision and at that point given as full a response as possible to the complaint. It should be made clear that any information obtained during the complaints investigation may need to be passed on to the regulatory body. Those parts of the original complaint

not included in the reference to the professional regulatory body should continue to be investigated under the complaints procedure.

Possible Claims for Negligence

5.42 ***The complaints procedure should cease if the complainant explicitly indicates an intention to take legal action in respect of the complaint.***

5.43 If a complainant reveals a prima facie case of negligence, or if it is thought that there is a likelihood of legal action being taken, the person in receipt of the complaint should inform the persons in the Trust/Board responsible for dealing with risk and claims management. Even if a complainant's initial communication is via a solicitor's letter, the inference should not necessarily be that the complainant has decided to take formal legal action. A hostile, or defensive, reaction to the complaint is more likely to encourage the complainant to seek information and a remedy through the courts.

5.44 In the early part of the process it may not be clear whether the complainant simply wants an explanation and apology, with assurances that any failures in service will be rectified for the future, or whether the complainant is in fact seeking information with formal litigation in mind. It may be that an open and sympathetic approach will satisfy the complainant. Where there is a prima-facie case of clinical negligence, the person dealing with the complaint should seek advice appropriately. This should not prevent a full explanation being given and, if appropriate, an apology offered to the complainant as appropriate. An apology is not an admission of liability. If formal legal action has been instigated, the complaints procedure should be brought to an end, with the complainant and the complained against being appropriately advised in writing.

5.45 In all prima facie cases of negligence, or where the complainant has indicated that they propose to start legal proceedings, the principles of good claims management and risk management should be applied. There should be a full and thorough investigation of the events. In any case where the Trust/Board accepts that there has been negligence, a speedy settlement should be sought.

6.1 *As part of its complaints procedure, the Trust/Board must establish a clear Local Resolution process. In the case of family health services, Local Resolution is the responsibility of the practitioner*

6.2 The primary objective of Local Resolution is to provide the fullest possible opportunity for investigation and resolution of the complaint, as quickly as is sensible in the circumstances. Complaints procedures of Trusts/Boards must therefore have a well-defined Local Resolution process, which lays emphasis on complaints being dealt with quickly and, wherever possible, by those on the spot - see Appendix 1. The intention of Local Resolution is that it should be open, fair, flexible, and conciliatory. The complainant should be given the opportunity to understand all possible options for pursuing the complaint, and the consequences of following any of these. This explanation should indicate that it might be necessary to look at the patient's/client's health/social services records.

6.3 The process should encourage communication on all sides. The aim should be to resolve a complaint during this stage to the satisfaction of the complainant while being fair to staff. Local Resolution should not be seen simply as a run-up process to Independent Review: its primary purpose being a comprehensive response that satisfies the complainant. The process of Local Resolution should provide for a range of different options for response to the complainant. Rigid, bureaucratic, and legalistic approaches should be avoided at all stages of the procedure, but particularly during Local Resolution. It is for Trusts/Boards to consider whether there would be an advantage in offering access to conciliation. (*See paragraph 6.17.*)

Role of Front-Line Staff

6.4 Complaints are most likely to be made to front-line staff on hospital wards, in clinics, at reception desks, or in social services departments. Management need to empower front-line staff to deal with complaints on the spot. Local guidance needs to assist front-line staff in distinguishing serious issues which need reference elsewhere, and in knowing when to refer complaints for fuller investigation by the Complaints Officer. Steps need to be taken to ensure effective arrangements are in place for dealing with complaints that are received over the telephone. Steps should also be taken to ensure that complainants are made aware of the role of HSS Councils in assisting them to pursue complaints and how to contact them.

6.5 The first responsibility of a recipient of a complaint is to ensure - before doing anything else - that the patient's/client's immediate health and social care needs are being met. This may require urgent action before any matters relating to the complaint are tackled. Whoever within the organisation receives the complaint should seek to understand the nature of the complaint and any nuances that are not immediately obvious.

6.6 If the recipient is unable to investigate the complaint adequately, or feels unable to give the assurances that the complainant is clearly looking for, then the complaint should be referred to the Complaints Officer for advice or for handling. Complainants should be encouraged to speak openly and freely about their concerns. And they should be reassured that whatever they may say will be treated with appropriate confidentiality and sensitivity.

6.7 Some complainants may prefer to make their initial complaint to someone who has not been involved in their care. In these circumstances they should be counselled to address their complaints to the Complaints Officer or, if they prefer, to the Chief Executive. While front-line staff should always encourage complainants to be forthcoming in expressing their concern and anxiety, particularly where they are disappointed with the care they have received, this should never be done at the expense

of overriding the right of complainants to make their complaint to the Complaints Officer or the Chief Executive.

6.8 When deciding whether or not to pass the complainant on to the Complaints Officer, front-line staff will need to take into account the seriousness of the oral complaint and the possible need for more independent investigation and assessment. While an important role of the Complaints Officer is to investigate complaints and to satisfy complainants, this must not preclude the Complaints Officer from advising front-line and other staff in the resolution of complaints.

6.9 Front-line staff also need to be empowered to use the information they gain from complaints to improve service quality, particularly oral complaints or criticisms which are not actually complaints where people want something put right, but not investigated. Mechanisms for achieving this can be agreed at team level and will be particularly important for sharing information relevant to the work of other teams, for example, those responsible for hotel services.

Role of the Chief Executive

6.10 The Citizen's Charter Complaints Task Force defined a complaint as 'an expression of dissatisfaction requiring a response'. In the majority of cases, complaints are made orally. All complaints, whether oral or written, should receive a positive and full response, with the aim of satisfying the complainant that their concerns have been heeded, and offering an apology and explanation as appropriate, referring to any remedial action that is to follow.

6.11 ***All written complaints must receive a response in writing from the Chief Executive. Some oral complaints are sufficiently serious, or difficult to resolve, that they should be recorded in writing by the Complaints Officer. These complaints should also receive a written response from the Chief Executive.*** The reply might take the form of a full personally signed response or a shorter letter covering a fuller report from another member of staff which the Chief Executive has reviewed and is content with.

6.12 Anyone handling a complaint, and particularly complaints officers handling written complaints, must ensure that any response given to a complainant which refers to matters of clinical judgement is agreed by the clinician concerned and, in the case of medical care, by the consultant concerned.

6.13 There may be occasions when a communication is critical of a service or the quality of care, but is not intended as a complaint. Chief Executives will wish to ensure that their organisations are receptive to comments and suggestions, whether critical or positive, as well as to complaints. Such communications are a useful form of feedback from patients/clients, which can be used to improve the quality of service, and also to give encouragement to staff when they are doing well.

Family Health Services Practitioners

6.14 From 1 April 1996 there will be a term of service obligation on family health services practitioners to have in place and to operate practice-based complaints procedures which comply with minimum agreed criteria. For general practitioners, it has been agreed that the minimum criteria will be:

- administration of practice-based procedures must be practice-owned and managed entirely by the practice - the Board will only become involved if the practice procedure does not appear to meet the criteria;
- the Board will only become involved in an individual complaint if asked to do so by the complainant and/or the practitioner;
- one person will be nominated by the practice to be responsible for overseeing

the administration of the procedure;

- practices must give the procedures publicity;
- practices must ensure it is clear how to lodge a complaint, and to whom;
- an acknowledgement or initial response should normally be made within two working days;
- the person nominated to investigate the complaint should make all necessary inquiries such as interviews, if appropriate, of the complainant, general practitioner(s) and practice staff;
- an explanation should normally be provided within two weeks (ie ten working days).

Action by the Board

6.15 There are two roles for Boards in the family health services Local Resolution process. Where, for example, a complainant does not wish to have a complaint dealt with by the practice, or is having difficulty in having the complaint dealt with by the practitioner Boards will, if both parties agree, act as *'honest broker'* between the complainant and the practitioner to resolve the complaint at practice level. Boards will also make lay conciliators available as a service to complainants and practices. Arrangements for appointing lay conciliators and, where appropriate, professional advisors to the lay conciliators are matters for the Board.

6.16 Patients and FHS practitioners need to feel confident in the new complaints procedure. When a Board is acting as intermediary between patient and practitioner by providing conciliation or arranging Independent Review it is essential that clear lines of communication are established between Board, patient and practitioner. This might be done via the Complaints Officer in the Board who can give information on the progress of the complaint. Within the Board only those who need to be involved in handling a complaint should be aware of its existence. Complaints about treatment provided under FHS arrangements may involve a statutory charge payable to the complainant. Boards will need to ensure that conciliators who may become involved fully understand the nature of such charges.

Family Health Services Conciliation

6.17 Conciliation is essentially a process of facilitating agreement between the complainant and practitioner, and may prove essential if complaints are to be handled successfully at practice level. It is most effective when used as early in the complaints resolution process as possible Boards should therefore continue to make conciliators available to practices where a conciliator's assistance is requested, either by the complainant or the practice. Confidentiality must be strictly observed during the process and conciliators should **never** be required to report to the Board the details of cases in which they are involved. Nor should conciliators provide information which might be used by the Board if there is an Independent Review of the complaint.

Trusts and Boards

6.18 It may be appropriate for the entire process of Local Resolution to be conducted orally, without any written communication, leaving the complainant completely satisfied with the outcome. However, where for example:

- the person dealing with the complaint suspects that the complainant may wish to take the matter further; or
- the complainant is satisfied with the oral response but has expressed the wish for a formal response to close the case;

it is recommended that Local Resolution may be best rounded off with a letter to the complainant. Any letter concluding the Local Resolution stage (whether signed by the Chief Executive because it was a written complaint, or by some other appropriate person) should indicate the right of the complainant to seek Independent Review of the complaint, or any aspect of the response to it with which the complainant remains dissatisfied, and that the complainant has twenty-eight days from the date of the letter to make such a request.

FHS Practitioners

6.19 Guidance to FHS practitioners does not differentiate between the handling of oral and written complaints. In both cases practices are advised to round off the complaint by giving a written summary of the investigation and its conclusions to the complainant, also indicating their right to seek an Independent Review and that the complainant has twenty eight days to make that request. Local Resolution will end at this point. Practices have been advised to keep records of complaints handling - which should be kept separate from patients health records - both for using complaints to improve procedures and services, and in case they are needed to enable the practice to cooperate with later stages of the complaints procedure, including Independent Review.

6.20 It should be borne in mind that the right of the complainant to request the convenor to set up an Independent Review panel is not a right to proceed automatically to Independent Review. The subtlety of this distinction may often be lost on complainants who may well be angry at the time as a result of their dissatisfaction with the outcome of Local Resolution - whether or not a final letter has been sent to the complainant - will assist with reducing the time the convenor may have to spend researching the background of the complaint, in the event of an application by the complainant to proceed to Independent Review.

Performance Targets for Local Resolution

6.21 Recognising that the primary purpose of Local Resolution is to satisfy the complainant whenever possible, while being scrupulously fair to staff, the following targets should be used with discretion. Where these targets are not being met, it is very important for the complainant to be informed of the delay and the reasons for it, as well as the likely revised timetable for dealing with the complaint. Similarly, where a complainant withdraws a complaint, it is important that the persons complained against (in the case of family health services, the practitioner) are informed immediately.

Trusts and Boards

6.22 Most oral complaints will be resolved on the spot or within two working days. Where this is not possible, and where there is a formal written complaint, the Trust/Board should aim to make either an initial acknowledgement to the complainant **within two working days** or, if they are able to resolve the complaint fully within this time, a response **in five working days**. For written complaints, and oral complaints recorded in writing, acknowledgements should always be in writing.

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6.23 Full investigation and resolution of all types of complaints should be sought **within twenty working days**, while recognising that there is likely to be great variation in the nature of complaints and in the ability of complainants to cope with their part of the process. Given the complexity that arises in some complaints, a clear referencing and dating system is needed for all communications with patients and FHS practitioners. First class post or, exceptionally special delivery mail, should be used. All communications should be marked 'Private and Confidential' and/or 'Personal'.

Family Health Service Practitioners

6.24 The aim should be for FHS practitioners to complete the Local Resolution process within **ten working days**. The possibility, however, of the Board being asked to provide support or conciliation (*see paragraphs 6.15 - 6.17*) will inevitably extend the period of Local Resolution. In these cases it would not be unreasonable for the performance target to be extended.

7 Convening an Independent Review Panel

Action by the Complainant

7.1 ***Complainants who are dissatisfied with the response from the Trust/Board or FHS practitioner as a result of the Local Resolution process may refer a request for an Independent Review panel to the convenor either orally or in writing. This request should be made within twenty eight working days from the completion of the Local Resolution process. Any request for an Independent Review panel received either orally or in writing by any other member or employee of the Trust/Board should be passed on to the convenor immediately.***

7.2 The twenty eight calendar day time limit for making the request applies to the period from the date when the letter was sent to the complainant at the conclusion of Local Resolution, including conciliation where it is used (*see paragraph 6.15 - 6.17*). The time limit for making the request applies to the initial request and not to the making of the subsequent written statement to the convenor (*see paragraph 7.4*).

Action by the Convenor

7.3 The request for a panel should be followed up by the appointed convenor immediately. The convenor should make arrangements so that a complainant's request for an Independent Review panel can be acknowledged in writing.

7.4 ***Before deciding whether to convene a panel, the convenor must obtain a statement signed by the complainant setting out their remaining grievances and why they are dissatisfied with the outcome of Local Resolution.***

7.5 The convenor will need to understand as quickly as possible why the complainant remains dissatisfied. It is important for the convenor to obtain the complainant's statement, in as explicit and detailed a form as possible, before starting his/her inquiries. The complainant should be encouraged to submit the written statement as quickly as possible so that a response can be made within the twenty-eight day time limit. Experience shows that complainants frequently do not set out clearly what their grievances actually are, or set out clearly why they are dissatisfied. The convenor should ensure complainants are aware of how to seek independent help in drawing up statements if they wish, for example from HSS Councils or patients' advocates. Alternatively, the convenor, or member of staff, may prepare the statement for the complainants approval. If the complainant has already clearly set out their remaining grievances, and there is no need to amend this, then the convenor should not require a new statement to be drawn up. Complainants need to be advised of the various options that are open to the convenor for dealing with the complaint at this stage.

7.6 Those who are complained against, including the FHS practitioner, should always be advised in writing of what the complainant has formally stated as his/her grievance. the initial communication to the practitioner advising that there is a request for Independent Review of a complaint involving them might contain details of the secretary of other individual nominated by the local representative committee to help practitioners deal with complaints.

7.7 When dissatisfied with the outcome of Local Resolution, a complainant does **not** have an automatic right to move to Independent Review (*see paragraph 6.20*). There may be occasions when the convenor feels that Local Resolution has been adequately pursued - in that the complaint has been properly investigated and an appropriate explanation given - and that nothing further can be done, although the complainant remains dissatisfied. The safeguard for the complainant lies in the right to put their case directly to the Commissioner should a convenor decide not to establish a panel. The Commissioner will be able to consider whether to recommend that:

- the initial decision of the convenor should be reconsidered; or
- it seems to him more appropriate to investigate the complaint himself.

Role of the Convenor

7.8 The role of the convenor is crucial to triggering events under Independent Review (*see Appendix 2*). It is important that the convenor distances him or herself from those involved in the complaint. The convenor's role is to ensure the complaint is dealt with impartially at the convening stage. It is not the convenor's function to defend those complained against, but rather to ascertain whether all opportunities for satisfying the complainant during Local Resolution have been explored and fully exhausted. And what issues, if any, should be referred to a panel. To this end the convenor will need to obtain a full picture of the events relating to the complaint. It is not the convenor's role to try to resolve the complaint on his/her own.

7.9 Before the convenor decides to convene a panel he or she will consult with the independent lay chairman on the Board's list. This should **not** be the same person who will chair the panel, if it is convened. The purpose of this contact is to provide the convenor with an external independent view and to aid him or her in assessing the grievance. It is, however, ultimately the convenor's decision as to whether or not to recommend proceeding with the establishment of a panel and to explain why he or she made this decision. (*For role of independent lay chairmen - see paragraphs 8.9 - 8.10*).

7.10 The convenor will decide on the panel's terms of reference. He/she should advise the complainant of the matters which the panel will **not** investigate, for example which the Trust/Board has decided should be subject to disciplinary investigation - except for FHS practitioners, where consideration of disciplinary action is not an option at this stage. - or matters that have already been dealt with adequately as well as those which **will** be dealt with. The convenor's statement to the panel of its terms of reference should not be an interpretation or embellishment of the complainant's written grievance, but set out clearly what are the issues he or she believes the panel should investigate. Similarly, the convenor should make it clear in writing the reasons for deciding why a panel should not be established. Failure to do so will be criticized by the Commissioner for Complaints if the complaint is subsequently referred to him.

Criteria for Establishing a Panel

7.11 **In deciding whether to convene a panel, the convenor will consider, in consultation with an independent lay chairman from the Board's list, whether:**

- ***the Trust/Board/FHS practitioner can take any further action*** *(short of establishing a panel) to satisfy the complainant;*
- ***the Trust/Board/FHS practitioner has already taken all practical action*** *and therefore establishing a panel would add no further value to the process.*

The convenor will need to take fully into account the advice of the independent lay chairman, although ultimately it is for the convenor alone to decide whether or not to direct the establishment of a panel.

7.12 The convenor should **not** consider the potential cost of setting up a panel as being a factor in his or her decision to recommend moving to Independent Review.

Clinical Advice to the Convenor

Clinical Complaints

7.13 ***Where the convenor considers that a complaint relates in whole or part to action taken in consequence of the exercise of clinical judgement, he or she must take appropriate clinical advice in deciding whether to convene a panel.***

7.14 The convenor must take appropriate clinical advice in deciding whether to convene a panel when he or she considers a complaint relates in whole or in part to action taken in consequence of the exercise of professional clinical judgement - ie any judgement that is made by a member of the clinical professions in the HPSS by virtue of their knowledge and skill, which a layman could not make. These will be known as 'clinical complaints'.

7.15 This process will be important in informing the convenor about any particular clinical considerations which he or she should take into account, and whether, for instance, there is any further practical action which could still be taken through the Local Resolution process. The key lies in the concept of action taken in consequence of clinical judgement.

7.16 Clinical judgement can be exercised by any of the recognised clinical professions working within the HPSS to provide care: doctors, nurses, midwives, health visitors, dentists, pharmacists, optometrists, clinical psychologists, members of professions allied to medicine, paramedics and ambulance technicians, laboratory and other scientific and technical staff. It is for the convenor to decide whether a complaint appears to be a clinical complaint and from whom to seek appropriate clinical advice. Such advice is expected to come at least initially from within the Board, but not from anyone who is in any way associated with the complaint. Advice may need to be sought from outside the Board.

7.17 Where medical or other clinical advice is needed, convenors are recommended to seek this initially from the Board's Director of Public Health, or equivalent professional officer, who in turn can direct the convenor to a suitable nominee from the list of clinical assessors. Where the Director of Public Health, or other professional officer, is the subject of the complaint, or where possible conflict of interest arises, some other appropriate independent medical, or other clinical opinion, such as the Department's Chief Medical Officer, should be sought. In those cases where an area officer for each of the professions allied to medicine does not exist the convenor should approach the particular service manager in the first instance, who in turn can direct the convenor to a suitable nominee from the list of clinical assessors.

7.18 In the case of family health services, the convenor should seek initial clinical advice from the Board's relevant Adviser, who in turn can direct the convenor to an independent practitioner from the same profession as the practitioner who is being complained about. The practitioner's name will come from a list of practitioners nominated by the relevant local professional representative committee, or as otherwise agreed with the professions or, in the case of GP fundholders, by the local GP fundholding groups within the Board or, by agreement, by local medical committees working with local GP fundholding interests.

7.19 *Where the convenor considers that a complaint relates in whole or part to action taken in consequence of the exercise of professional social work judgement, he or she must take appropriate professional advice in deciding whether to convene a panel.*

7.20 The convenor must take appropriate professional social work advice in deciding whether to convene a panel when he or she considers a complaint relates in whole or in part to action taken in consequence of the exercise of professional social work judgement - ie any judgement that is made by a member of the social work profession in the HPSS by virtue of their knowledge and skill, which a layman could not make.

7.21 In the case of personal social services the convenor is recommended to seek professional advice initially from the Board's Director of Social Services who in turn may suggest who else would be qualified to advise. Where the Director of Social Services is the subject of the complaint, or where possible conflict of interest arises, some other appropriate independent social services opinion, such as that of the Department's Chief Social Services Inspector should be sought.

Decision of the Convenor

7.22 Convenors are advised that they should not recommend the setting up of an Independent Review panel where:

- any legal proceedings have commenced, or there is an explicit indication by the complainant of the intention to make a legal claim against a Trust/Board, or one of their employees, or against a family health services practitioner; or
- it is considered that the Trust/Board, FHS practitioner has already taken all practicable action and therefore establishing a panel would add no further value to the process: consideration of the cost of instituting an Independent Review is not an appropriate reason for refusing to proceed; or
- it is believed further action as part of Local Resolution is appropriate and practicable:
  - either referral back to the Trust/Board Chief Executive, for consideration is thought preferable to beginning the Independent Review process; or
  - an invitation by the convenor to the FHS practitioner to reconsider Local Resolution, possibly with conciliation, as preferable to instituting the Independent Review process;
- for Trust/Board employees, it is considered that there is a prima facie case for a disciplinary investigation (*see paragraphs 5.31 - 5.32*) and referral by the convenor to the responsible officer in the Trust/Board is appropriate. The setting up of an Independent Review panel would follow automatically if no disciplinary investigation was pursued.

7.23 ***The convenor must inform the complainant, and any person alleged in the complaint to have taken any part in the action complained of, in writing of his or her decision as to whether or not a panel should be appointed, setting out clearly the terms of reference or the reasons for any decision to refuse a panel, and whether or not he or she believes there is further action the Trust/Board/FHS practitioner could take.***

7.24 ***Where a panel has been refused, the complainant should be advised of the right to complain to the Commissioner.***

7.25 ***The convenor must inform the Chief Executive of the Trust/Board of his or her decision as to whether or not a panel should be set up, or whether he or she believes there is further action which the Trust/Board could take as part of Local Resolution.***

7.26 Both the complainant and the respondent must be informed in writing of the convenor's decision as to whether or not an Independent Review panel is to be set up. The convenor should send to the Chief Executive of the Trust/Board, and the FHS practitioner concerned a copy of his/her communication which explains the decision to the complainant.

7.27 The convenor must set out the reasons for any decision to refuse a panel as fully as possible so that the convenor's views are clearly available should the complainant decide to exercise the right to refer the complaint to the Commissioner. This right should be recorded in the letter from the convenor to the complainant. The intention is to ensure that the complainant is fully informed of the reasons for not convening a panel and, if appropriate, why the convenor believes there should be a reference back to Local Resolution.

7.28 ***If the complainant remains dissatisfied following the reference back to the Trust/Board/FHS practitioner he/she may refer the complaint once again to the convenor to reconsider whether an Independent Review panel should be convened.***

Action by the Board

7.29 In order to avoid delay, Boards are advised to arrange for delegated powers to be given to the Chief Executive and an alternate executive director to formally establish a panel as soon as the advice of its convenor is known. The convenor will likewise advise the Trust/Board when he/she has decided against establishing a panel. If the recommendation of the convenor is that Local Resolution should be reactivated, this should be expedited by the Chief Executive.

Performance Targets for Convening

7.30 The convenor will arrange for acknowledgement of the complainant's request for an Independent Review panel **within two working days.**

7.31 Convening should not be a re-run of the action taken during Local Resolution. While recognising that assimilation of written and oral facts, and the conduct of adequate consultation, all need time if they are to be exercised thoroughly, the period required for a decision to be made as to whether to convene an Independent Review panel should **not normally exceed twenty working days** (ie four weeks) from the date of the complainant's request being received by the convenor.

Purpose of the Panel

8.1 The purpose of an Independent Review panel is to consider the complaint according to the terms of reference provided by the convenor, and in the light of the written complaint or statement provided to him or her by the complainant. The panel will investigate the facts of the case, taking into account the views of both sides. It will set out its conclusions, with appropriate comments and suggestions, in a written report.

Establishing the Panel

8.2 ***Independent Review panels will be composed of three members:***

- ***an independent lay chairman appointed by the Board;***
- ***a convenor (non-executive director of the Board) or appointed person; and***
- ***an independent person appointed by the Board.***

Where the convenor decides, after consultation with the independent lay chairman and after taking appropriate clinical advice, that the complaint is a clinical complaint, the panel will be advised by at least two independent clinical assessors nominated by the Board following advice from the relevant professional representative bodies. In the case of social services complaints two independent assessors will be nominated by the Board following advice from the BASW (NI).

The panel is to be established as a committee of the Board and the assessors are to be appointed by the Board to advise the panel.

8.3 In considering a complaint from, or on behalf of, a person suffering from mental disorder, and where the complaint relates to the care and treatment of that mental disorder, the convenor should consider co-opting a member of the Mental Health Commission onto the panel.

8.4 In order to avoid accusations of bias members or officers of HSS Councils will be excluded from panel membership.

Appointment of Panel Members

8.5 Boards will be responsible for recruiting independent lay chairmen and lay panel members. Criteria for selecting panel members should include:

- interest in the subject,
- impartiality and judgmental skills and,
- experience in working in small groups tasked with producing reports, where possible.

8.6 The names of persons held on the lists for the role of independent lay chairman and the third panel member will all be those of lay people. Only exceptionally will they be recently retired HPSS staff or lay non-executive directors of other Trusts/Boards. Practising or retired members of the clinical professions should not be chosen for this role. No panel member - other than the convenor or alternative person - should have any past or present links with the Board establishing the panel. The chairman and third panel member will always be lay people. Recruitment will be in accordance with equal

opportunities policy. **MAHI - STM - 097 - 6052**

8.7 Boards are responsible for putting in place arrangements for holding lists of independent chairmen and lay panel members. It will be the responsibility of Boards to organise access to broad training for independent chairmen and panel members and to decide their appropriate allocation to panels. Boards may find it helpful in liaising with each other in finding an appropriate chairman and panel members, where circumstances demand a wider trawl. Call-off from these lists should be organised in a balanced, independent way, so that no one panel member becomes regularly linked with a particular Trust/Board.

8.8 It is for Boards to issue formal letters covering the appointment of panel members to serve on a specific panel, including indemnity cover, and to ensure that arrangements are made to let panel members have appropriate background and briefing papers, together with the names of the assessors who have been appointed to assist their particular panel. The complainant should be informed of the panel members and assessors appointed to conduct the Independent Review. Respondents should similarly be advised of the panel members and assessors appointed to conduct the Independent Review.

Role of Independent Lay Chairman

8.9 There are two roles for the independent lay panel chairman (*see Appendix 4*):

- helping convenors, by providing independent advice and support during the convening period; and
- chairing panels when established.

The Board will formally appoint the panel chairman, bearing in mind the need for indemnity cover in respect of the advice given to the convenor by the chairman during the convening period.

8.10 Once the convenor's decision to establish an Independent Review panel has been made and the convenor has set out the panel's terms of reference, responsibility for leading the organisation of the panel's business falls to its independent lay chairman.

Function of the Panel

8.11 ***The function of the panel is to:***

- ***investigate the aspects of the complaint as set out in the convenor's terms of reference, taking into account the complainant's grievance as recorded in writing to the convenor;***
- ***make a report setting out its conclusions, with appropriate comments and suggestions.***

The panel will have no executive authority over any action by the Trust/Board, or family health services practitioner, and may not make any suggestion in its report that any person should be subject to disciplinary action or referred to any of the professional regulatory bodies.

8.12 The panel should be proactive in its investigations, always seeking to resolve the complainant's grievance in a conciliatory manner, while at the same time taking a view on the facts it has identified. The panel should be flexible in the way it goes about its business, choosing a method or procedure appropriate to the circumstances of the complaint. It should not act in a confrontational manner. Resolution of the complaint may be sought by the full panel, with its assessors, through separate meetings with the complainant and the person complained against. It is a matter for the panel to decide

whether the complainant and the person complained against should be brought together at the same meeting; similarly whether smaller meetings involving, say, any one member of the panel, with or without assessors, are appropriate in the circumstances.

8.13 *The panel will decide how to conduct its proceedings, having regard to guidance issued by the HPSS Executive, within the following rules:*

- *the panel's proceedings must be held in private;*
- *the panel must give both the complainant and any person complained against a reasonable opportunity to express their views on the complaint;*
- *if any of the panel members disagree about how the panel should go about its business, the chairman's decision will be final;*
- *when being interviewed by any members of the panel or the assessors, the complainant and any other person interviewed may be accompanied by a person of their choosing, who may speak to the panel members/assessors - except that no person interviewed may be accompanied by a legally qualified person acting as an advocate.*

8.14 The panel will have access to all the records held by the Trust/Board relating to the handling of the complaint. FHS practitioners will be asked to make available their records of the handling of the complaint. If the complaint is a clinical complaint, the panel must have access to the relevant parts of the patient's health records.

8.15 The panel has discretion as to how it should operate. It has a duty to keep records, bearing in mind the possibility of future investigation by the Commissioner for Complaints. Panels should work informally and be flexible in their approach, so that they can respond appropriately to differing kinds of complaint. The panel chairman will be the final arbiter. The panel should not act as a tribunal involving formal cross-examination of witnesses, nor should it operate in a confrontational, adversarial, or legalistic way.

8.16 Neither the complainant nor the respondent may be legally represented. The complainant may, however, be supported on all occasions by a person of their choosing who, even if legally qualified, may not act in a legal capacity. This could be an adviser, say from the HSS Council, who may speak on behalf of the complainant. It may also be appropriate for the complainant to be accompanied by a second person, such as a relative, for emotional support.

8.17 Any person mentioned in the complaint who is interviewed may be similarly supported by a representative of their trade union or professional organisation, or appropriate manager or colleague, who can act in the capacity of personal adviser.

Identification of Assessors

8.18 ***Where the complaint is wholly or partly related to clinical matters, panels must be advised by at least two independent clinical assessors. The independent clinical assessors' role is to advise and make a report, or reports, to the panel on the clinical aspects of complaints. The assessors should decide, in consultation with the panel, how to exercise their responsibilities having regard to guidance issued by the HPSS Executive and their professional bodies.***

8.19 The role of an assessor is to advise the panel or its individual members. Assessors should not act independently to resolve a complaint. Where a complaint raises issues about more than one medical specialty or health and social care profession, at least one assessor for each medical specialty or health or social care profession should be available to advise the panel. In cases where only one discipline is under scrutiny there will be two assessors from the relevant discipline. In some cases it may be appropriate for there to be more than two assessors and it will be for the convenor and independent

lay chairman of the panel to make this decision.

8.20 Boards will hold copies of the lists of assessors for hospital and community health services, family health services and social services complaints, and assessors with experience of exercising clinical judgement in a purchasing context.

8.21 The professional bodies' role in ensuring that lists of appropriate independent assessors, who are acceptable to the profession concerned, are kept up to date (and revised at least annually), will be crucial to the general standing and efficacy of the assessor system:

- the BMA has undertaken to continue this role for hospital medical and dental staff;
- the Central Committee for Community Dental Services of the British Dental Association will undertake this role for community dentists;
- Nursing professional bodies will ensure that appropriate independent nursing assessors, acceptable to the profession, are identified;
- local medical committees will make arrangements for preparing lists of appropriate assessors from general medical practitioners;
- assessors for GP fundholding complaints will be nominated by recognised local fundholding groups working in conjunction with local medical committees;
- Boards will nominate clinicians with experience in exercising clinical judgement in a purchasing context;
- the British Association of Social Workers (NI) will undertake this role for social services;
- Those professional bodies who represent other professions which might be involved will ensure that lists are available.

8.22 Boards will select assessors to serve individual panels. Normally assessors will be selected from names of those working outside the geographical area of the Trust/Board concerned, but there will be discretion on this point. If the Board has any difficulty in determining appropriate assessors they should consult the appropriate professional body. Boards will also have access to the lists held in Great Britain, where it is appropriate to appoint an assessor from outside Northern Ireland.

8.23 Boards will need to ascertain the availability of assessors before making formal appointments. Normally assessors for hospital and community health services and social services complaints will be selected from outside the Board area concerned. In the case of FHS panels assessors should be chosen from a list held by the Board and nominated by the local representative committees or, in the case of GP fundholders, by recognised local GP fundholding groups working in conjunction with local medical committees. FHS assessors should not come from within the Board area of the practice or practitioner against whom the complaint was made. When selecting assessors it is important that they have no connection with any of the parties to the complaint. This might call into question their independence or objectivity in respect of the complaint. When there is doubt about the choice of an assessor the Board should contact the appropriate professional body.

8.24 Responsibility for formally appointing and communicating with the chosen assessors will rest with Boards, who should issue letters covering their appointment to assist a specific panel, including indemnity cover. They will ensure that arrangements are made to let the assessors have appropriate documentation.

Release of Assessors

8.25 The role of the assessor is crucial to the success and impartiality of the new complaints procedure. If the role is to be carried out thoroughly and successfully, then assessors will need to be granted prompt release from their commitments. Trusts and other employers are encouraged to recognise that the system of assessors will only work successfully if there is recognition that release needs to be granted quickly, so that delays can be avoided (*see paragraphs 8.20 - 8.23*).

Role of Assessors

8.26 The role of the assessors is to advise the panel, as and when required, on those aspects of the complaint involving clinical (or other professional) judgements (see Appendix 5).

8.27 ***At least one assessor must be present when the panel, or a member of the panel interviews either or both of the parties on occasions when matters relating to the exercise of clinical (or other professional) judgement are under consideration.***

8.28 The assessors must have access to all the patient's/client's health and social services records held by the Trust/Board/FHS practitioner which together with information about the handling of the complaint. Assessors will need to acquaint themselves with any circumstances where a patient or client might be denied access to information on the record, or where the patient has asked for personal information to be withheld from other parties.

8.29 Assessors may interview/examine complainants, who may have a person of their choosing present. Assessors should check if the patient/client has ever been denied access to all or part of their health or social services record. Where the complainant is not the patient/client, care must be taken not to breach patient/client confidentiality. Care must also be taken not to breach third party confidentiality. Assessors should not normally explain their findings to either the patient/client or complainant at this stage, before advising the panel of their views.

8.30 Assessors may also interview any person complained against, who may have a person of their choosing present. They should not normally explain their findings to the person complained against before advising the panel of their views.

8.31 There may be occasions when a patient's/client's health/social services record is no longer in the possession of the person complained against. In these circumstances, every effort should be made by the Trust/Board to provide the person complained against with access to it for the purpose of framing a response. In the case of a FHS practitioner, if it is appropriate to return the record then the whole, or relevant part of the record might be photocopied or inspected at the Trust's/Board's premises.

Assessors' Reports

8.32 It will be open to assessors to provide combined or individual reports. The assessors' reports should **not** be made available to the complainant - or the consultant/clinician/other professional complained about - in advance of the reports being made available to panel members. The panel may decide, in consultation with the assessors, to release their reports to the complainant and the complained against if it is believed this will aid resolution of the complaint. Otherwise assessors' reports will only

become accessible to them as part of the panel's final report, initially as a draft.

8.33 Assessors should take care - since their reports may be made available at a later date to others than just panel members - that their reports contain no information which may cause serious harm to the physical or mental health of the patient/client or of any individual. Nor should they contain information about, or provided by, a third party (other than a health or social care professional) who can be identified from the information - unless he/she has consented to its disclosure.

8.34 ***The assessors' reports must be attached to the panel's final report when it is issued. If the panel disagrees with the assessors reports it must state why it has disagreed.***

8.35 If the chairman of the panel finds it appropriate to meet the complainant - for example, as a way of rounding off resolution of the complaint - at least one of the assessors should be present if the complaint relates to a clinical matter. The assessor should be able to give a personal explanation to the complainant of any clinical findings.

Panel's Final Report

8.36 The panel may find it helpful to provide the complainant and the person complained about, with the opportunity to check a draft report for factual accuracy within, say, a period of **fourteen days** before it is formally issued in its final form. The assessors' reports should be made available in time for their preliminary circulation with the panel's draft report. Those receiving the draft report should be reminded that the report is confidential to them and the panel members. The complainant, and anyone complained about, should be asked to inform the panel if he or she wishes to consult on the content of the draft report with an adviser who has not been previously involved in the complaint, such as the HSS Council. The responsibility for ensuring the panel completes its report within the target time limit rests with the panel chairman.

8.37 *The panel's final report must be sent to:*

- *the complainant;*
- *the patient/client if a different person from the complainant and alive and competent to receive it;*
- *any person named in the complaint;*
- *any person interviewed by the panel;*
- *the clinical assessors or other professional assessors, as appropriate;*
- *the Trust/Board Chairman and Chief Executive;*
- *the practitioner, where the complaint is about FHS practitioners/GP fundholders;*
- *the Director of Performance Review and Secondary Care in the HPSS Executive;*
- *in the case of GP Fundholder complaints the Director of Primary Care and Purchasing Development in the HPSS Executive;*
- *the Chairman and Chief Executive of the independent provider, where the complaint is about services provided by the independent sector.*

The report will have a restricted circulation. The panel will not send it to any other person or body. The panel chairman has the right to withhold any part of the report and all or part of the assessor's report in order to ensure confidentiality of clinical information.

8.38 The panel's final report should set out the results of its investigations, outlining its conclusions, with any appropriate comments or suggestions. The panel may **not** make any recommendations or suggestions relating to disciplinary matters.

8.39 The complainant may wish to show the report to a representative of the HSS Council or other appropriate adviser. The Chief Executive may need to show the report, or sections of it, to Board members and a FHS practitioner may need to show it to colleagues in their practice. These, and any other similar arrangements, will need to protect the overall confidentiality of the report.

Follow-up Action by Trusts/Boards

8.40 ***Following receipt of the panel's report, the Chief Executive must write to the complainant informing them of any action the Trust/Board is taking as a result of the panel's deliberations. And of the right of the complainant to take their grievance to the Commissioner if they remain dissatisfied.***

8.41 Trusts/Boards should consider what arrangements are necessary for ensuring that action is taken on the outcome of Independent Review panel reports, and that action in individual cases has been taken where it had been earlier agreed to do so. Trusts/Boards will also be responsible for ensuring that the action taken is communicated quickly and clearly to the complainant.

Completion of the Complaints Procedure

8.42 It needs to be made very clear to the complainant when the complaints procedure has been completed. The Commissioner for Complaints will normally only embark on an investigation when the procedure has been exhausted.

Trusts/Boards/GP Fundholders (*see Appendix 6a*)

8.43 Completion of the complaints procedure for Trusts/Boards - except in the case of FHS practitioners (*see paragraph 8.46*) - will be when the Chief Executive writes to advise the complainant of the outcome of the Board's consideration of the panel's report and the complainant's right to complain to the Commissioner. It is recognised that it may take a Trust/Board some time to consider how to respond to a panel's report, particularly if there are policy review or changes which need consultation with others before a final decision can be made. Nevertheless, the Chief Executive should strive to communicate to the complainant in writing - **within twenty working days** from the publication of the panel's report - any matters such as a formal apology, approval of a ex-gratia payment, or an indication of the timescale in which the Board has agreed to consider policy issues, plus information about their right to complain to the Commissioner if they are still dissatisfied. If, following this action, the Board takes any further decisions relating to the outcome of the case, then the complainant should be appropriately informed by the Chief Executive.

8.44 Completion of the complaints procedure for complaints about services purchased by Boards or GP Fundholders from the independent sector, is when the panel's report is sent to the complainant by the Board Chief Executive. The Chief Executive should send the panel's report to the complainant and the independent provider under suitable cover letters as soon as possible after receiving it. The covering letter must advise the complainant of the right to refer their complaint to the Commissioner if still dissatisfied. If the panel has commented about the possibility or desirability of making changes to the services purchased by a Board, which are the subject of the complaint, the Chief Executive should consider, in consultation with the provider as necessary, how those services can be improved and the implications for the Board's purchasing policy. The Chief Executive will then wish to follow up the panel's report with a further letter setting out any changes which have been decided on.

8.45 In cases of care purchased by a GP Fundholder, the Chief Executive will also send the panel report to the fundholder. Where suggestions have been made about improvements to a service which has been purchased by a GP Fundholder, the Chief Executive will want to tell the complainant that he is inviting the fundholder to respond personally to the complainant on those matters. Likewise, when the Chief Executive is writing to the fundholder, he will want to suggest that a response goes from the practice direct to the complainant.

8.46 For services purchased by Trusts from the independent sector, the normal Trust complaints procedure will apply.

FHS Practitioners (*see Appendix 6b*)

8.47 Completion of the complaints procedure for family health services is when the panel's report is sent to the complainant by the Board's Chief Executive. The Chief Executive should send the report to the complainant and the practitioner under suitable covering letters as soon as possible after receiving it. The covering letter must advise the complainant of the right to complain to the Commissioner. If the panel has commented about the possibility of making changes to a practitioner's services or organisation the Chief Executive will want to tell the complainant that he/she is inviting the practitioner to respond personally to the complainant on these matters. Likewise, when the Chief Executive is writing to the practitioner, he will want to suggest that a response goes from the practice directly to the complainant.

Administrative Support, Fees and Expenses

8.48 The Board will provide any administrative support which the convenor, the independent lay chairman, the panel and its assessors need. All the expenses arising out of the Independent Review process, including any fees or expenses paid to panel members and assessors, will be met by the Board establishing the panel. Boards will need to determine the level of administrative support that will be necessary for the convening and Independent Review processes, bearing in mind the fluctuating nature of the demand for this support.

Panel Members

8.49 Panel members, including convenors, will be eligible to receive travel expenses, subsistence, and loss of earnings allowances. Boards should indicate in appointment letters that the particular panel chairman and third panel member will be appropriately indemnified.

Assessors

8.50 Arrangements for payments to independent assessors of all professions while advising a particular panel, together with eligibility for travel expenses and subsistence allowances, will be advised separately by the HPSS Executive.

8.51 Arrangements for funding locum expenses of certain FHS practitioners, and the responsibility for the payment of locums in respect of other assessors, will be advised separately by the HPSS Executive.

8.52 Assessors will be formally appointed by Boards to a particular panel and as such will be covered for indemnity while carrying out their role as advisers.

8.53 Where assessors find it more convenient to make their own arrangements for, say, typing their reports, they should agree a rate of payment with the Board in advance.

Performance Targets for Panels

8.54 For complaints against Trusts/Boards the formal appointment of the panel members and assessors should be made **within four weeks** of the convenor's formal letter to the complainant confirming his or her decision to recommend that a panel should be set up. While complaints are bound to vary in complexity, a panel should aim to complete its work **within twelve weeks** of the formal appointment of the panel members and assessors. The Chief Executive of a Trust/Board should write to the complainant **within four weeks** of the panel's final report informing them of any action the Trust/Board is taking as a result of the panel's report and of their right to complain to the Commissioner. The overall target for the Independent Review process is **six months** from the date when the complainant first requests a panel to the date when the Chief Executive writes following the panel's report.

8.55 In the case of family health services complaints, the aim is for panels to complete their work **within three months** of the date on which the complainant approached the convenor with the request for a panel to be set up.

Summary of Time Limits and Performance Targets

8.56 Time limits and performance targets have been summarised in APPENDIX 7.

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Complaints about Purchasing Decisions by Boards

9.1 Complaints about Boards purchasing decisions may be made by, or on behalf of any individual personally affected by a purchasing decision taken by the Board. The complaints procedure may not deal with complaints about the merits of a decision where the Board has acted properly and within its legal responsibilities. Of course, the public or the HSS Council may wish to raise general issues about purchasing issues with the Board and they should receive a full explanation of the Board's policy. These are **not**, however, issues for the new complaints procedure. Panels may criticise the way in which a purchasing decision has been reached - for example on the grounds that the Board did not consult properly or take appropriate clinical advice - but where a purchasing decision has been taken properly and reasonably, panels will not be able to suggest an alternative decision.

9.2 The Board must have a Local Resolution process and a designated Complaints Officer to deal with purchasing complaints and other complaints about the Board's own actions and decisions. It must appoint at least one or more of its non-executive directors to act as a convenor for the Independent Review of complaints about the Board. (*See paragraph 5.26 - 5.27 for guidance on the appointment of additional convenors.*) The Board will nominate an independent lay chairman to link with the convenor and to chair the panel, if one is established. The third member of the panel will be another independent lay person nominated by the Board.

9.3 Where a complaint concerns the exercise of clinical judgement, the Board will nominate at least two clinical assessors (or other professionals as appropriate) with experience of exercising clinical judgement in a purchasing context.

Complaints about Purchasing Decisions by GP Fundholders

9.4 Complaints about purchasing decisions by GP Fundholders, and about all uses of the allotted sum paid to the practice, may be made by, or on behalf of any existing or former patient of the fundholding practice concerned, from the time when it joined the fundholding scheme, subject to the time limit for making complaints. Complaints will only be dealt with through the new complaints procedure if they are made by, or on behalf of a specific individual personally affected by a purchasing decision made by the GP Fundholder.

9.5 GP Fundholders will be required as a condition of remaining in the fundholding scheme to set up and run a practice-based complaints procedure to deal with purchasing complaints. In practice this is likely to be subsumed within their practice procedures for dealing with family health services related complaints. They will also be required to cooperate with the complaints review procedures organised on their behalf by their Board.

9.6 Panels may criticise the way in which a purchasing decision has been reached - for example on the grounds that the fundholder allowed concerns about their budget to interfere with a clinical decision about the needs of an individual patient - but where a purchasing decision has been taken properly and reasonably, panels will not be able to suggest an alternative decision.

9.7 The Independent Review for complaints about purchasing decisions by GP Fundholders will follow the same structure as those for the review of family health services complaints.

9.8 Where a panel is convened to consider a complaint which relates wholly or partly to a purchasing decision by a GP fundholder, the Board must **always** appoint assessors with experience of exercising clinical judgement in a purchasing context. These will normally be a GP fundholder chosen in consultation with local fundholding groups, working in conjunction with local medical committees and the Board's Director of Public Health. If a panel is to consider a complaint which relates partly to a GP Fundholder purchasing decision and partly to the provision of family health services, one of the assessors should be a GP Fundholder and one a GP assessor nominated by the Board from a list of names put forward by the local medical committees in the Board's area.

Complaints about Services Purchased from the Independent Sector

9.9 Services for patients/clients may be purchased from the independent sector by Trusts, Boards, or GP Fundholders. The new complaints procedure will apply equally to services provided by the independent sector. Complaints about the actual services purchased from the independent sector must be treated as such and **not** as complaints about purchasing decisions (although a complainant may also wish to complain about the related purchasing decision at the same time and may pursue this through the same procedure in parallel).

9.10 Trusts will need to ensure that their contracts with independent providers specify that the provider will cooperate with the Trust's own Local Resolution and the Independent Review process. Boards, and GP Fundholders, should specify in their contracts with independent providers that the provider must set up and run a local complaints procedure as far as possible identical to, and as effective as the Local Resolution which HPSS providers are required to provide. Independent providers must cooperate with the Independent Review procedure. Contracts made by Trusts/Boards/GP Fundholders should include a requirement on the independent provider and their staff to cooperate with any Independent Review process that is set up, and to indemnify them for the costs of setting up and running the arrangements.

9.11 Where a Trust has purchased the service concerned, it will be responsible for ensuring Local Resolution by the independent provider in the same way as for complaints about services the Trust provides direct.

9.12 Where the Board or GP Fundholder has purchased the service concerned, the convening and panel stages of the review process will be organised by the Board in the same way as for reviews of complaints against purchasing decisions. The questions to be addressed will, however, be about the services concerned. Complaints may be pursued in this way by, or on behalf of existing or former users of services purchased from the independent sector by either the Board or any fundholding practice within the Board's area. Such complaints must relate to the services in question.

9.13 If a complaint concerns the exercise of clinical judgement, the Board will nominate at least two clinical assessors (or other professionals as appropriate) to advise the panel. If the complainant wishes to pursue a complaint both about the actual services, and the purchasing decision involved, the assessors must represent between them the appropriate experience for both aspects.

9.14 A complaint under the procedures of the Registered Homes (NI) Order 1992 (through the Inspection Unit Manager of the relevant Board) if the independent provider is registered under that Order does not preclude a complainant pursuing a separate complaint under the HPSS complaints procedure.

9.15 If a complaint against an independent provider (registered under the Registered Homes Order) is not resolved locally, the convenor may, with the complainant's consent, delay the instigation of Independent Review until the Inspection Unit Manager of the Board registering the independent provider has had the opportunity to attempt to resolve the complaint.

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9.16 HSS Councils will continue to assist clients and clients who wish to complain about purchasing decisions, and to pursue general issues arising from these complaints with the Board concerned. The complaints procedure does not affect existing requirements to consult extensively with HSS Councils and others on policy decisions.

10 Role of the NI Commissioner for Complaints (The Commissioner)

10.1 *Acting on Complaints* confirmed that the jurisdiction of the NI Commissioner for Complaints would be extended to all complaints by HPSS patients and clients. A Bill amending and widening his powers in the *Commissioner for Complaints Act (NI) 1969* is expected to become law later this year.

10.2 For the first time the Commissioner will be able to investigate complaints about:

- HPSS services provided by FHS practitioners, their staff, or their deputies or locums;
- actions taken wholly or partly as the result of the exercise of clinical judgement;

10.3 It is intended that the new legislation should put beyond doubt the Commissioner's power to investigate complaints about any HPSS-funded care or treatment provided in whole, or in part, by non-HPSS providers.

10.4 The Commissioner will continue to investigate complaints about services provided, or not provided, and about maladministration where actual hardship or injustice has been caused to the complainant or to the person on whose behalf the complaint is made. These will include complaints about the way the HPSS has handled complaints - currently the biggest single cause of grievances referred. The Commissioner will, for example, be able to investigate a complaint that a convenor has refused to recommend the setting up of an Independent Review panel, or that the Local Resolution or Independent Review investigations have been mishandled.

10.5 It is intended that complainants should have exhausted the new complaints procedure before referring a complaint to the Commissioner save that the Commissioner should have discretion in any individual case to override that requirement where he or she decides that it would not be reasonable for it to apply.

10.6 In deciding whether to investigate a complaint under the new jurisdiction, the Commissioner will expect to have access to all papers relating to both Local Resolution and Independent Review investigations. Where a case has been the subject of an Independent Review panel, these papers will include the report of the panel and the associated independent assessors' reports. In deciding whether to investigate a case, the Commissioner will wish to satisfy him or herself that there are grounds for intervention. The Commissioner will obtain independent professional advice as necessary to help him or her with cases involving clinical (or other professional) issues. The legislation defining the bodies and persons to whom the Commissioner must send the reports of his investigations will be amended to take account of his or her new jurisdiction.

10.7 Trusts/Boards will need to ensure that appropriate references are made to the role of the Commissioner when publicising their new complaints procedure, and in the responses they make to individual complainants. Family health services practitioners and independent providers of services will need to take similar action.

10.8 The Commissioner proposes to publish a revised leaflet about these new powers for the public, HPSS staff and family health services practitioners who will operate the new system.

10.9 Transitional provisions relating to the Commissioner's new powers are referred to in Section 11.

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11 Transitional Arrangements

11.1 The new complaints procedure will become operational from 1 April 1996. It is recognised that there will need to be a transitional period during which existing complaints procedures will run in parallel with the new procedure. Complaints received before 1 April 1996 should be dealt with under old procedures. Any complaint first made on or after 1 April 1996 - notwithstanding whether the action concerned took place before or after 1 April 1996 - should be dealt with under the new complaints procedure.

11.2 The following rules will apply in relation to complaints against hospital consultant medical and dental staff of Trusts under the previous clinical complaints procedure:

- if, by 1 April 1996, a complaint has not been referred on by the Trust to the Board's Director of Public Health, under the second stage of the old clinical complaints procedure, then the complaint should be dealt with under the new complaints procedure;

- if, however, the complaint has been referred to the Board's Director of Public Health before 1 April 1996, but a decision has not been made to set up an independent professional review, the Director of Public Health will, refer the complaint back to the convenor of the Board originally receiving the complaint, for consideration in accordance with the new complaints procedure. This will be as if a request for a panel had been made by the complainant to that convenor;

- if, on the other hand, before 1 April 1996, the Director of Public Health has made a decision on the complaint, including a decision to set up an independent professional review, then the complaint should be followed through under the old procedure by the relevant Board.

Costs of appointing assessors under the old procedure will be passed on by the Board to the originating Trust.

11.3 For FHS practitioners complaints, if, **on or after 1 April 1996** a complaint is made relating to events which took place before that date, it will be investigated as follows:

- complaints relating to events which occurred **on, or after 1 January 1996** will be investigated using the new procedure;

- complaints relating to events which occurred **before 1 January 1996** will be investigated under the new arrangements **only** where the complainant can show that he or she had good cause for not making the complaint within the appropriate period under the service committee procedures.

11.4 Legislation to extend the powers of the NI Commissioner for Complaints to mirror that of the GB Health Service Commissioner Bill will be introduced as soon as possible. Complainants will not be able to refer complaints, in respect of clinical matters and about family health services, to the Commissioner until the legislation is enacted.

Local Monitoring and Recording of Complaints

12.1 *Management Boards of Trusts/*Boards must receive quarterly reports on complaints, in order to:*

- *monitor arrangements for local complaints handling;*
- *consider trends in complaints;*
- *consider any lessons which can be learned from complaints, particularly for service improvement;*
- *Trusts/*Boards must publish annually a report on complaints handling and send copies to all Trusts/Boards and GP Fundholders with which it has contracts, all relevant HSS Councils and the HPSS Executive. This information should be included in Boards' Annual Reports.*

Reports must avoid any breaches of patient/client confidentiality.

** (Only relevant to complaints about Boards themselves. Complaints against FHS practitioners, GP fundholders, and independent providers will not be included.)*

12.2 In their role in monitoring implementation of the Charter for Patients and Clients, Boards are required to monitor the arrangements made by providers for dealing with complaints and action taken to improve performance as a result of complaints. An increase in the number of complaints is not, in itself, a reason for thinking that a service is deteriorating. It could mean that the organisation is becoming more responsive to complaints. The important point is to handle complaints well and to feed the lessons learnt into quality improvement.

Collection of Complaints Statistics

12.3 The HPSS Executive will continue to monitor the number and type of complaints made in Northern Ireland. Arrangements for the collection of information on hospital and community services/family health services complaints will be through the completion by Trusts/Boards of the CH8 central return, which has been revised to take into account the new procedures. There will be a revised central return CHB to be completed by Boards for FHS complaints.

12.4 General medical practitioners and dentists will be required by their terms of service to provide Boards with information on the number of complaints received in each practice or surgery, to be included in this return. However, detailed information on Local Resolution will not be required. Boards will be required to provide information on cases which proceed to Independent Review, including those where the convenor decides that a panel investigation is not appropriate.

13 Training

13.1 Training will be the key to making the new complaints procedure effective. All HPSS bodies will need to take action now to ensure that staff understand the intentions that lie behind the new procedure and how the new processes will work.

13.2 All staff and non-executive directors of Trusts/Boards should know how to react and what to do if approached by a complainant. The initial response to someone who feels aggrieved can be crucial in establishing the confidence of the complainant that their grievance will be treated appropriately. Steps should be taken to improve the awareness of staff to the fundamental importance of responding well to complaints. Improving the communications skills of staff throughout the organisation must be a priority to ensure that complaints handling is improved.

13.3 All FHS practitioners will be required to operate Local Resolution procedures within their practices. The intention is to create a channel for constructive discussion and information-seeking so that, wherever possible, the relationship between a patient and their practitioner can be maintained, or saved. Family health services practitioners, who have until now dealt with service committee procedures, will perhaps be facing the greatest cultural change of all. Boards will need to work positively with local representative committees to assist practices, particularly in the early stages, and to ensure that training and support is available for practitioners, practice managers, and staff who are introducing Local Resolution into their practices.

Regional Initiatives

13.4 The HPSS Executive has distributed a training pack for Trusts/Boards to prepare their staff to undertake the Local Resolution complaints process.

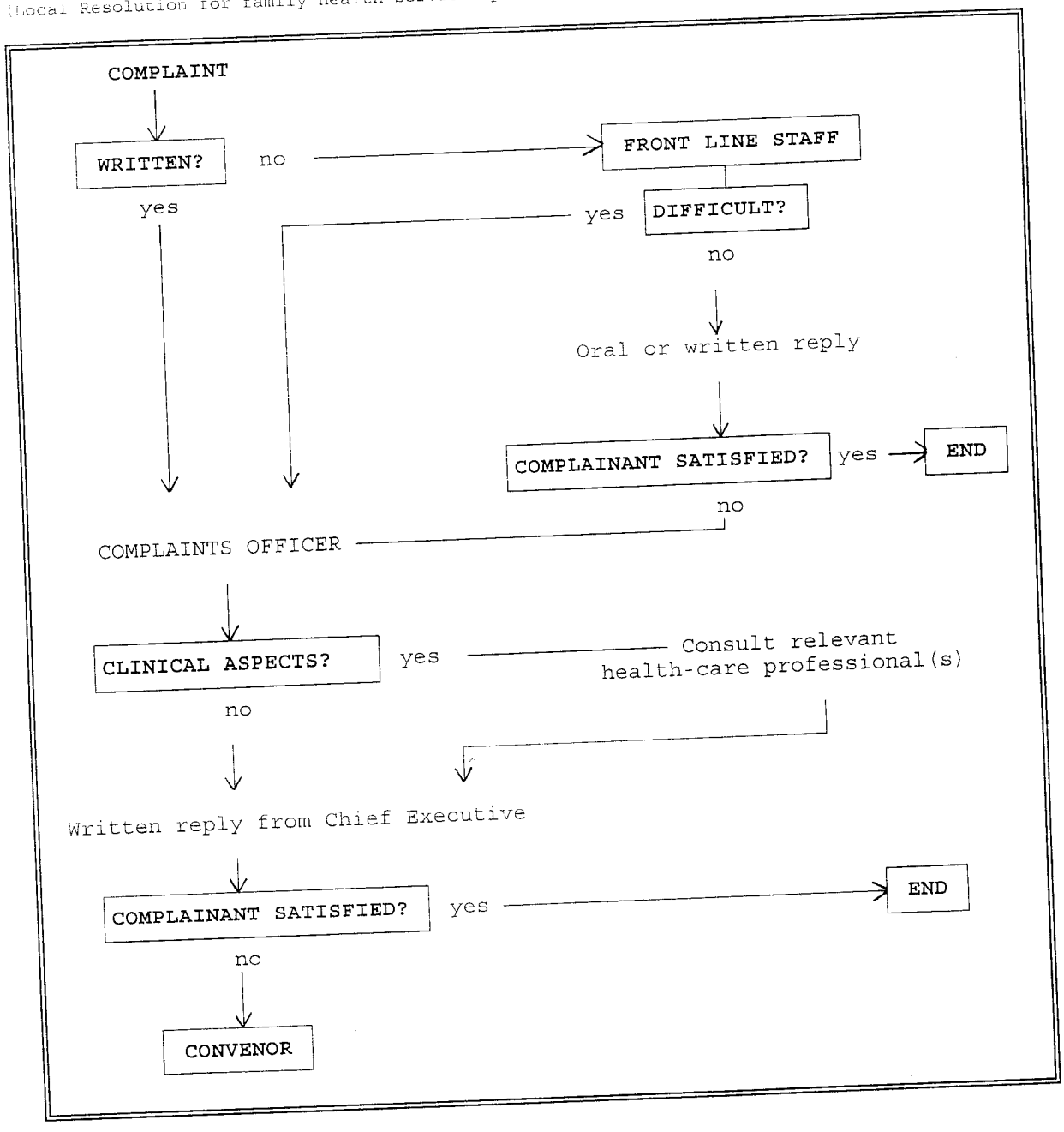
13.5 Guidance booklets for Family Health Service practitioners on practice-based complaints procedures have been distributed for every FHS practitioner, with particular emphasis on Local Resolution.

13.6 A further training pack covering the Independent Review panels will be available in April/May 1996.

13.7 Briefing material is being prepared for clinical assessors and will be distributed in June 1996.

LOCAL RESOLUTION FOR TRUSTS/BOARDS

(Local Resolution for family health services practitioners - see practice-based guidance booklets)



ROLE OF THE CONVENOR

The convenor will be a non-executive director of the Board, or a person specifically charged by the Board to act in this role, who will:

- respond to an oral or written request by a complainant who is dissatisfied with the outcome of Local Resolution (the complainant's request should be made within twenty-eight days of completion of the Local Resolution process: the convenor has discretion to extend this period if there are exceptional circumstances why there has been delay);
- formally acknowledge the request within two working days (the convenor will be appropriately assisted in his/her task by a manager appointed by the Board);
- immediately consult with one of the independent lay panel chairmen on the Board's list in order to consult over a decision as to whether or not to convene a panel;
- call for all papers and documents relating to the Local Resolution;
- advise any person who is complained against;
- request the complainant to provide a written statement to elucidate exactly why he/she remains dissatisfied, if the initial request is either not clear or not full enough (the convenor should ensure the complainant is aware of the help that is available from the HSS Council or other sources);
- seek appropriate independent clinical (or other professional) advice, where the convenor considers there is a clinical element to the complaint, initially approaching either local head of the profession concerned or obtaining advice from an appropriate person on the list of assessors, accessed through the Board;
- in consultation with the prospective independent lay panel chairman, decide whether or not a panel should be set up, within twenty working days of receiving the complainant's request;
- liaise with other convenors if the complaint involves more than one body.

The convenor will decide **not** to establish a panel if:

- the complainant has commenced any legal proceedings, or proceedings explicitly threatened;
- the Trust/Board/family health services practitioner has already taken all action that is reasonably possible, so that a panel is unlikely to add anything to the outcome;
- further action is believed to be appropriate and practicable by the Trust/Board/family health services practitioner.

If the convenor decides to refuse a request for Independent Review, he/she must inform the following, in writing, of the reasons for the decision, and whether he/she believes that Local Resolution should be reactivated:

- the complainant, with advice of the right to appeal to the Commissioner of Complaints;
- the Chief Executive;
- any person who is complained against;
- the independent lay panel chairman with whom he/she has consulted;

- anyone else with whom he has consulted.

If the convenor decides that a panel should be convened, he/she will:

- decide the terms of reference for the panel, outlining the issues to be excluded from its consideration, eg any matters where the Trust/Board has instituted disciplinary investigation or referred on to a professional regulatory body;

- advise the complainant in writing of his decision and the terms of reference for the panel, the issues to be excluded from its consideration and why, and when the panel is likely to be set up;

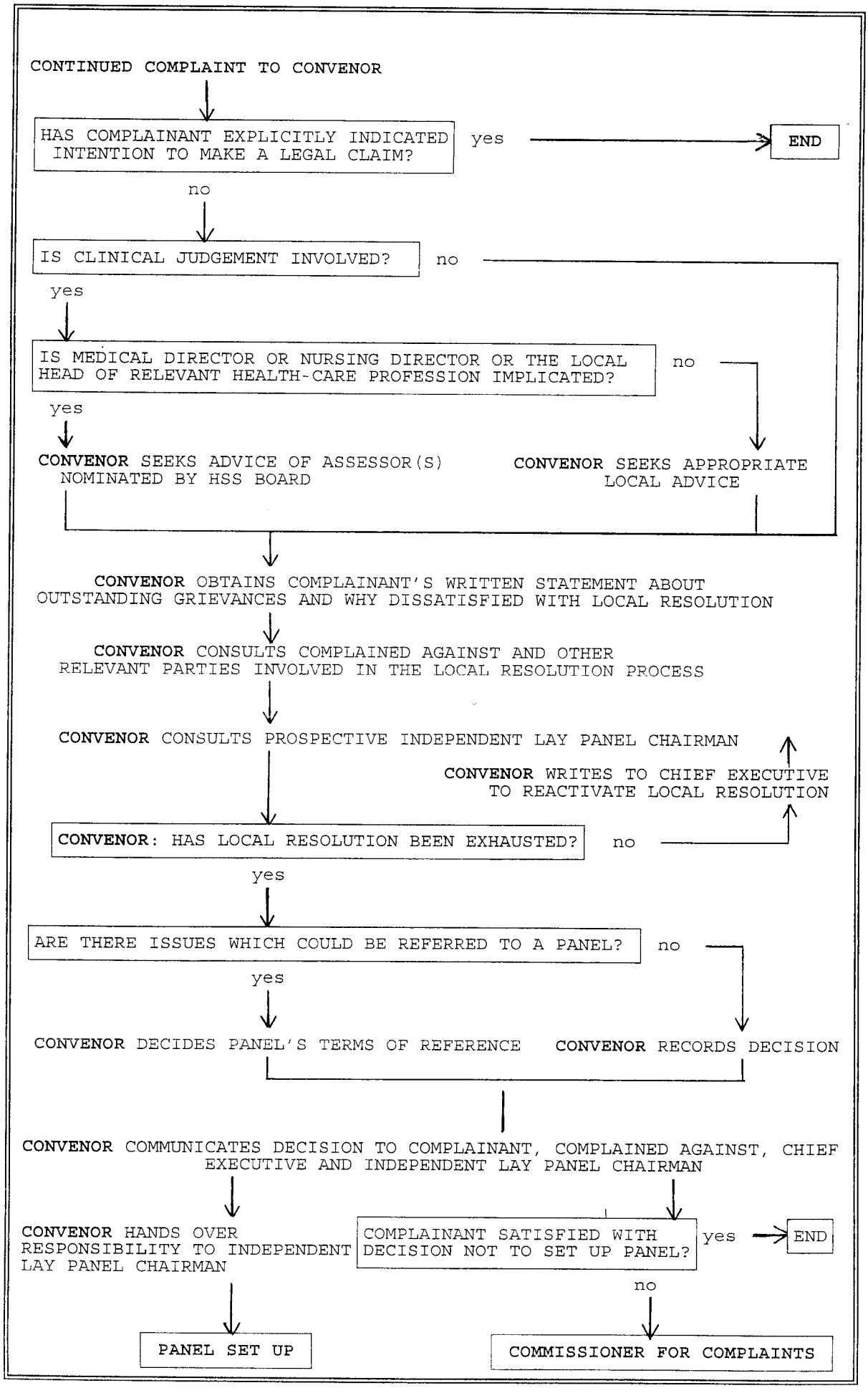
- advise any person who is complained against in writing of his decision and the terms of reference for the panel, the issues to be excluded from its consideration and why, and when the panel is likely to be set up;

- advise the independent lay panel chairman of his decision, with the terms of reference and the complainant's written grievance, thereby handing over responsibility for the next stage;

- advise the Chief Executive in writing of:

  - the decision and terms of reference of the panel;
  - the need for a further member of the panel;
  - whether there is a need to appoint assessors to assist the panel, and that appropriate arrangements should be made for their formal appointment;
  - the need for administrative assistance to support the panel.

CONVENING ROLE



APPENDIX 4

ROLE OF THE INDEPENDENT LAY CHAIRMAN

The role of the independent lay chairman is in two parts:

First

- to help convenors, by providing independent advice and support during the convening period: prospective panel chairmen may need to read reports and documents that are passed to him/her by the convenor, but it is not for the convenor to make the ultimate decision as to whether or not a panel is to be convened;

- to keep a personal record of the part they have played in the convening process, in case of need for future reference, for example investigation by the Commissioner for Complaints.

Second

- once the decision has been made by the convenor to establish an independent review panel, to ensure that he/she understands the terms of reference being provided for the panel and to decide on arrangements for the panel's business;

- to decide with the other panel members how the panel should operate, and to make appropriate arrangements to ensure full records of the panel's activities are kept bearing in mind a possible subsequent investigation by the Commissioner for Complaints (the Board appointing the panel has responsibility for providing appropriate administrative support for the panel and its assessors);

- to ensure members of the panel and assessors have received appropriate documentation, including the convenor's report and the complaint's grievance as recorded in writing to the convenor;

- in the light of discussion with panel members and also, where appropriate, the assessors, to decide the way in which the panel will proceed with its business, always bearing in mind its objective is to resolve and satisfy the complainant's grievance, while at the same time being fair to staff who are involved in the complaint;

- to exercise discretion as chairman of the panel as to how the panel should operate if any of the panel members disagree about how the panel should go about its business: the chairman's decision will be final;

- to decide, with the panel, arrangements for meeting the complainant and those who are complained against, together with those chosen to accompany them;

- to agree with the panel and its assessors the way in which the latter will meet with the complainant and the complained against, and how they should make their report;

- to lead the panel in shaping its report, setting out the results of its investigations, outlining its conclusions, with any appropriate comments or suggestions;

- to ensure there are no recommendations or suggestions relating to disciplinary matters

contained in the report;

- to decide, with the panel and, when appropriate, its assessors, what parts of the draft report are to be shown to the complainant and any person complained against;

- to ensure the work of the panel maintains momentum and as far as possible meets the target time limit for the panel to make its final report and, where this is likely to be exceeded, that an appropriate explanation is forthcoming to the complainant and those involved in the complaint;

- to send the report as formally required under the complaints procedure, ensuring its confidentiality.

APPENDIX 5

ROLE OF THE ASSESSOR

The role of the assessors is to advise the panel as and when required, on those aspects of the complaint involving clinical (or other professional) judgements.

The following set of questions is meant to be a framework within which all health care professions can operate. The questions are meant to be an *aide memoire*; they will not all be relevant in a particular complaint, so they will need to be tailored to the individual complaint; and they will need to be adapted for each profession.

1. Were the actions of the health care professional(s) based on a reasonable and responsible exercise of clinical judgement of a standard which could reasonably be expected of his/her/their peers by patients in similar circumstances?

2. Did the health care professional(s) respect the right of the patient (and the relatives/carers with the patient's consent) to influence decisions about his/her care?

3. Did the actions of the health care professional(s) conform with the codes of practice and/or rules of his/her/their profession(s)?

4. Was the necessary information and/or support expert professional advice available to the health care professional(s) to enable him/her/them to form a proper judgement and offer appropriate care?

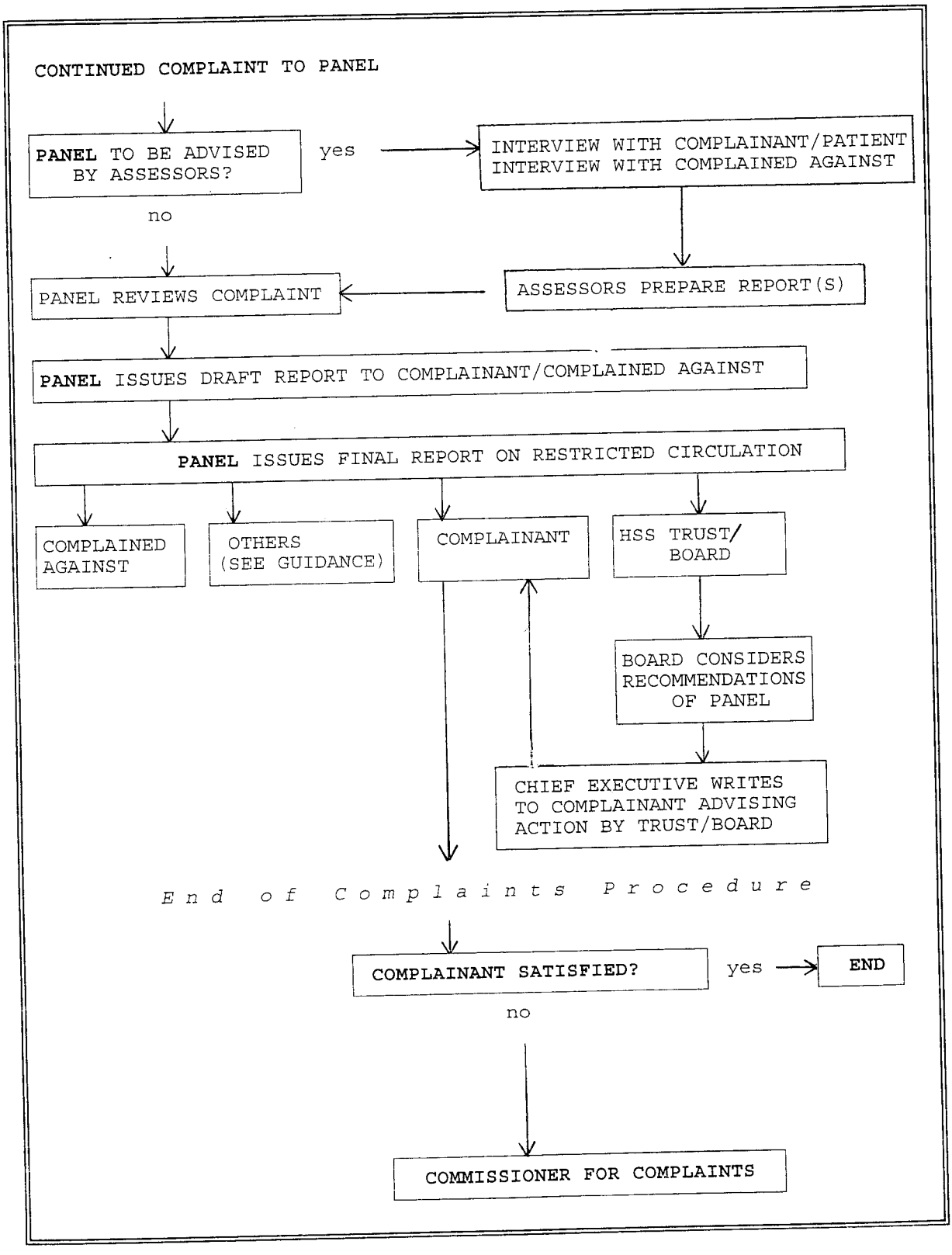
5. Did the health care professional(s) fail to recognise the limits of his/her/their professional competence?

6. If there was delegation to a junior (or subordinate) member of staff of responsibility for the care of the patient, was it agreed? and did the health care professional satisfy himself/herself that the junior (or subordinate) member of staff was competent to undertake that care?

7 Was there failure to refer the patient to another health care professional?

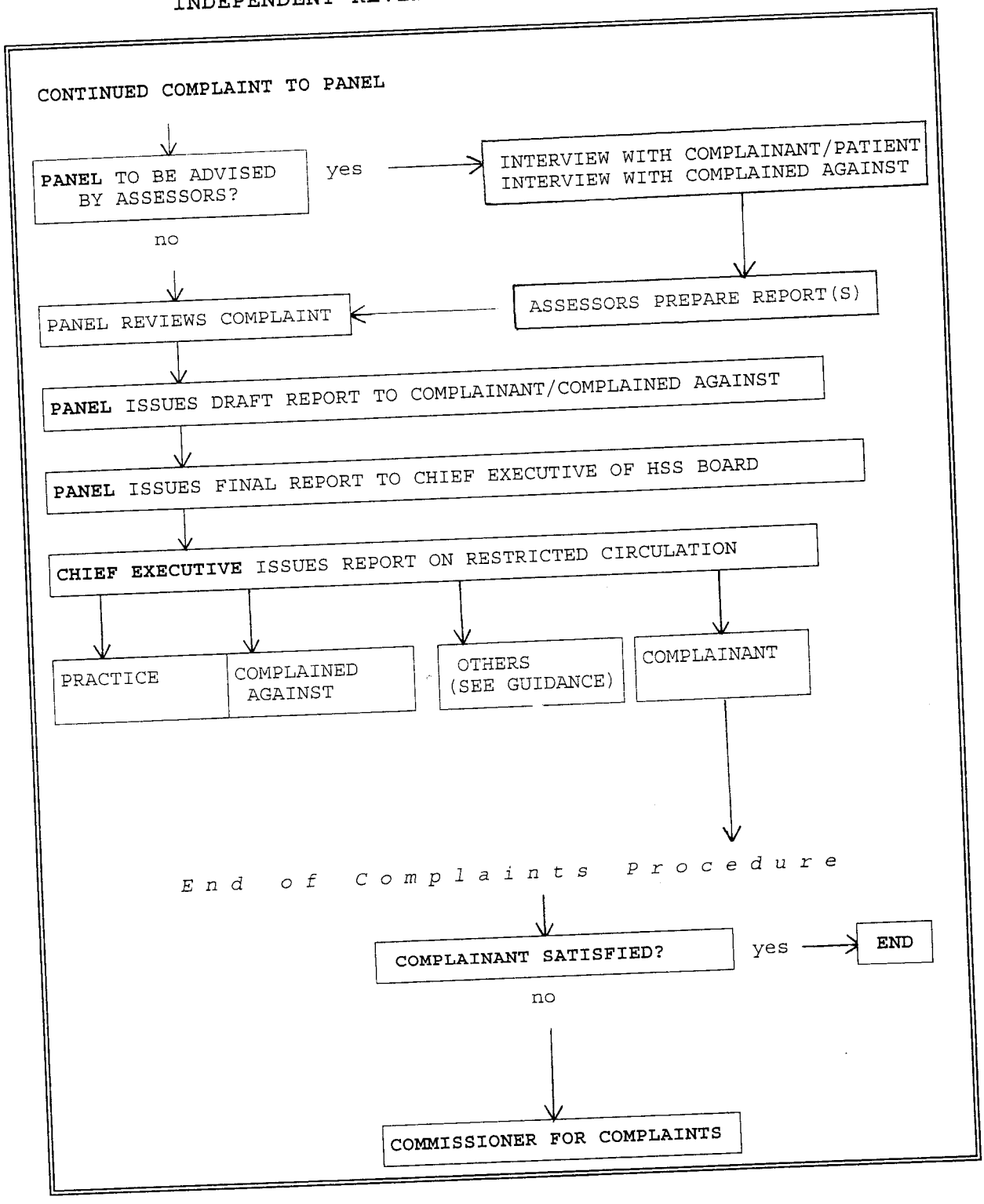
APPENDIX 6a

INDEPENDENT REVIEW FOR TRUSTS AND BOARDS



APPENDIX 6b

INDEPENDENT REVIEW FOR FHS PRACTITIONERS



SUMMARY OF TIME LIMITS/PERFORMANCE TARGETS

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EVENT	TIME ALLOWED	PARAGRAPH
Original complaint	6 months from event, *or* 6 months of becoming aware of a cause for complaint, but no longer than 12 months from event: discretion to extend	5.12
Local Resolution		
Oral complaint	Dealt with on the spot or referred	6.22
Acknowledgement	2 working days of receipt, *or* full reply within 5 working days	6.22
Full response, by trust/Board, *or* family health services practitioner	20 working days of receipt, *or* normally 10 working days for practice-based complaints or, if this is not possible, as soon as reasonably practicable thereafter.	6.23 6.24
Complainant to apply for Independent Review	28 calendar days of receipt of response to Local Resolution	7.1
Independent Review for Trust/Board complaints		
Acknowledgement by convenor of request for Independent Review	2 working days of receipt	7.30
Decision by convenor to set up panel, or not	20 working days of receipt of request	7.31
Appointment of panel members	20 working days of decision by convenor to establish a panel	8.53
Draft report of panel	50 working days of formal appointment of panel and assessors	8.53
Final report of panel	10 further working days	8.53
Response to complainant by Board	20 working days of receipt of panel's report	8.53
Independent Review for family health services practitioner complaints		
Acknowledgement by convenor of request for Independent Review	2 working days of receipt	7.30
Decision by convenor to set up panel, or not	10 working days of receipt of request	8.54
Appointment of panel members	10 working days of decision by convenor to establish a panel	8.54
Draft report of panel	30 working days of formal appointment of panel and assessors	8.54
Final report of panel	10 further working days	8.54
Final report sent to complainant by chief executive of Board	5 working days of receipt of panel's report	8.54

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The HPSS does all that it can to make sure its patients and clients are treated properly and promptly. But sometimes things can go wrong. The complaints procedure set out in this guidance is intended to ensure that patients and clients who are dissatisfied with the service or treatment provided have their concerns dealt with fully.

The key objectives of the complaints procedure include – ease of access, with rapid, open processes; an approach that is fair, honest, and aims to resolve the problem and satisfy the concerns of complainants; and learning from complaints. It aims to provide a quick but thorough response that answers the concerns raised. Where possible, this is done by those directly involved in the care of the individual concerned. The guidance should be read the 'Guidance on Implementation of the HPSS Complaints Procedure', issued March 1996.

This guidance deals with complaints about hospital and community health and social services. The target audience is those dealing directly with the complaints process at Board and Trust levels. It is not designed to be all-embracing and Boards and Trusts are expected to operate the complaints procedure within the spirit of the Guidance, while adhering to the legal requirements of the appropriate Directions and Regulations.

The guidance issued to general medical and dental practitioners, pharmacists and opticians in 1996 remains current.

Complaints in relation to the provision of personnel social services for children are not incorporated within the HPSS complaints procedure and should be handled through the procedures put in place under the Children's (NI) Order 1995. See paragraph 4.21.

1.1 A complaint is ***"an expression of dissatisfaction"***. Patients/clients may not always use the word "complaint". They may offer a comment or suggestion that can be extremely helpful. It is important to recognise those comments which are really complaints and need to be handled as such.

1.2 The aim should be to resolve most complaints at local level. Each HPSS body dealing with the public must establish and publicise its complaints procedure. The first stage of that procedure is local resolution.

1.3 The objective of local resolution is to provide the fullest opportunity for investigation and resolution of the complaint, as quickly as is sensible in the circumstances, aiming to satisfy the complainant while being scrupulously fair to staff.

1.4 Local resolution should not be seen as a 'run-up' to independent review: its primary purpose is to give a comprehensive response that fully addresses the complainant's concerns. The process should provide different ways of responding to the complainant. d r r d r d d d r d r r d r d r r

1.5 Complaints may be made by:

a patient or client
former patients, clients or visitors using HPSS services and facilities;
someone acting on behalf of existing or former patients/clients providing they have obtained the patient's/client's consent;
any appropriate person in respect of a patient/client who has died, e.g. the next of kin or their agent.

1.6 Complaints by a third party should be made with the written consent of the affected individual. Exceptions are if that individual is a child, is incapable, (for example, rendered unconscious due to an accident, judgement impaired by learning disability, mental illness, dementia, or brain injury, serious communication problems) or where the subject of the complaint is deceased.

1.7 Where a person is unable to act for him/herself, his/her consent shall not be required. Where a complaint is made on behalf of an individual, it is good

practice to explain to the person making the complaint that information from an individual's health and social services records may need to be disclosed to those investigating the complaint[1].

1.8 A person with parental responsibilities (e.g. a parent or guardian) can pursue a complaint on behalf of a child. Where the child is of sufficient maturity and understanding[2], they can either pursue a complaint themselves or be expected to consent to the complaint being pursued on their behalf by a parent or other third party. The position should be explained to the child in simple language, with sensitivity given to the child's condition. It may also be a good practice to obtain the child's consent in writing to information being released, where this is possible.

1.9 The complaints officer may refuse to deal with a complaint if he/she decides that the person making the complaint – on behalf of a patient/client who is unable to act for him/herself, or in respect of a patient who has died – is not a suitable person to pursue the complaint. The complaints officer can then arrange for a suitable/acceptable person to act with respect to the complaint. The refusal to deal with a complaint should only be used in circumstances and should not be used indiscriminately. The situation where a person may be deemed to be unsuitable to represent an incapacitated person might include:

where the person has a serious conflict of interest; or
where the person has no legitimate interest in the welfare of the patient/client.

1.10 Staff handling a complaint, which is clearly arising from a patient's mental disorder, should deal with it in a way that does not leave the patient feeling disregarded. It should be remembered that to the patient concerned their complaint is real and valid and that any distress they are experiencing could be increased if he/she believes that their concerns are being minimised by staff. Further guidance is set out in Annex 1D.

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1.11 Complaints may be made to any member of staff, for example receptionists, auxiliaries, nurses and doctors. Staff need to be trained and empowered to deal with complaints on the spot. Front-line staff should seek assistance and advice

[1] Access to Health Records (Northern Ireland) Order 1993

[2] The Protection and Use of Patient and Client Information – Children and young people, paragraph 4.10, HSSE, March 1996

from senior staff as necessary. Senior staff must also ensure that there are procedures in place to use the information gained from these complaints to improve service quality.

1.12 The first responsibility of a recipient of a complaint is to ensure that, where applicable, the patient's/client's immediate health and social care needs are being met before taking action on the complaint. Thereafter, the complainant's concerns should be dealt with rapidly and in an informal, sensitive and confidential manner.

1.13 Some complainants may prefer to make their initial complaint to someone who has not been involved in the care provided. In these circumstances, the complaint should be dealt with by an appropriate senior officer, a patient liaison officer, or the complaints officer. The complaints officer is also available to support and advise front-line staff on the handling of complaints.

1.14 Where a complainant raises a clinical matter, the response should be discussed with the clinician or other relevant professional officer concerned.

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1.15 A complaint should be made as soon as possible after the action giving rise to it, normally within of the event.

1.16 If a complainant was not aware that there was cause for complaint, the complaint should normally be made within of their becoming aware of the cause for complaint, or of the date of the event, whichever is the earlier.

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1.18 If the discretionary extension of the time limit is rejected by the complaints officer then the procedure will be as follows:-

the complainant may complain about the refusal to exercise discretion to waive the time limits;
if the refusal is maintained, the complainant may request the convenor to consider setting up a panel for Independent Review of the complaint about refusal to waive the time limit: the normal requirements as to convening decisions will apply – including a time limit for a convening request;
the convenor may then decide to take no further action; or
to refer the complaint back for Local Resolution; or
to set up a panel to consider a complaint.

1.19 If the convenor decides to refer the complaint about the time limit back to the Trust/Board, the Complaints Officer – or Chief Executive, if it is referred specifically to him/her – should review very carefully the decision not to accept the complaint in the light of the convenor's conclusion that further action through Local Resolution is possible.

1.20 If the Convenor rejects the request, then the complainant has the right to complain to the Commissioner for Complaints.

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1.21 In many cases, complaints are made orally. It is important that front-line staff are trained and confident in dealing with comments and concerns expressed by patients, clients and their relatives. Staff should encourage complainants to speak openly and freely about their concerns and reassure them whatever they say will be treated with appropriate confidence and sensitivity. It may be appropriate for the entire process of local resolution to be conducted orally. The complaints officer, or a patient liaison officer, should be available to support staff in the local resolution of concerns or complaints.

1.22 All oral complaints should receive an honest and objective full response. The response should:

show that the complainant's concerns have been considered;
offer an explanation and an apology, if appropriate;
give an explanation of what further steps can be taken in the complaints process if not satisfied; and
give an indication of remedial action that is to follow.

1.23 Best practice suggests that local resolution should normally be rounded off with a letter. If it is considered that a complaint can be resolved by discussion, then there should be a clear record made of that discussion. If a letter is considered appropriate, it should confirm the oral response given. Trusts should endeavour to issue this letter within five working days from receipt of the complaint. See Summary of Target Timescale.

1.24 d d r d r r r r r d r r r r r r r r r Consideration should be given to collecting data on oral complaints, even when they are not confirmed in writing, so that lessons can be learnt which may help to improve service delivery.

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1.25 A written complaint should be acknowledged within r d This includes complaints that are received orally or by telephone which are considered sufficiently serious or difficult to resolve that they need to be recorded in writing.

1.26 The acknowledgement letter should always thank the complainant for drawing the matter to the attention of the Trust. For example:

"Thank you for bringing this matter to my attention. I understand that you are concerned about …".
"Further to our telephone conversation of … I would like to thank you for bringing this matter relating to … to my attention".

1.27 There should be a statement expressing sympathy or concern over the incident. This is a statement of common courtesy, not an admission of guilt. For example:

"I regret the discomfort experienced …."
"I regret the anxiety this incident has caused you and your family".

1.28 An outline of the proposed course of action to be taken or of investigations being conducted should be included.

1.29 A full investigation of a complaint should normally be completed r d . The complainant must be informed of any delay where this target is not being met.

1.30 All written complaints should receive a written response that is honest, factual, and addresses all the issues raised.

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1.31 The Trust must designate a 'complaints officer', who is readily accessible to the public and front-line staff. The complaints officer's role is to oversee the complaints procedure on behalf of the Chief Executive to whom he/she is accountable.

1.32 The complaints officer should:

deal with complaints referred by front-line staff;
provide support and help staff to respond to complaints;
have access to all the relevant records (including personal medical records) which are essential for the investigation of any complaint referred to him/her;
take account of any corroborative evidence available relating to the complaint, e.g. witness to a particular event;

identify training needs associated with the complaints procedure and ensures that these are met[3];
be aware of the availability of, and advise complainants about, the support available from the health and social services councils (see Annex 1A) or through advocacy (see Annex 1B);
be aware of the role and availability of conciliation services (see Annex 1C);
be aware of the role and availability of the Medical and Dental Defence Union to assist staff.

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1.33 The Chief Executive should 'sign-off' all formal complaints. However, there may be some circumstances (for example a major Trust with multiple sites) where, in the interests of a speedy reply a designated executive director of the Trust undertakes this task on the Chief Executive's behalf. In such circumstances, the arrangements for clinical governance must ensure that the Chief Executive maintains an overview of complainants' concerns and the organisation's ability to deal with those concerns.

1.34 The response should:

address the concerns expressed by the complainant and show that each element has been fully and fairly investigated;
include an apology where things have gone wrong;
report the action taken to prevent a recurrence;
inform the complainant of their right to seek advice from the health and social services councils;
include the right to request an independent review of the complaint within 2 d of the date of the letter if the complainant remains dissatisfied with any aspect of the response, and ask the complainant to clearly state the points on which he/she remains dissatisfied.

[3]Acting, Listening, Improving: A Training Manual on Effective Complaints Handling within the HPSS, HSS Executive, April 1996, under cover of PRSC (PR) 2/96

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Original complaint	6 r *or* 6 r of a cause for complaint, but no longer than 12 months from event: discretion to extend
Local Resolution:	
Verbal complaint	Dealt with on the spot or referred
Acknowledgement	2 r d of receipt unless full response issued within 5 working days
Full response	2 r d of receipt
Apply for Independent Review	2 d r d of the date of response to Local Resolution

A working day is any weekday (Monday to Friday) which is not a local or normal public holiday.

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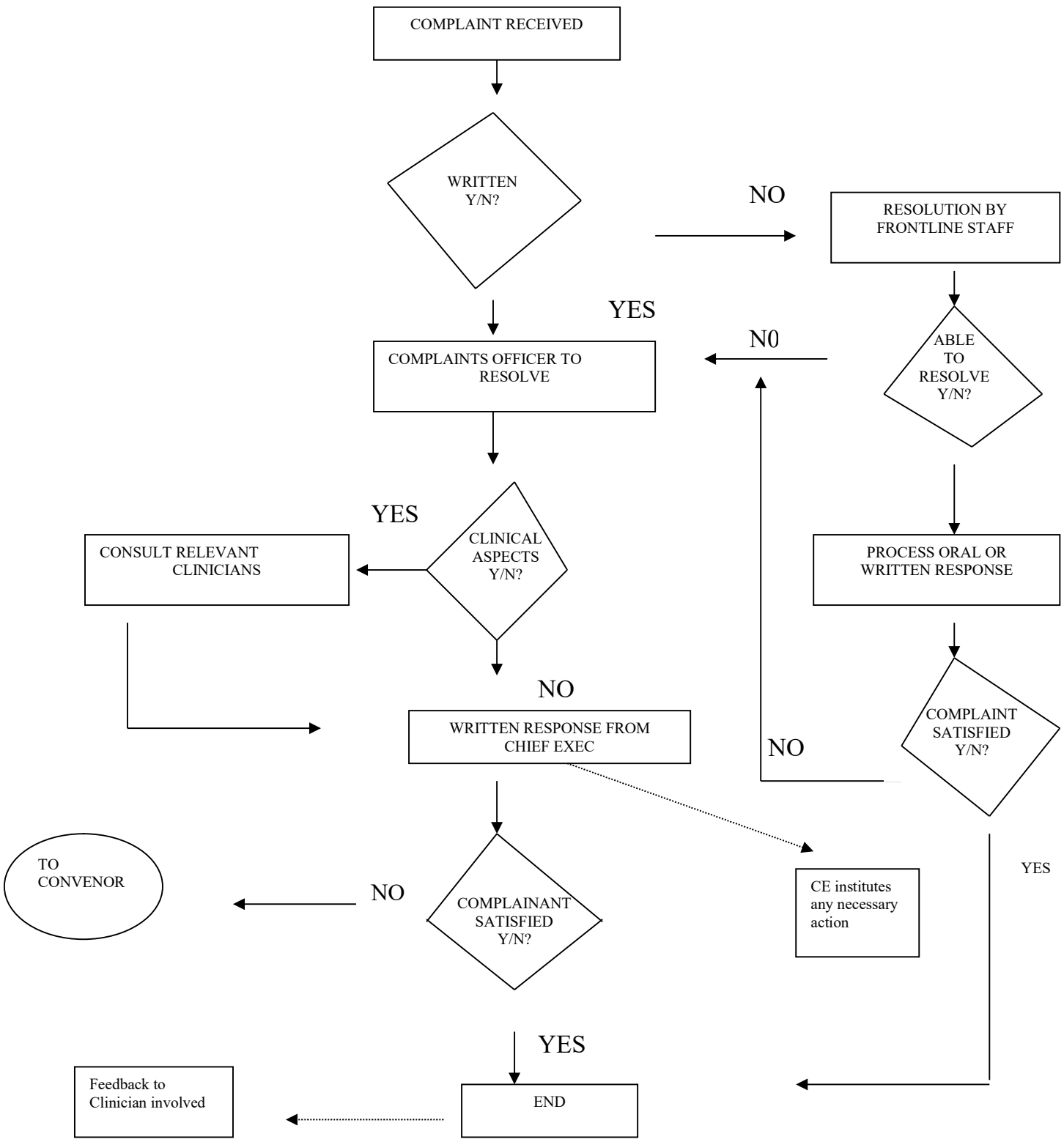

1. Health and social services councils are independent bodies established by statute to represent the public interest in the HPSS.

2. The main duties of the health and social services councils are to:

   monitor the quality of local services;
   represent the public's interest in health and social services issues;
   provide information, advice and support on health and social services issues;
   offer advice, information and help to people who want to complain about a service.

3. If a person feels unable to deal with the complaint alone, the staff of the health and social services councils can offer a wide range of assistance and support at any stage of the complaints procedure. This assistance may take the form of:

   information on the procedure and advice on how to make a complaint;
   help in accessing medical/social services records;
   discussing the substance of the complaint and drafting letters;
   making telephone calls;
   support in preparing for meetings;
   support at meetings and independent reviews;
   referral to other agencies, for example advocacy services;
   preparing a request for an independent review; and
   preparing a complaint to the Commissioner for Complaints.

4. All advice, information and assistance with complaints are provided free of charge and are confidential.

1. Advocacy is recognised as an important way of giving people a stronger voice by helping them to make informed choices about, and to remain in control of, their own health and social care. Advocacy helps people gain access to information they need to understand the options open to them, and to make their views and wishes known.

2. Advocacy is not new. People do it every day for their children, for their elderly or disabled relatives, and for their friends. Concerned individuals do it for people who are particularly vulnerable or undervalue.

3. In the HPSS, advocacy has been available mainly for vulnerable groups, such as people with mental health problems, learning disabilities, and older people (including those with dementia). However, people who are normally confident and articulate can feel less able to cope because of illness, anxiety, and lack of knowledge and be intimated by professional attitudes that may seem paternalistic and authoritarian.

4. Boards and Trusts should encourage the use of advocacy services, including those provided by health and social services councils, to facilitate access to the complaints procedure.

1. Conciliation is a voluntary process that seeks to resolve difficulties by examining and reviewing a complaint with the help of an outside person who is qualified, trained and experienced as a conciliator. Conciliation can be especially useful in resolving difficulties arising from a breakdown in the relationship between a health service professional and his/her patient/client. Boards and Trusts should offer to make a conciliation service available to the staff and the patient/client as early in the complaints resolution process as possible.

2. The aim of conciliation is to enable both parties to address the issues in a non-confrontational manner with the aim of reaching an agreement that both can accept. It is best used at an early stage in the handling of the complaint. The function of the conciliator is to assist the process, Any resolution of the complaint must come from the parties concerned. The conciliator seeks to clarify the issues and to help explore the options. Essentially, the conciliator works to ensure that good communication takes place between the parties.

3. Confidentiality is vital in the conciliation process. The conciliator should encourage the participants to explore the issues involved in the complaint in an open manner. The content of the conciliation process remains confidential and neither the conciliator nor the participants should provide information from the process to any other person. The conciliator should advise the Board/Trust when conciliation has ceased and whether a resolution was reached. No further details should be provided.

4. Conciliation can also be a useful means of resolving complaints where the complainant has requested an independent review but the convenor believes further local resolution would be appropriate, for example where the complaint involves a difficulty in a relationship with a member of staff. Boards should ensure that their induction training for convenors makes them aware of conciliation, its usefulness and limitations, and equips them to consider its use as a means of resolving appropriate complaints.

5. Serving members of health and social services councils are ineligible to take up posts as lay conciliators as there may be conflicting interests involved. It is not recommended that those engaged in advocacy take up posts as conciliators for the reasons outlined above. A helpful introduction to good practice in the use of conciliation is *Conciliation and Mediation in the NHS – a practical guide,* Bob Debell, Radcliffe Medical Press, 1997.

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1. Making a complaint about health and social care can be intimidating, especially for people with mental health problems or learning disabilities. Complainants should not be deterred from using the HPSS complaints procedures because clinical staff believe their complaints to be based on mental disorder.

2. Complaints made by people with learning disabilities, who are not mentally ill, should be treated in exactly the same way as complaints made by other patients. Special care must be taken to help all patients who have difficulties with communication.

3. There should be explicit arrangements for advising and supporting complainants with mental health problems or with learning disabilities. People suffering mental health problems are very vulnerable members of society and care needs to be taken to ensure that this is not an excuse not to investigate legitimate complaints.

4. If a patient makes a complaint during an acute illness, the complaints officer should register the complaint and consider advising the patient that inquiries into it should be delayed until the patient's condition has improved. The complaints officer will want to take medical advice on this matter. When the patient is feeling better, he/she should be asked whether he/she wishes to proceed with the complaint. A delay such as this will need either the agreement of the patient or someone who is able to act on behalf of the patient and who is independent of the complaints officer. The decision about whether a patient is well enough to proceed with the complaint should be made by a muti-disciplinary team, and the complaints officer should refer regularly to this team to establish when this point has been reached.

5. Where the complaints officer believes that a complaint should not be investigated because it appears that it is a manifestation of the patient's mental illness, a full report on the patient's mental state should be sought.

6. If the report confirms the complaints officer's view, a system should be set up whereby the current and any subsequent recurrent complaints are scrutinised by an independent assessor, such as a senior clinician or manager who is entirely independent of the patient's current clinical team. Each episode of complaining should be treated as a fresh complaint.

7. Where a complainant is alleging physical injury, a physical examination should be carried out without delay in each case by medical staff and clearly reported. If a patient refuses a physical examination, or if his or her mental state (for example, degree of agitation) makes this impossible, this should be clearly documented. A further physical examination should be attempted as soon as possible.

8. Very careful consideration must be given to complaints alleging offences that could be reportable to the police, and there should be explicit policies about the arrangements for such reporting. Staff need to be aware that a decision not to report an alleged offence is a serious decision, while the reporting of trivial or clearly delusional matters is unlikely to be in the patient's best interests.

9. Particular attention should be paid to any suggestion of corroboration of the complaint from other patients, visitors, or staff. Such corroboration should be precisely recorded and careful consideration given to its relevance to any decision about delaying investigation of the complaint.

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2.1 Complainants who are dissatisfied with the result of local resolution may request an independent review. This request should be made within d of the date of the letter concluding local resolution. Any request for an independent review received orally or in writing by any member of/or employee of the Trust/Board should be passed to the convenor immediately through the convenor's office. d r
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2.2 HSS Boards are required to appoint one of their non-executive directors as a convenor. The workload in some Boards may require the appointment of more than one convenor and the Board may wish to consider appointing other people to this role who are not employees of the Board but who have received appropriate training. It is suggested that any such appointments are initially short term and, if successful, they can be extended. Appointments should be staggered where more than one convenor is appointed. Any person appointed in this way may carry out the full role of a convenor, including serving on a panel. All such convenors should be indemnified as if they were non-executive directors.

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2.3 The role of the convenor is crucial in deciding whether there should be an independent review. It also provides complainants with an independent and informed view on whether any more can be done to resolve their complaint. The convenor must decide whether to:

refer the complaint back for further local resolution (possibly suggesting that both parties might be offered conciliation);

set up a panel to consider the complaint; or

take no further action.

2.4 r r r r r
r The convenor should be fully apprised of guidance and issues relating to his/her role.

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2.5 Boards should provide any administrative support that the convenor needs. However, it is important that the convenor acts, and is seen to act, independently of the Board. Boards therefore should consider establishing a convenor's office. For further information see Annex 2A.

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2.6 The convenor is responsible for ensuring the complainant's request for an independent review is acknowledged in writing within r d The acknowledgement should:

indicate how the independent review process request will be activated;
request that the complainant or their representative set out their concerns in writing, stating why they are dissatisfied with the outcome of local resolution, if they have not already done so;
indicate how to seek independent help and support from the health and social services councils and/or patient advocacy services.

2.7 The convenor is also responsible for ensuring that:

the complained against is advised in writing as soon as possible of what the complainant has stated are his/her concerns;
a full picture of the events relating to the complaint is obtained, including relevant medical records;
appropriate clinical advice is taken when a complaint relates to the exercise of clinical judgement (see Annex 2B);
the complaint is dealt with impartially;
all opportunities for resolving the complaint during local resolution have been explored and fully exhausted.

2.8. In reaching a decision, the convenor must:

consult an independent review panel lay chairman;
take appropriate clinical or professional advice where the complaint relates in whole or part to action taken in consequence of the exercise of clinical judgement.

This process must be completed within r d of the date of receipt of the complainant's request by the convenor.

2.9 In considering the request for an independent review, the convenor must :

re-run the action taken during local resolution;
investigate or attempt to resolve the complaint on his/her own;
try to defend either those complained against or the complainant.

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2.10 A lay chairman will assist the convenor in making an independent assessment of the complaint. However, deciding whether to establish a panel is the convenor's sole responsibility. The convenor must explain in writing his/her decision to the complainant, and any person alleged in the complaint to have taken any part in the action complained off. (See Annex 2C – role of independent lay chairman.)

2.11 r r r r d r r r r r d Clinical advice initially should be sought from the medical director of the Board, or equivalent professional officer. Where these officers are the subject of the complaint, or where possible conflict of interest arises (for example, if this person has already been involved in the handling of the complaint) then the convenor should seek the advice of an independent professional person. This may be one of the Department's professional officers, or someone from the list of clinical assessors for panels. See Annex 2B.

2.12 d d r r r r d d r r rr d r d r d r d If not, whether further local resolution or a panel would be an appropriate next step. In reaching a view on this, the clinical adviser may need to consider whether appropriate care or treatment was provided. Clinical advice should be given to the convenor in the form of a report passing judgement on the quality or adequacy of the clinical care given to the patient. Clinical advice be restricted to answering the question asked.

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2.13 Where the convenor considers that a complaint relates in whole or in part to action taken in consequence of the exercise of professional social work judgement (i.e. any judgement that is made by a member of the social work profession in the HPSS by virtue of their knowledge and skill, which a layman could not make), he/she must take appropriate professional advice in deciding whether to convene a panel.

2.14 Advice should be sought in the first instance from the Board's Director of Social Services who may in turn suggest someone else who is qualified to advise. Where the Director is the subject of the complaint, or where possible conflict of interest arises, some other appropriate independent opinion should be sought. This may be the Department's Chief Inspector of Social Services, or someone from the list of clinical assessors for panels.

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2.15 After seeking appropriate advice, the convenor must decide whether to:

take no further action;
refer the complaint back for further local resolution (perhaps involving conciliation – see Annex 1C); or
set up a panel to consider the complaint.

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2.17 The convenor may decide that local resolution has been adequately pursued – in that the complaint has been properly investigated and an appropriate explanation given – and that nothing further can be done, even thought the complainant remains dissatisfied. The complainant should be advised in writing of the reason for this decision and informed of their right to put their case directly to the Commissioner for Complaints. See Section 3.

2.18 The letter should refer to the following:

consultation with the independent lay chair;
the fact that clinical advice has been sought where the complaint is of a clinical nature;
each of the complainant's concerns having been fully addressed.

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2.19 Where, having taken any appropriate clinical advice, the convenor feels that local resolution has not adequately addressed a complainant's concerns, the case should be passed back to the service provider for further local consideration, perhaps involving conciliation. The complainant should be informed in writing of the reason for this decision.

2.20 If the complainant remains dissatisfied following the referral he/she may ask the convenor to reconsider whether an independent review panel should be convened.

2.21 When the convenor feels, for whatever reason, that further local resolution would not be appropriate and that there are grounds for the complainant's continued dissatisfaction, he/she may decide to convene an independent review panel. The cost of instituting an independent review panel is not a reason for refusing to convene a panel.

2.22 Convenors should not set up an independent review panel where:

the complainant has stated orally or in writing that he/she intends to pursue a remedy by way of proceeding in a court of law; or
he/she considers there may be a case for a disciplinary investigation. See Section 4 Useful Information.

2.23 In either of these cases, the papers should be referred immediately to the person in the Board who deals with these matters.

2.24 Consideration of whether to set up an independent review panel should follow automatically if disciplinary action is not pursued. Should a complainant decide against proceeding with litigation, they can ask for their request for an independent review to be re-considered.

2.25 The convenor's decision to establish a panel must be given in writing to:

the complainant;
any person alleged in the complaint to have taken any part in the action complained about;
the Chief Executive of the relevant Trust/Board/independent provider;
senor partner for FHS complaints.

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2.26 Having decided to establish a panel, the convenor must define its terms of reference drawing on the complainant's written statement of complaint. Terms of reference set out what the panel is to investigate, for example:

'What information was made available to Mrs X about her husband's condition."
'How was Mr 'X's' discharge from hospital managed.'

2.27 The convenor must inform those listed at para 2.25 and the nominated panel members of the terms of reference. If the complainant disagrees with the terms of reference he/she may ask the convenor to reconsider them. While the convenor's decision is final, the complainant should be advised of their right to take the matter up with the Ombudsman if they remain dissatisfied.

2.28 In order to avoid delay, Boards are advised to give delegated powers to the Chief Executive and an alternate executive director to establish a panel as a committee of the Board as soon as the decision of its convenor becomes known.

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2.29 The Convenors Office is responsible for communicating with, ascertaining availability of, and formally appointing the chosen panel members.

2.30 Independent review panels must be composed of three members:

independent lay chairman (from the Board list);
the convenor (non-executive of the Board or appointed person); and
a third independent lay panel member (from the Board list).

2.31 Where, having taken appropriate clinical advice, the convenor decides that the complaint has clinical elements, the panel must be advised by at least two independent clinical assessors. See Annex 2D. See Annex 2C for Role of Panel Members.

2.32 In considering a complaint from, or on behalf of, a person suffering from mental disorder, the convenor should consider co-opting a member of the Mental Health Commission onto a panel.

2.33 In order to avoid accusations of bias members or officers of health and social services councils will be excluded from panel membership.

2.34 The convenor's office should arrange for panel members and clinical assessors to:

be told the composition of the panel and its assessors;
have indemnity cover. In the most unlikely event of legal proceedings, no financial risk would be taken by the panel member or clinical assessor, assuming they acted in good faith;
have appropriate background and briefing papers.

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2.35 The role of the clinical assessors is to advise the panel, as and when required, on those aspects of the complaint involving clinical judgement having regard to this guidance and the advice of their professional body, e.g. the appropriate Royal College. Ideally, the assessors should provide an agreed report. This report should be in two parts:

a summary report that excludes all personal clinical information relative to the patient/client being examined; and
a confidential annex that incorporates any personal, clinical information that the clinical assessors feel is essential to enable the panel to make sense of the complaint.

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2.37 The role of independent lay chairman is to:

provide independent advice and support during the convening period;
chair panels when established;
promptly issue the report of the panel.

2.38 The responsibility for leading the organisation of the panel's business rests with its chairman. See Annex 2C.

2.39 The panel is established to:

consider a complaint whose terms of reference have been clearly defined;
investigate the facts of the case, taking into account all the evidence;
investigate the complainant's concerns in a conciliatory way;
provide a written report setting out its conclusions with appropriate comments and suggestions.

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2.40 The Chairman, I consultation with the other members of the panel, will decide how to consider the complaint keeping in mind the Directions and this guidance. However, the general rules of conduct for the panel are:

the process should be informal, flexible, and not confrontational, adversarial, legalistic or tribunal-like;
its proceedings must be held in private;
it has a right of access to all the records relating to the handling of the complaint;
it must be able to see the relevant parts of the patient's health or social services records when dealing with a clinical/social services complaint;
the complainant, and any person complained against, must have a reasonable opportunity to express their views;
advice may be taken from appropriately appointed assessors if the complaint is a clinical one;
the complainant, the complained against or any other person invited to give information to the panel, may be accompanied by a person or persons of

their choosing to provide support, for example a friend, relative or health and social services council representative;
if the person supporting the complainant or the complained against has a legal background or qualification he/she cannot act in a legal capacity;
only with the approval of the chairman may those accompanying the complainant and the complained against contribute to the panel's proceedings;
the needs of the complainant, including the specific needs of those from ethnic minority communities and those with physical and other disabilities, should be considered fully. For example, people with mental health problems may find it hard to concentrate and require regular breaks from the proceedings;
reasonable records of the panel's proceedings should be kept to facilitate the preparation of its report. Tape recording panel proceedings or using stenographic or shorthand notewriters to provide a verbatim record of the discussion is not recommended.

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2.41 The panel chairman may find it appropriate to meet the complainant as a way of rounding off resolution of the complaint. This may be particularly helpful in a complex case to ensure that the two parties understand the outcomes. If the complaint relates to clinical matters, at least one assessor should be present to give a personal explanation to the complainant of any clinical findings. Where there are assessors from different disciplines, each should be present.

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2.42 At the conclusion of the panel's work, a report will be produced. The chairman is responsible for issuing the report within the target timescale of r d from the date of the formal appointment of the panel and assessors. The Chairman may delegate the writing of sections of the draft to panel members and, subsequently, edit the report into a final draft. r r r r r r

2.43 The panel should provide the complainant and the complained against with the opportunity to check its draft report (which might not include the final conclusions of the panel) for factual accuracy within, say, a period of r d before it is formally issued in its final form. The assessors' report should be made available in time, for its circulation with the panel's draft. Those receiving the draft should be reminded that the report is confidential to them and the panel members.

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2.44 There is no right or wrong way of framing and structuring a panel report. The report of the panel include:

findings of fact relevant to the complaint;
the opinion of the panel on the complaint, having regard to the findings of fact;
the reasons for the panel's opinion;
the report of the assessors and
where the panel disagree with any matter included in the report of the assessors, the reason for its disagreement.

2.45 The panel may include in its report:

action the service provider might take to satisfy the complainant and suggestions arising from its investigation that it considers would improve the services provided or the provider's efficiency and effectiveness.

2.46 r r d r r d r

2.47 r r d r r r d r r r r r r d r r d r Panel chairs should judge each case on its own merits. In exceptional cases, the chairman may decide that the complainant should not see the full report. This may be because the chairman considers that it would be detrimental to the complainant's health. Or because the chairman judges it to contain information by or about a third party which, if the complainant was allowed to see it, would constitute a breach of confidentiality (for further guidance see Section 4, Useful Information).

2.48 For further good practice on Report Structure, see Annex 2E.

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2.49 Unless the chairman decides otherwise, the panel's final report, including the assessors' summary report and the confidential annex, should be sent to the:

complainant;
patient/client, if a different person from the complainant and alive and competent to receive it;
panel members;
complained against;
clinical assessors.

2.50 Unless the chairman decides otherwise, the panel's final report including the assessor's summary report, d , will have a restricted circulation. It should be sent to:

any person interviewed by the panel (other than the complainant or the complained against);
the Trust/Board Chairman and Chief Executive;
the senior partner in the case of FHS complaints;
the Chairman and Chief Executive of the independent provider, where the complaint involves services provided by the independent sector and
the service commissioner.

2.51 The panel shall not send the report to any other person or body. The complainant may wish to show the report to a representative of the health and social services council or other appropriate adviser.

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2.52 Following receipt of the panel's report, the Trust Chief Executive/Independent Provider Chief Executive may need to show the report, or sections of it, to his/her board so that it can consider the action needed to implement its recommendation(s). Any such arrangement must protect the overall confidentiality of the report.

2.53 The Chief Executive is responsible for ensuring the board's decisions are communicated quickly and clearly to the complainant. The Chief Executive or a designated senior Director (see para 1.29) should send a letter to the complainant, within r d from the receipt of the panel's report. This should inform the complainant of:

any matters such as a formal apology or approval of an ex-gratia payment;
action being taken as a result of the panel's deliberations and an indication of the timescale for its implementation;
his/her right to refer the complaint to the Commissioner for Complaints.

2.54 The issue of this letter completes the HPSS complaints process. If, following this action, the board takes further decisions relating to the outcome of the case, then the complainant should be informed by the Chief Executive.

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2.55 The panel and its assessors should be provided with appropriate administrative support.

2.56 The Board establishing the panel will meet all the expenses arising out of the independent review process, including any allowances paid to panel members and

any payments and expenses paid to assessors. Assessors who find it more convenient to make their own arrangements for, say, typing their reports, will need to agree a rate of payment with the Board in advance.

2.57 The Board should speak to assessors to estimate the likely time commitment in individual cases before work begins and, where appropriate, to authorise additional work. Payment will be for work done (ie there is no four day minimum payment). While the amount to be paid in an individual case is a matter for local decision, it would be understandable if assessors were not willing to contract for less than half a day.

2.58 Panel members, including convenors, are eligible for travel expenses and subsistence and loss of earnings allowances[4]. Boards should indicate in appointment letters that the particular panel chairman and the third panel member will be appropriately indemnified.

[4] Current rates are set out in HSS Executive circular PRSC (PR) 1/96

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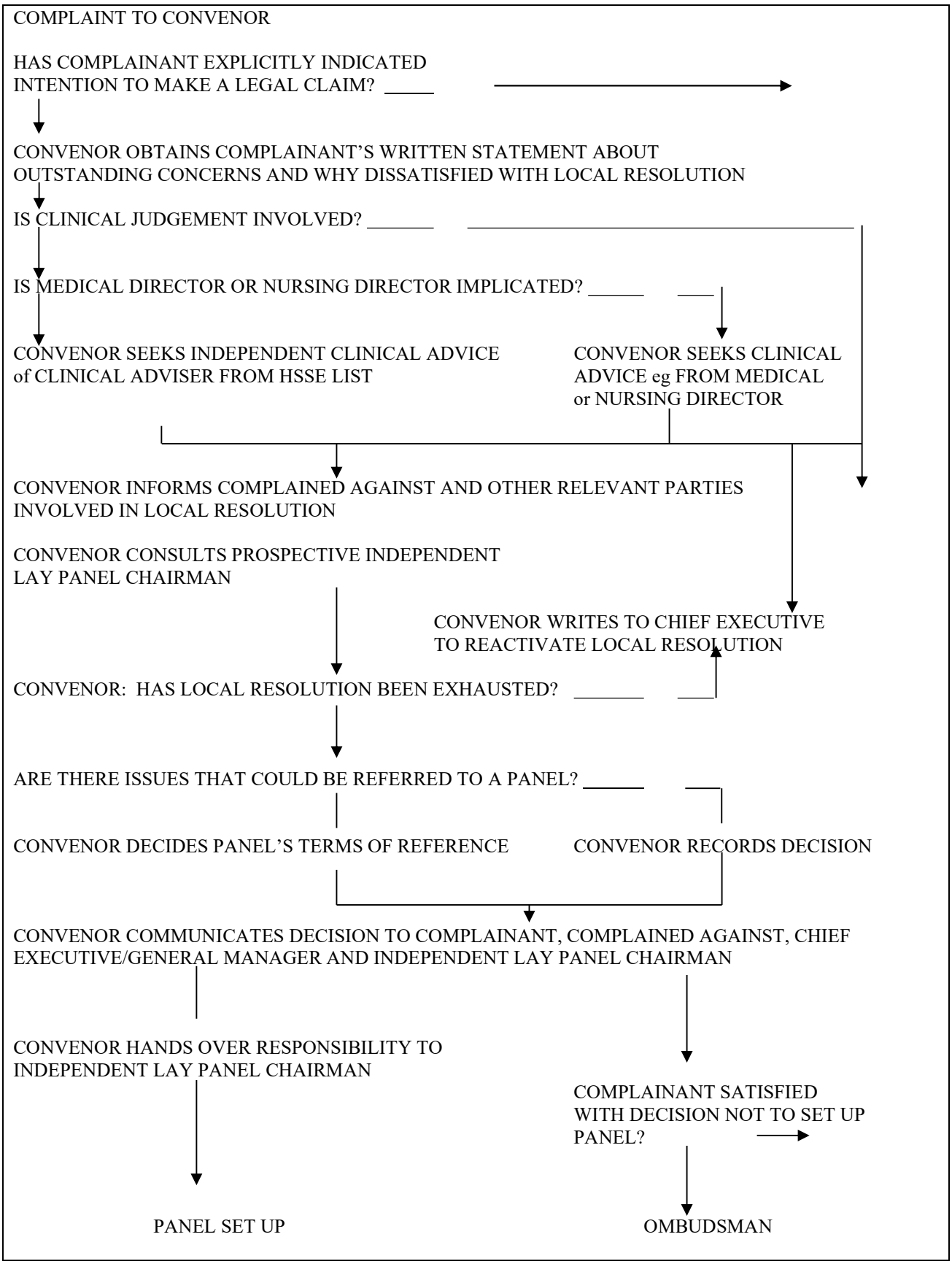
	M
Acknowledgement by convenor of request for independent review	2 r d of receipt
Decision by convenor to set up panel, or not	2 r d of receipt of request
Appointment of panel members	2 r d of decision by convenor to establish a panel
Draft report of panel	5 r d of formal appointment of panel and assessors
Final report of panel	1 r r r d
Response to complainant by Trust	2 r d of receipt of panel's report

MM


COMPLAINT TO CONVENOR
HAS COMPLAINANT EXPLICITLY INDICATED INTENTION TO MAKE A LEGAL CLAIM?
CONVENOR OBTAINS COMPLAINANT'S WRITTEN STATEMENT ABOUT OUTSTANDING CONCERNS AND WHY DISSATISFIED WITH LOCAL RESOLUTION
IS CLINICAL JUDGEMENT INVOLVED?
IS MEDICAL DIRECTOR OR NURSING DIRECTOR IMPLICATED?
CONVENOR SEEKS INDEPENDENT CLINICAL ADVICE of CLINICAL ADVISER FROM HSSE LIST
CONVENOR SEEKS CLINICAL ADVICE eg FROM MEDICAL or NURSING DIRECTOR
CONVENOR INFORMS COMPLAINED AGAINST AND OTHER RELEVANT PARTIES INVOLVED IN LOCAL RESOLUTION
CONVENOR CONSULTS PROSPECTIVE INDEPENDENT LAY PANEL CHAIRMAN
CONVENOR WRITES TO CHIEF EXECUTIVE TO REACTIVATE LOCAL RESOLUTION
CONVENOR: HAS LOCAL RESOLUTION BEEN EXHAUSTED?
ARE THERE ISSUES THAT COULD BE REFERRED TO A PANEL?
CONVENOR DECIDES PANEL'S TERMS OF REFERENCE
CONVENOR RECORDS DECISION
CONVENOR COMMUNICATES DECISION TO COMPLAINANT, COMPLAINED AGAINST, CHIEF EXECUTIVE/GENERAL MANAGER AND INDEPENDENT LAY PANEL CHAIRMAN
CONVENOR HANDS OVER RESPONSIBILITY TO INDEPENDENT LAY PANEL CHAIRMAN
COMPLAINANT SATISFIED WITH DECISION NOT TO SET UP PANEL?
PANEL SET UP
OMBUDSMAN

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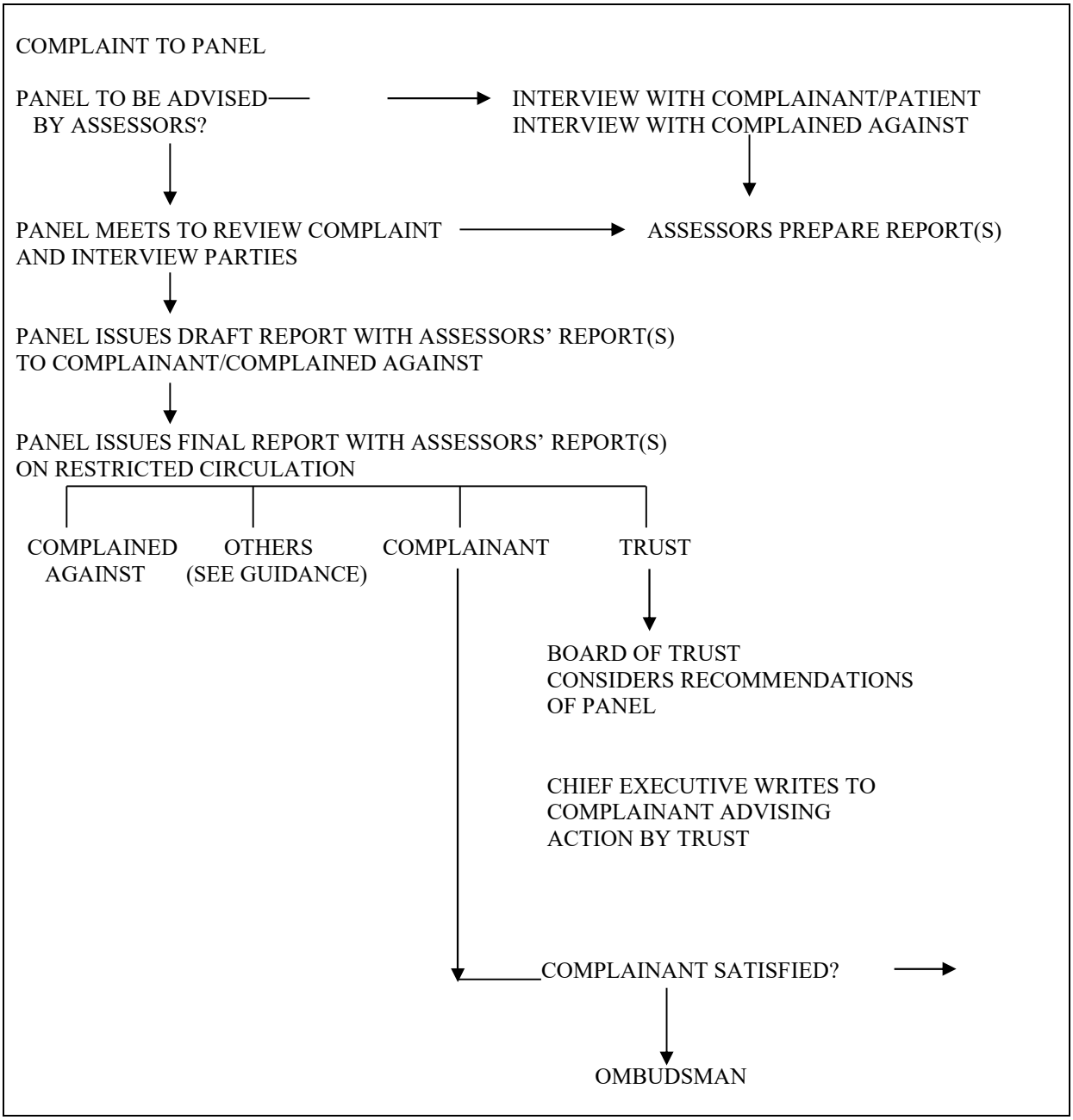
MM



1. It is important that the convenor acts, and is seen to act, independently of the Board. The office therefore should use its own letterhead paper headed 'Office of the Independent Lay Convenor'. The use of a PO Box address may reinforce independence of the convenor. A senior member of staff should manage the convenor's office.

2. Responsibility for the following action rests with the convenor supported by administrative staff as appropriate.

3. The convenor should:

acknowledge the oral or written request for an independent review within 2 working days;
ask the complainant to provide a written statement of why he/she remains dissatisfied, if not already provided;
immediately obtain the name of a person held on the list of independent lay panel chairmen;
call for all papers and documents relating to the local resolution;
advise anyone who is complained against;
advise the complainant that help is available from the health and social services council or other source of patients' support;
seek appropriate independent clinical advice where there is a clinical element to the complaint;
consult an independent lay panel chairman, and decide whether or not a panel should be set up; and
liaise with other convenors if the complaint involves more than one body.

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4. The following must be informed in writing of the reasons for the decision, and whether local resolution should be reactivated:

the complainant, who should be advised of the right to approach the Ombudsman;
the Trust Chief Executive/senior FHS partner/Independent Provider Chief Executive;
any person who is complained against;
the independent lay panel chairman, and anyone else who was consulted.

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5. The following must be informed in writing of the decision, the agreed terms of reference for the panel, any issues excluded from its consideration and why, and when the panel is likely to be set up:

the complainant;
any person who is complained against;
the independent lay panel chairman consulted;
the Trust Chief Executive/Senior FHS partner/independent provider Chief Executive.

6. The Board should provide:

the lay panel chairman;
the third panel member;
the names of clinical assessors required to assist the panel.

7. The convenor's office should:

formally appoint clinical assessors;
provide the panel members and the clinical assessors with all necessary papers, including the complainant's written statement of concern;
provide indemnity cover for the panel and its assessors;
inform the complainant of the names of the appointed panel members and assessors.

1. Convenors are reminded of the need to obtain appropriate clinical advice when necessary. Such d d r r r r d d r rr d r d r d r d d r r r r r r d r r

2. At the convening stage, the clinical adviser is being asked for their opinion on whether the clinical aspects of the complaint have been fully and fairly addressed at local resolution. They are not being asked to give an opinion on, or a report on the clinical aspects of the care. This is the clinical assessor's task whenever a panel is convened.

3. there will be cases where the clinical adviser needs to form an opinion on the clinical care given, but this should only be used to give advice on whether the clinical aspects of the case have been fully and fairly addressed at local resolution. Any opinion on the clinical care received should be passed to the convenor.

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1. Boards are responsible for putting in place arrangements for holding lists of independent chairmen and lay panel members. Boards must organise access to and training of chairmen and panel members.[5]

2. Boards should assist each other in finding an appropriate chairman and panel members where circumstances demand a wider trawl. Boards should organise the allocation of chairmen and members in a balanced independent way, so that no one person becomes regularly linked with a particular Trust or particular type of complaint.

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3. At the convening stage, the lay chairman should:

   provide the convenor with support and advice; and
   keep a record of the part he/she played at this stage.

4. When appointed to a panel, the lay chairman, with appropriate administrative support, will be responsible for ensuring that:

   all panel members have a clear understanding of the panel's terms of reference;
   arranging and chairing all meetings of the panel;
   ensuring that members and assessors have all necessary documents;
   ensuring reasonable records of the panel proceedings are kept.

5. The Chairman is responsible, in consultation with the other panel members, for:

   deciding how the panel will conduct its business;
   arranging meetings with the complainant and complained against and ensuring that, if appropriate, at least one assessor is present;
   discussing the required format of their report with assessors;
   leading the panel in drafting its report.
   setting out the agreed conclusions and finings; and any comments recommendations; and
   ensuring no recommendation relates to disciplinary matters;

[5] Independent Review – A Training and Information Pack for Independent Review Panel Members. HSS Executive, 1996

circulating the draft report to the complainant and complained against to check factual accuracy.

6. The Chairman is responsible for finalising the report and ensuring the final report (including the clinical assessors' summary report and the confidential annex) is sent to:

the complainant;
the patient/client if a different person from the complainant and alive and competent to receive it;
the complained against;
the panel members;
the clinical assessors.

7. A copy of the final report, (including the assessors' summary report but not the confidential annex) should also be sent to:

any person named in the complaint;
any person interviewed by the panel at the Chairman's discretion;
the Trust/Board Chairman and Chief Executive;
senior FHS partner;
the Chairman and Chief Executive of the independent provider where the complaint is about services provided by the independent sector;
Service commissioner.

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9. A sample checklist that may help chairmen to 'sign-off' the final report is given at Annex 2F.

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10. The third panel member must:

seek to resolve the complaint in a fair and impartial manner;
work under the terms of reference laid down for the panel;
consider the information gleaned form reports and interviews in a fair and unbiased way;
consider the assessors' advice on clinical matters;
contribute to the development of appropriate ways of working to gain information from interviewees;
contribute with the other panel members to the completion of the report.

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1. Where the complaint is wholly or partly related to clinical matters, independent review panels must be advised by at least two independent clinical assessors on relevant matters. Assessors are not formally part of the panel; their role is to advise on clinical issues and, wherever possible, make a joint report, to the panel. The assessors should decide, I consultation with the panel, how to exercise their responsibilities having regard to guidance issued by the Department and their professional bodies. Assessors should not act independently to resolve a complaint.

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2. On receipt of a request for assessors to advise a panel, the Board should take advice from the professional body on the selection of appropriate assessors from the list held centrally by the Department.

3. Where a complaint raises issues about more than one medical discipline or health and social care profession, at least one assessor from each relevant discipline or profession should be appointed to advise the panel. In cases where only one discipline is under scrutiny, two assessors should be appointed from that discipline. In some cases it may be appropriate for there to be more than two assessors and it will be for the panel chairman to make this decision.

4. The Department holds the UK-wide lists of assessors for all types of complaints. Professional organisations are involved in ensuring lists are kept up to date.

5. Clinical assessors for hospital and community health and social services should be selected from outside the Board area. The Board's convenor's office will check availability and issue a formal letter of appointment, provide indemnity cover and copies of all necessary documents.

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6. One assessor in each discipline must be present when the panel, or a member delegated by it, interviews either or both of the parties about matters of clinical judgement.

7. The assessors must have access to all of the patient's/client's health or social services records relating to the handling of the complaint held by the Trust. They will need to acquaint themselves with any circumstances where the patient/client

might have been denied access to information in the record, or where the patient/client might have been denied access to information in the record, or where the patient/client has expressed the wish for information to be withheld from other parties.

8. The assessors may interview the patient/client who is the subject of the complaint with their consent. The patient/client may have someone of their choosing present. These interviews may be held before the day the panel is due to meet or on the same day. The Assessors may also interview any person complied against, who may also have a person of their choosing present. Assessors must take care not to break any third-party confidence. Assessors should not normally explain their findings to either the patient/client or complainant before advising the panel of their views.

9. Where a patient's/client's health or social services record is no longer in the possession of the complained against, the Trust or FHS practitioner should make every effort to provide them with access to it for the purpose of framing a response.

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10. The assessors' report/s should be divided into two parts:

a summary report that excludes all personal clinical information relative to the patient/client being examined; and
a confidential annex that incorporates any personal, clinical information that the clinical assessors feel is essential to enable the panel to make sense of the complaint.

11. The assessors' summary report will be attached to the panel's final report when it is issued. d d
d d

12. The assessors' report should not be made available to the complainant or the complained against before it is made available to panel members. The panel may decide, in consultation with the assessors, to release the report to the complainant and the complained against if they believe this might aid resolution of the complaint. Otherwise the assessors' report will only be made available to them when the panel's draft report is issued for checking its factual accuracy.

13. Assessors should remember that their report may be made available at a later date to other than panel members and ensure that neither it, nor the confidential annex contains information that might cause serious harm to the physical or mental health of the patient/client or of any individual. They should also ensure that it does not contain information about, or provided by a third party (other than a

health professional involved in the patient's care) who could be identified from that information, unless he/she has consented to such a disclosure.

14. d r r r r d d r r d r r r r d

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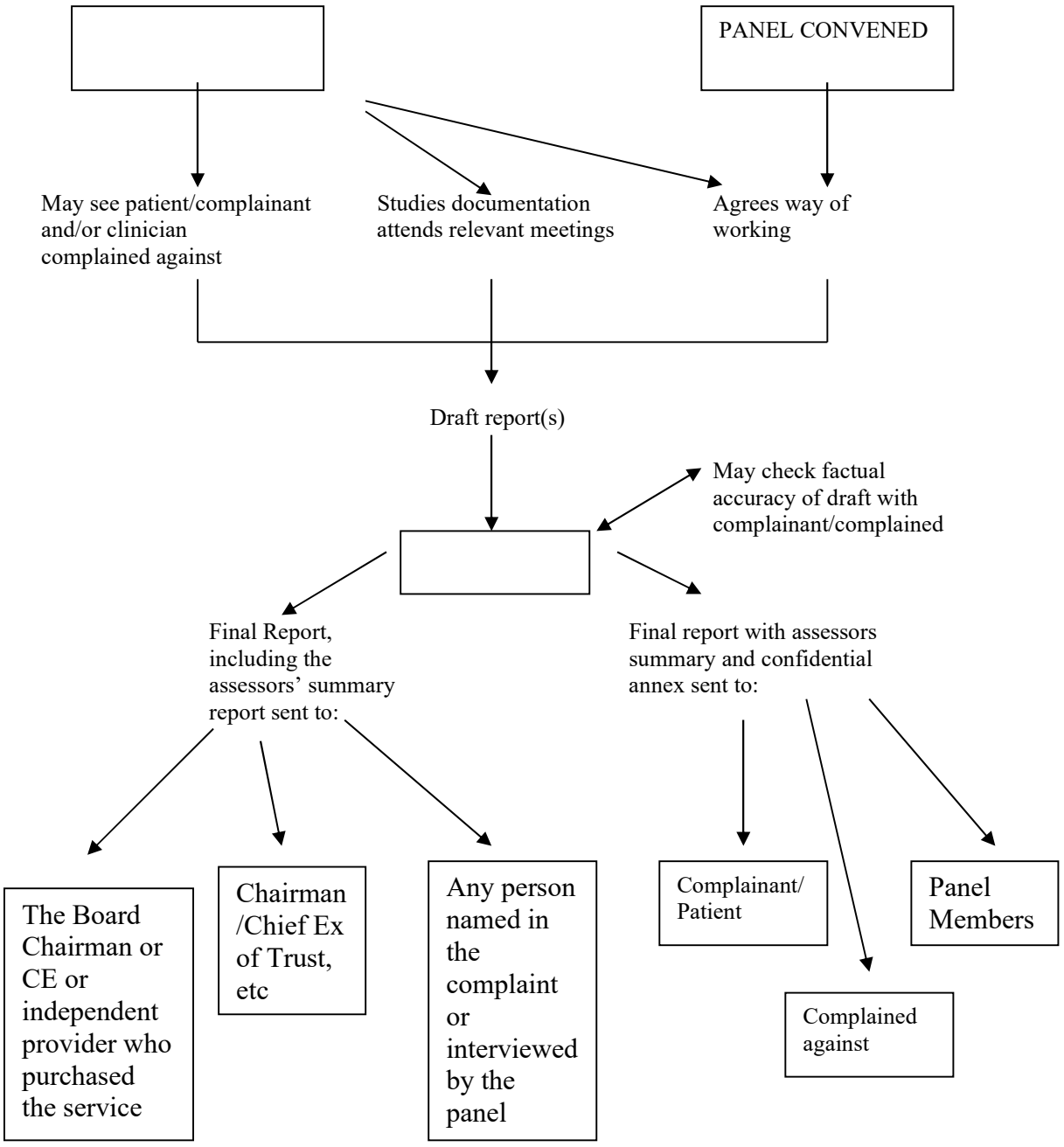

1. There is no right or wrong way of framing and structuring the panel report. However, experience suggests the report should:

   address each issue in the terms of reference;
   include a brief summary of the background, identifying the complaints considered. It is not necessary to include a case history;
   summarise all the oral evidence given to the panel for each aspect of the complaint, referring, as necessary, to documentary evidence from the contemporaneous records and from correspondence or other sources;
   explain the findings for each aspect of the complaint clearly;
   consider whether any matters could have been handled better and whether a recommendation would be appropriate; (Recommendations should not relate to issues of a disciplinary nature.)
   provide clear explanations of meaning if it is necessary to use abbreviations and HPSS terminology;
   be short and focused on the main concerns of the complainant;
   be circulated to the complainant and complained against in its draft form to check for factual accuracy.

2. When circulating the draft report:

   fourteen days can be considered a reasonable consultation period;
   remind those receiving the draft that the report is confidential to them and the panel members;
   ask the complainant, and anyone complained against, to inform the panel, if he/she wishes to consult on the content of the draft report with an adviser who has not been previously involved in the complaint, eg the health and social services council.

3. The panel may decide to feed the report back in person to the complainant and complained against.

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r ***covers points which the guidance[1] and directions[2] stipulate must be covered.***

Tick for Yes

1. Does the report include all relevant findings of fact? ☐
2. Has the panel expressed its opinion with regard to the facts? ☐
3. Has the panel given reasons for its opinions? ☐
4. If the complaint is clinical, is the assessors' report appended? ☐
5. If the panel disagrees with the assessors have they given reasons? ☐
6. The report must not suggest disciplinary proceedings against anyone. Has it complied with this? ☐

r r ***covers points, which the guidance suggests, may be included in the report but which are not compulsory.***

7. Does the report include suggestions on ways to improve services? ☐
8. Does the report include suggestions on ways to improve efficiency/effectiveness? ☐
9. Does the report suggest action which the HSS Trust/Board/FHS practitioner/independent provider might take to satisfy the complainant? ☐

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1 *Complaints – Listening…Acting …Improving: Guidance on implementation of the HPSS Complaints Procedure*
issued 25 March 1996 under cover of HSSE circular PRSC (PR) 1/96.

2 The HPSS Complaints Procedures Directions (NI) 1996
- articles 25(1)(b) assessors' report, 27 (1-5) report of panel;

Miscellaneous Complaints Procedures Directions (NI) 1996
- articles 26(1)(b) assessors' report, 28 (1-5) report of panel;

The HPSS (Special Agencies) Complaints Procedures Directions (NI) 1996
- articles 25(1)(b) assessors' report, 27 (1-5) report of panel;

Directions to HSS Boards for Dealing with Complaints about FHS Practitioners
- articles 32(1)(b) assessors' report, 34 (1-5) report of panel;

d r ***covers general points of good practice.***

10.	Is the report dated?	☐
11.	Is it signed?	☐
12.	Are the names and status of panel members given? (eg: chairman, convenor, independent lay member)?	☐
13.	Is there information on the qualifications and speciality of each assessor?	☐
14.	Does the report make clear what use the panel has made of the assessors' advice?	☐
15.	Is clinical evidence presented so that a lay person can understand it?	☐
16.	Does the report contain the necessary background information to make sense of the complaint?	☐
17.	Are the terms of reference (TOR) stated clearly at the beginning of the report?	☐
18.	Does it say whether the TOR was agreed with the complainant?	☐
19.	Have all the terms of reference been fully addressed in the report?	☐
20.	Does the report include information on how the review was conducted?	☐
21.	Does it say who gave oral and/or written evidence?	☐
22.	If the complaint is clinical, have all relevant clinicians given evidence?	☐
23.	Does the report refer to all the oral and documentary evidence needed to support the findings of fact and opinions?	☐
24.	Is it clear in the report which type of evidence is being referred to (eg: oral/written)?	☐
25.	If suggestions/recommendations are given, are they clear and unambiguous?	☐
26.	Do they follow logically from the findings?	☐
27.	Does the report say whether the complainant saw all or part of the report in draft?	☐
28.	Is the report factually accurate?	☐

29.	Have the assessors provided a written report as required to under the directions?	☐
30.	Is it dated?	☐
31.	Is it signed?	☐
32.	Are the assessors' qualifications given?	☐
33.	Do the assessors have appropriate qualifications/experience?	☐

34. Is it clear on what issues the assessors were asked to advise? ☐

35. Is it clear what written or oral evidence they had in giving their advice? ☐

36. Does the assessors' report express the views of both/all assessors? ☐

37. If the assessors reported separately, are both reports attached?

38. If a joint report, is it clear where they agree and/or disagree? ☐

39. Does the report explain clinical terms? ☐

40. Does it reach clear conclusions supported by evidence/expert opinion? ☐

The guidance says that the panel <u>may</u> circulate the draft report so that it can be checked for factual accuracy. Circulation should be <u>restricted</u> to those who <u>need</u> to see it.

41. Was the draft report circulated to:

    (a) the complainant? ☐

    (b) any person complained against? ☐

42. Was the assessors' report issued with the draft report? ☐

See question 47 for reports about FHS practitioners.

43. Was the report issued to:

    (a) the complainant? ☐

    (b) the patient/client, if he/she is not the complainant? ☐

    (c) the person subject to the complaint? ☐

    (d) anyone else who was interviewed by the panel (*only where appropriate – see 46a)*? ☐

    (e) the assessors (*only where appropriate – see 46b)*? ☐

    (f) the Chairman of the HSS Trust/Board? ☐

    (g) the Chief Executive of the HSS Trust/Board/independent provider/FHS practitioner? ☐

d r ***chairs have the right to withhold any part of the report where it is necessary to protect a person's confidentiality or health and welfare.***

44. In order to protect confidentiality was the report/part of the report withheld from:

    (a) a relevant person? ☐

    (b) any third party? ☐

45. Was the report/part of the report withheld to protect the health and social welfare of:

(a) the complainant? ☐

(b) a relevant person? ☐

(c) a third party? ☐

r r r ***in order to protect confidentiality, chairs have discretion to only send extracts from the report to interested parties. This could include sections referring to named individuals, .i.e interviewees, while assessors may only need to see the summary of findings and recommendations.***

46. Were relevant extracts (*where appropriate)* sent to:

(a) anyone else who was interviewed by the panel? ☐

(b) the assessors? ☐

r r ***the guidance and FHS directions outline arrangements for issuing reports about FHS practitioners. Chairs must make any circulation requirements clear to HSS Board CEs when issuing the final report on a FHS complaint. See also questions 47-49 on protecting confidentiality.***

47. Was the report issued to the Chief Executive of the HSS Board? ☐

48. Was the Chief Executive instructed to forward the report, as required, to:

(a) the complainant? ☐

(b) the FHS practitioner complained about? ☐

(c) any person who is not a participant but who was interviewed by the panel (*only where appropriate – see 46a*)? ☐

(d) the patient if he/she is not the complainant? ☐

(e) the assessors (*only where appropriate – see 46b)*? ☐

(f) the chairman of the HSS Board? ☐

r r ***chairs must ensure that complainants are aware of their right to contact the NI Commissioner for Complaints.***

49. Did the copy sent to the complainant include a notice explaining their right to approach the Commissioner for Complaints if they are not content with the outcome of the review? ☐

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The Ombudsman's Jurisdiction

What can the Ombudsman investigate?

Is there anything the Ombudsman can't investigate?

What can the Ombudsman do for the complainant?

The Ombudsman's Initial Investigation

Good Practice for Trusts

Professional Advisers

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3.1 The Ombudsman deals with complaints from people who claim to have suffered injustice because of maladministration by government departments and public bodies in Northern Ireland.

3.2 The Northern Ireland Ombudsman's Office was established in 1969. Current powers and responsibilities are laid down in the Ombudsman (Northern Ireland) Order 1996 and the Commissioner for Complaints (Northern Ireland) Order 1996. From 1 December 1997 these powers were extended, by the Commissioner for Complaints (Amendment) (Northern Ireland) Order 1997, to include all complaints by, or on behalf of, HPSS patients.

3.3 The legislation, for the first time, brought within the Ombudsman's jurisdiction complaints about:

HPSS services provided by primary care services practitioners, their staff, or their deputy or locums;

actions taken wholly or partly as the result of the exercise of clinical judgement.

3.4 The legislation also made other changes:

to clarify the Ombudsman's powers to investigate complaints about independent sector providers where they have contracted to provide HPSS services;

to give staff employed by Trusts, Boards, FHS practitioners; independent providers and those working for them, a right to complain to the Ombudsman if they consider that they have suffered injustice as a result of complaints procedures operated by HPSS bodies. Staff would be expected to have gone through established local grievance procedures before approaching the Ombudsman.

3.5 The legislation allows the Ombudsman to pass information discovered in the course of an investigation to a professional regulatory body (for example, the General Medical Council) and/or to an employing authority, if he believes that to be necessary to protect the health or safety of patients or the public.

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3.6 The Ombudsman can consider complaints from people who claim to have suffered injustice because of maladministration by any body within the Ombudsman's jurisdiction.

3.7 The term 'maladministration' is not defined in the Ombudsman's legislation but is taken to mean poor administration or the wrong application of rules. Some examples, which the Ombudsman may regard as maladministration, include:

avoidable delay;
faulty procedures or failing to follow correct procedures;
not telling complainants about any rights of appeal they have;
unfairness, bias or prejudice;
giving advice which is misleading or inadequate;
refusing to answer reasonable questions;
discourtesy and failure to apologise properly for errors;
mistakes in handling claims;
not offering an adequate remedy where one is due.

3.8 The main stages at which complaints may be made to the Ombudsman are where:

the responsible HPSS body, primary care services practitioner, or independent provider, has refused to investigate a complaint because it fell outside the HPSS time limits, and the relevant convenor has upheld that decision;

a complainant is dissatisfied following local resolution and the convenor has refused his request for an independent review;

the complainant is dissatisfied with the process or the outcome of the independent review.

3.9 Where a complaint falls into one or other of the first two of these categories, the Ombudsman may, if he considers the complaint warrants it, recommend that the decision of the convenor should be reconsidered, in preference to an Ombudsman investigation of the substance of the original complaint. This reflects the Ombudsman's view that the HPSS complaints procedure should be fully exhausted before he investigates, and that such investigations should be a local HPSS responsible wherever possible. Similarly, when a complaint falls into the third category, he may recommend that the panel reconsider it, or that a fresh panel is set up.

3.10 When the Ombudsman decides to investigate a complaint, HPSS Trusts and Boards should appoint a liaison officer who has suitable seniority and authority. The Ombudsman provides advice on the functions of liaison officers when a Statement of Complaint is sent to the Trust/Board.

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3.11 The Ombudsman generally will not investigate a complaint if:

the action complained of took place more than 12 months ago;
a person can appeal to a tribunal;
a person could go to court;
the organisation has not done anything wrong;
it is about government policy or the content of legislation; or
the Ombudsman thinks the action or decision being complained about is reasonable.

3.12 A number of the decisions taken by government and public bodies are left to the discretion of the individual body, ie the decision is one which depends on the judgement of the decision maker(s) rather than, for example, on satisfying any stated conditions. The Ombudsman can only investigate such a discretionary decision if there is evidence that there has been maladministration in the way the decision is made, or if the decision is clearly unreasonable.

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3.13 Following an investigation, the Ombudsman may conclude that a complaint was wholly or partly justified, or that it was not justified. If it is found that the complain it justified, the Ombudsman can recommend that the body complained about should provide a remedy. Although the Ombudsman has no power to enforce the recommendations the bodies almost always accept them. Where a recommendation is made under the Commissioner for Complaints legislation, the complainant may seek damages in the County Court if a public body fails to provide the recommended remedy.

3.14 It is not the Ombudsman's role to obtain compensation for individuals. However, if it is decided that a person has suffered because of something an organisation done wrong, the Ombudsman will try to get the organisation to put the person in the position he/she would have been if they had been treated fairly in the first place. This may involve recommending a consolatory payment, but often the Ombudsman may consider that an apology is sufficient and will also tell the organisation to improve its procedures so that no-one else suffers in the same way.

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3.15 In deciding whether to investigate a complaint the Ombudsman will have access to all papers relating to any local resolution and independent review investigations. Where a case has been the subject of an independent review, these papers will include the report of the panel and the associated independent assessors' reports. In deciding whether to take on a case, the Ombudsman will wish to satisfy himself that there are sufficient grounds for an investigation by him. He will obtain independent professional advice as necessary to help him with cases involving clinical issues.

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3.16 The possibility of an investigation by the Ombudsman reinforces the need to ensure that complainants are always given clear and specific reasons why any request for local resolution or independent review is not accepted. Panel reports and subsequent letters from Chief Executives to complainants about the action to be taken, should clearly address the concerns of the complainants. Similarly, where complaints are not upheld following local resolution or independent review, there should always be well-reasoned explanations, demonstrably grounded wherever possible, on verified facts. Where action is being taken, for example to change procedures or improve services, the complainant should always receive a specific indication of what those are.

3.17 Trusts/Boards should ensure that appropriate references are made to the role of the Ombudsman when publicising their complaints procedure, and in the responses they make to individual complainants. r d d and understand that Ombudsman has discretion, case-by-case, on whether he investigates complaints within his jurisdiction, and that he will determine whether there are adequate grounds for any investigation.

3.18 The Ombudsman has published a leaflet for the general public to explain his new powers. Copies are sent to Trusts. As a matter of good practice, complaints officers and convenors may wish to enclose a copy of the Ombudsman's leaflet with any letter referring to the complainant's rights to take their concerns to the Ombudsman.

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3.19 The Ombudsman has access to independent medical, dental, nursing, PAMs, and pharmaceutical advisers, to help him on a case-by-case basis. While independent of the HPSS complaints procedure, the Ombudsman is a key component of it. The prompt release by Trusts and other employers of professional staff invited by the Ombudsman to advise on particular cases is essential in ensuring that he is

able to discharge his new responsibilities effectively. Releasing staff to advise the Ombudsman must be regarded as of equal priority to the release of staff to advise independent review panels.

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Legal Framework
Key Objectives of Complaints Procedure
Patient/Client Confidentiality
Third Party Confidence
Use of Anonymised Information
Distribution of Statement of Complaint and Independent Review Panel Reports
Role of Chief Executives
Access to Health or Social Services Records
Code of Practice on Openness in the HPSS
Complaints under the Children Order
Role of Registration and Inspection Units
Complaints affecting more than one HPSS Body
Continual/Vexatious Complainants
Staff Grievance Procedures
Disciplinary Action
Investigation by a Professional Body
Independent Inquiries and Criminal Investigation
Possible Claims for Negligence
Complaints about services commissioned by Boards
Complaints against Independent Providers
HPSS Private Pay Beds
Training
Monitoring

Annex 4A: Definition of a Habitual/Vexatious Complainant

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4.1 The following Directions provide the legal framework for the complaints procedure:

The Health and Personal Social Services Complaints Procedures Directions (NI) 1996, issued 1996;

Directions to Health and Social Services Boards on procedures for dealing with complaints about family health services practitioners, issued 1996;

The Miscellaneous Complaints Procedures Directions (NI) 1996, issued 1996;

The Health and Personal Social Services (Special Agencies) Complaints Procedures Directions (NI) 1996, issued 1996;

Directions to Health and Social Services Boards on Procedures for Dealing with Complaints about Family Health Services Practitioners and Providers of Personal Medical Services, issued 1998; and

Directions to Health and Social Services Boards Concerning the Implementation of Pilot Schemes (Personal Medical Services), issued 1998.

4.2 The following Regulations affect the complaints procedure:

The General Medical Services Regulations (NI) 1997;
The General Dental Services Regulations (NI) 1993;
The General Ophthalmic Services Regulations (NI) 1986;
The Pharmaceutical Services Regulations (NI) 1997;
The Health and Social Services (Fundholding Practices) Regulations (NI) 1993.

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4.3 The key objectives of the HPSS complaints procedure, introduced on 1 April 1996, are:

ease of access for patients and complainants
a simplified procedure, with common features for complaints about any of the services provided as part of the HPSS
separation of complaints from disciplinary procedures

making it easier to extract lessons on quality from complaints to improve services for patients
fairness for staff and complainants alike
more rapid, open processes
an approach that is honest, thorough, with the prime aim of resolving the problems and satisfying the concerns of the complainant.

4.4 The Department remains committed to achieving all these objectives. They are a key part of action flowing from the Charter for Patients and Clients and Well into 2000, the agenda for improving health and well-being[7].

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4.5 Advice on patient/clients confidentiality is given in a code of practice[8] and Trusts must follow this advice in its use and handling of personal health information connected with a complaint.

4.6 It is not necessary to obtain the patient's/client's express consent to the use of their personal information to investigate a complaint. Even so, it is good practice to explain to the patient/client that information from his/her health or social services records may need to be disclosed to the complaints officer, to clinical assessors, and possible to the convenor and panel members, but only if they have a demonstrable need to know, for the purposes of investigating the complaint. If the patient/client objects to this, it should be explained to him/her that this could compromise the investigation and his/her hopes of a satisfactory outcome to the complaint. The patient's/client's wishes should always be respected, unless there is an overriding public interest in continuing with the matter.

4.7 Where a complaint is made on behalf of a patient/client who has not authorised someone to act for him/her, care must be taken not to disclose health or social services information to the complainant, unless the patient/client has expressly consented to its disclosure.

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4.8 The duty of confidence applies equally to third parties who have given information or who are referred to in the patient's/client's records. Particular care must be taken where the patient's/client's records contain information provided in confidence, by, or about, a third party who is not a health or social services professional. Only that information which is relevant to the complaint should be considered for disclosure, and then only to those *within* the HPSS who have a demonstrable need to know in connection with the complaint investigation. Third

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7 Well into 2000 – A Positive Agenda for Health and Well-being, DHSS, 1997

8 The Protection and Use of Patient and Client Information – Guidance for the HPSS, HSS Executive, March 1996

part information must not be disclosed to the patient/client unless the person who provided the information has expressly consented to the disclosure.

4.9 Disclosure of information provided by a third party outside the HPSS also requires the express consent of the third party. If the third party objects then it can only be disclosed where there is an overriding public interest in doing so.

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4.10 Where anonymised information about patient/client and/or third parties would suffice, identifiable information should be omitted. Anonymising information does not of itself remove the legal duty of confidence but, where all reasonable steps are taken to ensure that the recipient is unable to trace the patient/client or third party identity, it may be passed on where justified by the complaint investigation. Where a patient/client or third party has expressly refused permission to use information, then it can only be used where there is an overriding public interest in so doing.

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4.11 The statement of complaint should be sent to any person who is subject to a complaint about a Trust, Board, or independent provider. For complaints about family health services the statement must go to the person subject to the complaint and to any other person named in the complaint. Convenors may also need to give a copy of the lay chairman with whom they consult, or to any advisors in respect of clinical issues. Only exceptionally should it be necessary to circulate the statement more widely at the convening stage. If a panel is established further limited circulation to panel members and assessors will be necessary.

4.12 The distribution of the final report of an independent review panel is set out in paragraph 2.42. Panel chairmen have authority to withhold any part of the report from any person or organisation if they consider it necessary to protect the confidentiality of the patient/client or third party, or the health of the patient/client or complainant.

4.13 Lay chairmen need to ensure that the covering letter to Chief Executives of Trusts/Boards/independent providers/FHS practitioners enclosing their copy of the report explains that the report should be circulated only to those officers and professionals who need to see the report. Others, for example those who are not themselves the subject of the complaints should receive only those parts of the report that relate to the information given by them.

4.14 The circulation of final reports on FHS complaints is not the responsibility of panel chairmen. The chairman is only required to send a copy to the Chief

Executive of the Board that established the panel. It is the duty of the Chief Executive to arrange for distribution. The Chief Executive however does have authority to decide if any part of the report should be withheld from any of those to whom he is required to send it. That authority lies with the panel chairman. The Chief Executive should abide by a chairman's decision to withhold any part of a report.

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4.15 The complaints procedure may be used to investigate a complaint about any aspect of an application to obtain access to health or social services records as an alternative to making an application to the courts. This does not affect the patient's/client's right to take the matter to a court if he/she remains dissatisfied with the outcome of an investigation.

4.16 Where the complaint relates to a decision to withhold access to all or part of the record, the role of an independent review panel is to advise the record holder of their opinion. It remains the responsibility of the record holder to decide whether access should be granted. Care must be taken to ensure that in reporting the outcome of an investigation into a complaint about access to health or social services records, the patient/client does not obtain information to which he/she is not entitled. This is particularly important in the following circumstances:

when access has been denied on the grounds that it would cause serious harm to the physical or mental health of the patient or any other individual;

where information relates to or was provided by a third party who could be identified from that information and who had not consented to its disclosure; or

4.17 Access to health records compiled before 30 May 1994 is at the discretion of the record holder, having regard to the fact that such records were not compiled in the expectation that they would be disclosed to the patient. This is an additional factor to be borne in mind when considering whether to grant access to such records.

4.18 It remains current policy that patient's/client's should be allowed to see what is written about them in their health or social services records whenever possible.

4.19 Complaints records should normally be kept separate from health or social services records, subject to the need to record any information that is strictly relevant within the patient's/client's health or social services records.

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4.20 Complaints about non-disclosure of other information under the Code[9] can be considered under the HPSS complaints procedure.

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4.21 Complaints made in relation to personal social services for children should always be considered under the Representations and Complaints Procedures established under the Children (NI) Order 1995.

4.22 The Children Order Representations and Complaints Procedures apply to services provided under Part IV of the Order and to Schedule 5, paragraph 6 (matters regarding the "usual fostering limit"). The effect of Part IV is that the Children Order procedure applies to all personal social services provided to children and their families under the order. Complaints from those providing services for children (day care, child minding, residential care) which relate to registration requirements do not fall within the Representations and Complaints Procedures and should be addressed under the specific procedures set out in the Order.

4.23 Some personal social services for children fall outside the scope of Part IV of the Children Order, for example, adoption, matters relating to the work of the Area Child Protection Committees, and the production of welfare reports in private law cases. Guidance already issued under the Children Order urges Trusts to adopt a flexible approach and to consider all matters relating to personal social services for children under the procedures for Children Order cases. Particular regard should be given to Volume 3 (Chapter II) in the Children Order Guidance and Regulations. r r
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4.24 Independent and statutory residential and nursing homes that provide services under contract to the HPSS must operate a complaints procedure that meets the requirements of the HPSS complaints procedure. Complainants should normally be encouraged to complain to the service provider under local resolution, but retain the right to complain directly to the local registration and inspection unit, if they so wish.

9 Code of Practice an Openness in the HPSS, HSS Executive, October 1996

4.25 Registration and inspection units have a statutory duty to investigate any complaint that they receive about the care and well-being of residents. Complaints handled by units will normally be investigated in line with the requirements of the HPSS complaints procedure[10]. The unit will seek to resolve complaints under local resolution, with residents having the right to seek independent review if they remain dissatisfied. Exceptions will be those of a serious nature that indicate a breach of registration requirements, including the fitness of those working in or responsible for the home that may lead to cancellation of registration. These will be handled separately under the statutory duty imposed by The Residential Homes (NI) Order 1992.

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4.26 Where an HPSS body receives a complaint which is solely concerned with services provided by another health body or a body outside the HPSS, the complaints officer, in consultation with the complainant, should arrange that it is passed immediately to the correct body. This action should be confirmed in writing to the complainant and the body concerned.

4.27 Where a complaint relates to the actions of two or more HPSS bodies – for example, two Trusts, or a family health services practitioner and a Trust, there should be full co-operation between the complaints staff of these bodies to resolve the complaint. Where a complainant wishes to pursue such related complaints to independent review, the convenors involved should liaise with the aim of establishing close co-operation with the respective bodies. Good practice suggests that a final draft response should be shared prior to being sent. Legally, separate panels need to be established, but they might nevertheless comprise the same panel chairman and, in some cases, the same third panel member. It may also be possible in these circumstances for the same assessors to be used.

4.28 The chairman might also wish to establish close working arrangements between the panels – possibly meeting on the same day, in the same place – and ensuring that between them they deal with all issues. While each panel must make its own separate report, this could help the chairman ensure commonality of findings and also that each HPSS body received appropriate advice.

4.29 Habitual and/or vexatious complainants can be a problem for HPSS staff. The difficulty in handling such complaints can cause undue stress for staff and placing a strain on time and resources. HPSS staff are trained to respond with patient and sympathy to the needs of all complainants but there are times when there is

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10 Registration and Inspection Unit Complaints Procedure, Eastern HSS Board, November 1997

nothing further, which can reasonably be done to assist them or to rectify a real or perceived problem.

4.30 There are two key considerations when determining how to handle such complaints. The first is to ensure that the complaints procedure has been rr d so far as possible; that r r d r d ddr d and to appreciate that even habitual or vexatious complaints may have aspects that contain some substance. The need to ensure an equitable approach is crucial.

4.31 The second is to identify the stage at which a complaint has been habitual or vexatious. One approach is to develop an approved policy that is formally incorporated into the complaints procedure. Implementation of such a policy should only occur in r . Information of habitual and vexatious complaints could also be made available the public as part of the material on the complaints process as a whole.

4.32 d d r r r r r r r r d r r . Judgement and discretion must be used in applying the criteria to identify potential habitual or vexatious complainants and in deciding the action to be taken in specific cases. The policy should only be implemented following careful consideration by, and with the authorisation of, the Chairman and Chief Executive of the Trust or their deputies in their absence.

4.33 Where complainants have been identified as habitual or vexatious in accordance with the criteria in Annex 4A, the Chief Executive and Chairman (or appropriate deputies in their absence) will determine what action to take. The Chief Executive (or deputy) will implement such action and will notify the complainant in writing of the reasons why he/she has been classified as habitual or vexatious complainants and the action to be taken. This notification may be copied for the information of others who may be involved, for example conciliator, health and social services council, Member of Legislative Assembly, Member of Parliament. A written record must be kept of the reasons why a complainant has been classified as habitual or vexatious.

4.34 The Chief Executive and Chairman may decide to deal with complaints in one or more ways, for example:

> Try to resolve matters, before invoking this policy, by drawing up a signed 'agreement' with the complainant (and if appropriate involving the relevant practitioner in a two-way agreement) which sets out a code of behaviour for the parties involved if the Board is to continue processing the

complaint. If these terms are contravened, consideration would then be given to implementing other action as indicated in this section.

Decline contact with the complainants either in person, by telephone, by fax, by letter or any combination of these, provided that one form of contact is maintained.

Notify the complainant in writing that the Chief Executive has responded fully to the points raised and has tried to resolve the complaint but there is nothing more to add and continuing contact on this matter will serve no useful purpose. The complainants should also be notified that the correspondence is at an end and that further letters received will be acknowledged but not answered.

Inform the complainant that in extreme circumstances the Trust reserves the right to pass unreasonable or vexatious complaints to its solicitors.

Temporarily suspend all contact with the complainant or investigation of a complaint whilst seeking legal advice or guidance from the HSS Executive, or other relevant agencies.

4.35 Once complainants have been determined as 'habitual or vexatious' there needs to be a mechanism for withdrawing this status at a later date if, for example, complainants subsequently demonstrate a more reasonable approach or if they submit a further complaint for which normal complaints procedures would appear appropriate. Staff should previously have used discretion in recommending 'habitual or vexatious' status at the outset and discretion should similarly be used in recommending that this status be withdrawn when appropriate. Where this appears to be the case, discussion will be held with the Chief Executive and/or the Chairman (or their deputies). Subject to their approval, normal contact with the complainants and application of the HPSS complaints procedure will then be resumed. See Annex 4A for further guidance on the definition of a vexatious complainant.

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4.36 It is important to recognise that the HPSS complaints procedure is designed to address the concerns of patients and clients, not those of staff. Trusts and other HPSS bodies have separate procedures for handling staff grievances. Local procedures will also cover more general grievances. Disputes about contractual matters between Boards and primary care services practitioners should not be handled through the complaints procedures. Staff may complain about the way they have been dealt with under the HPSS complaints procedure and provided they have exhausted the local grievance procedure, may take the matter up with the Ombudsman. FHS practitioners may also complain to the Ombudsman about the way they been dealt with under the complaints procedure.

4.37 If any complaint received by a member or employee appears to raise matters normally dealt with by:

an investigation under the disciplinary procedure;
one of the professional regulatory bodies;
an independent inquiry into a serious incident; or
an investigation of a criminal offence.

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4.38 When a decision is made to embark upon a disciplinary investigation, action under the complaints procedure on any matter which is the subject of that investigation must cease. Where there are aspects of the complaint not covered by the disciplinary investigation, they should continue to be dealt with under the complaints procedure. The Chief Executive must advise the complainant in writing that a disciplinary investigation us under way; that they may be asked to take part in that process; and how any outstanding aspects of their complaint not affected by the disciplinary investigation will be taken forward.

4.39 If there are not outstanding issues from the complaint requiring investigation, the complainant should be advised in writing by the Chief Executive that no further action will be taken other than through the disciplinary procedure.

4.40 If referral for disciplinary investigation is made during local resolution, then this part of the procedure should be completed by a letter from the Chief Executive setting out the action taken by the Trust. When referral occurs during the independent review process, a similar letter should be issued on completion of that process. In drafting these letters, the overall consideration must be to ensure that when the investigation has moved into the disciplinary procedure, the complainant is not left feeling that their grievance has only been partly dealt with.

4.41 If the complainant asks to be informed of the outcome of the disciplinary investigation, the Trust's response must balance the need to reassure the complainant that their grievance has been dealt with seriously and satisfactorily, with the need to protect the right of confidentiality of its staff. The guiding principle should be that the complainant should receive the same consideration and information as if the matter had been dealt with under the complaints procedure. They therefore have a right to know what happened; why it happened; and what action has been taken to prevent it happening again. They can also be

told, in general terms that disciplinary action may be imposed as a result of the complaint.

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4.42 A similar approach should be adopted in a case referred to a statutory regulatory body, for example the UKCC for nurses, midwives and health visitors. The Chief Executive must inform the complainant in writing of the referral to the regulatory body, and explain that: the Trust now has no control over what happens or over what period; giving as full a response as possible on the matter; and indicating that the information may need to be passed to the regulatory body. The letter should also explain how any other aspect of their complaint not covered by the referral to the regulatory body will be investigated under the complaints procedure.

d d r d r

4.43 Where an independent inquiry into a serious incident or a criminal investigation is initiated, the Chief Executive should immediately advise the complainant of this in writing. As the complaints procedure cannot deal with matters subject to any such investigation, consideration of those parts of the original complaint must be suspended until the other investigation is concluded. When this happens before the investigation of the complaint has been completed, a full report of the investigation thus far should be made available to the complainant.

4.44 When the independent inquiry or criminal investigation has concluded, consideration of that part of the original complaint on which action was suspended can recommence if there are outstanding matters which remain to be dealt with.

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4.45 In the early part of the process it may not be clear whether the complainant simply wants an explanation and apology, with assurances that any failures in service will be rectified for the future, or whether they are in fact seeking information with litigation in mind. It may be that an open and sympathetic approach will satisfy the complainant. r d

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r d r d d r

d The Chief Executive should advise the complainant and the complained against in writing of this decision.

4.46 At the first indication of a possible claim for negligence, or where the complainant has initiated legal proceedings, the principles of good claims management and risk management should be applied. There should be a full and thorough

investigation of the events. In any case where negligence has been accepted, a speedy settlement should be sought.

4.47 It is not the intention of the complaints procedure to deny someone the opportunity to pursue a complaint if the person subsequently decides

If he/she then wishes to pursue their complaint through the complaints process the investigation of their complaint should commence or resume.

r d rd

4.48 Complaints about commissioning decisions made by Boards may be made by or on behalf of any individual personally affected by a commissioning decision taken by the Board. Of course health and social services councils may wish to raise general concerns about commissioning issues with the Board. They should receive a full explanation of the Board's policy. These issues should not, however, be dealt with under the complaints procedure. Panels may criticise the way in which a commissioning decision has been reached – for example on the grounds that the Board did not consult properly or take appropriate clinical advice – but where a purchasing decision has been taken properly and reasonably, panels will not be able to suggest an alternative decision.

4.49 Where a complaint concerns the exercise of clinical judgement, the Board will nominate at least two clinical assessors to the panel with experience of exercising clinical judgement in a commissioning context. If the complainant wishes to pursue a complaint both about the actual services and the commissioning decision involved, the assessors will need to represent between them the appropriate clinical experience for both aspects.

d d r d r

4.50 The complaints procedure applies equally to services provided for HPSS patients and clients by the independent sector. Complaints about the actual services purchased from the independent sector must be treated as such as and not as complaints about commissioning decisions. If a complainant wishes to complain about the related commissioning decision at the same time this should be pursued through the same procedure in parallel.

4.51 Boards should specify in their contracts with independent providers that the provider must set up and run a local resolution process as far as possible as identical to and as good as local resolution that HPSS providers are required to provide, and that they must co-operate with the independent review procedure. Contracts made by Boards and Trusts should include a requirement on the independent provider and its staff to co-operate with any independent review process that is set up, and to indemnify them for the costs of setting up and running the arrangements.

4.52 Where a Board has commissioned the service concerned, the convening and panel stages of the independent review process will be organised by the Board in the same way as for review of complaints against other commissioning decisions. However, the questions to be addressed will be about the service concerned. Complaints may be pursued in this way by, or on behalf of, existing or former HPSS users of services purchased from the independent sector by the Board. Such complaints must relate to the services in question.

4.53 A complaint under the procedures of the Registered Homes (NI) Order 1992 (through the Inspection Unit Manager of the Board and if the independent provider is registered under the Order) does not preclude a complainant pursuing a separate complaint under the HPSS complaints procedure.

4.54 If a complaint against an independent provider registered under the Order is not resolved locally the convenor may, with the complainant's consent, delay the instigation of independent review until the Inspection Unit Manager (of the Board registering the independent provider) has had the opportunity to attempt to resolve the complaint.

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4.55 The complaints procedure covers any complaint made about the Trust's staff or facilities relating to care in private pay beds, but not to the private medical care provided by the consultant outside his HPSS contract.

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4.56 Training is the key to making the complaints procedure work effectively. Training materials have been provided for Trusts and Boards, who have a responsibility to ensure that staff are competent and confident in dealing with expressions of concern or complaint. The improvement of these skills continues to be a high priority of the Chief Executives and their boards. Boards should also consider the scope for joint training of staff, convenors, lay chairmen and panel members. Convenors and other staff should not be asked to undertake their role without appropriate training.

4.57 Good practice suggests that key players will benefit from regular informal discussion of matters of common interests. The annual publication of the Ombudsman's Report offers useful points for such discussions. The Department will consider holding seminars on matters of regional interest, and is in regular touch with complaints officers and convenors on such matters.

M r

4.58 The boards of Boards and Trusts should receive quarterly reports on complaints, in order to:

monitor arrangements for local complaints handling;
consider trends in complaints; and
consider any lessons that can be learned from complaints, particularly for service improvement.

4.59 Trusts/Boards* must publish annually (in their Annual Report) a report on complaints handling and send copies to relevant health and social services councils. These reports must not breach patient confidentiality.

Only relevant to complaints about Boards themselves. Complaints against FHS Practitioners, GP Fundholders, and Independent Providers will not be included

4.60 Directions require Boards to monitor arrangements for dealing with complaints. Patient's and Client's Charter guidance reinforces this and requires Trusts to keep the relevant commissioning authorities informed of progress in dealing with complaints. An increase in the number of complaints is not in itself a reason for thinking the service is deteriorating. It might mean the organisation is becoming more responsive to complaints. The important point is to handle complaints well and to feed the lessons into quality improvement.

4.61 Consideration should be given to collection of local data on:

oral complaints not recorded in writing;
patients' comments and suggestions;
changes in practice and procedure as a consequence of complaints handling.

4.62 Complaints handling should be monitored on a regular basis through, for example patient satisfaction surveys. Such information will enable providers to improve the quality of their services, and help to inform purchasers in the contracting process.

4.63 The Department will continue to monitor the number and type of complaints, and action taken to improve the quality of services as a result of complaints. Hospital and community health and social services statistical collection will continue to be through the completion by Trusts and Boards of the CH8 and CHB returns.

M

1. Complainants (and/or anyone acting on their behalf) may be deemed to be habitual or vexatious complainants where previous or current contact with them shows that they meet M of the following criteria:

2. Where complainants:

r r where the HPSS complaints procedure has been fully and properly implemented and exhausted (eg where investigation has been denied as 'out of time', where a convenor has declined a request for independent review).

of a complaint or r or seek to prolong contact by r r r r r upon receipt of a response whilst the complaint is being addressed. (Care must be taken not to discard new issues that are significantly different from the original complaint. These might need to be addressed as separate complaints).

Are d d d of treatment given as being factual, e.g. drug records, nursing records or deny receipt of an adequate response in spite of correspondence specifically answering their questions; or d d r when a long period of time has elapsed.

r d r which they wish to have investigated, despite reasonable efforts of staff and, where appropriate, the local health and social services council to help them specify their concerns; d r r r d d r r of the Trust or Board to investigate.

r r to an extent that is out of proportion to its significance and continue to focus on this point. It is recognised that determining what is a 'trivial' matter can be subjective and careful judgement must be used in applying this criterion.

Have r d r d towards staff at any time – this will in itself cause personal contact with the complainant and/or their representatives to be discontinued and the complaint will, thereafter, only be pursued through written communication. (All such incidences should be documented).

Have in the course of addressing a registered complaint had an r with the Board placing unreasonable demands on staff. (A contact may be in person or by telephone, letter or fax). Discretion must be used in determining the precise number of 'excessive contacts' applicable under this section, using judgement based on the specific circumstances of each individual case).

Have r d or been personally r r r on more than one occasion towards staff dealing with their complaint. (Staff must recognise that complainants may sometimes act out of character at times of stress, anxiety, or distress and should make reasonable allowances for this. They should document all incidents of harassment).

Are known to have r rd d meetings or face-to-face/telephone r the prior knowledge and consent of other parties involved.

r d d r d r (eg insist on responses to complaints or enquiries being provided more urgently than is reasonable or normal recognised practice).

EHSSB

PROCEDURE AND GUIDANCE FOR HANDLING COMPLAINTS

1. Introduction

1.1 This document sets out the procedure for Board Staff on how complaints relating to purchasing of services are to be handled. It reflects the new arrangements for dealing with complaints which became effective from 1 April 1996 and should be read in conjunction with "Guidance on Implementation of the HPSS Complaints Procedure" issued by the HPSS Executive in March 1996 and supplemented in April 2000.

1.2 The proper handling of complaints, suggestions or queries is a fundamental responsibility of the Board. Complaints should therefore be dealt with promptly, sympathetically and constructively. It is important that every complainant should feel that his or her complaint has been dealt with appropriately.

1.3 The HPSS Complaints Procedure is designed to address patients' and clients' complaints, not staff grievances, which will continue to be handled separately. Disputes on contractual matters between Boards and Family Health Services practitioners should not be handled through the Complaints Procedure. Staff of Boards may complain about the way they have been dealt with under the Complaints Procedure and, provided they have exhausted the local grievance procedure, may complain to the Commissioner for Complaints. Family Health Services practitioners may complain to the Commissioner about the way they have been dealt with under the complaints procedure.

2. Procedures

2.1 The key objectives for introducing the new procedure are:

- ease of access for patients and clients;
- a simplified procedure, with common features;

- separation of complaints from disciplinary procedures;
- more rapid, open processes, with an emphasis on early resolution;
- fairness for staff and complainants alike;
- an approach which is honest, thorough, and with the prime aim of resolving the problem and satisfying complainants concerns; and
- making it easier to learn from complaints, in order to improve services and standards.

3. Definitions

3.1 Complaint:

(Para 6.10) The Guidance of Implementation of the HPSS Complaints Procedure defines a complaint as

"an expression of dissatisfaction requiring a response".

A criticism of a service or the quality of care, whether written or oral, becomes a complaint when it requires a response. A single communication may include more than one complaint.

3.2 Complainant:

Complainants will be existing or former users of a Board's services and facilities. People may complain on behalf of existing or former patients/clients provided they have their consent. If the patient/client is unable to act then consent is not needed.

Where a complaint concerns family health services, complainants will be existing or former patients of a practitioner who has arrangements with a Board to provide family health services.

Complaints to the Board may also be from existing or former users of services provided by a Trust or family health services practitioner

which have not been resolved locally and where the complainant has requested the Board to make arrangements for a review of the matter.

4. Complaints about Purchasing Decisions by Boards

4.1 The Board will not be involved at the initial stages in resolving complaints about services provided by Trusts. There will, however, need to be both Local Resolution and Independent Review arrangements for dealing with complaints about purchasing decisions by the Board. The Board will also respond to complaints about its own actions and decisions.

4.2 Complaints about a Board's purchasing decision may be made by, or on behalf of, any individual personally affected by a purchasing decision taken by the Board. The Complaints Procedure may not deal with complaints about the merits of a decision where the Board has acted properly and within its legal responsibilities. The public or the HSS Council may wish to raise general issues about purchasing issues with the Board and they should receive a full explanation of the Board's policy. These are not, however, issues for the new Complaints Procedure.

4.3 Local Resolution of Complaints about Purchasing Decisions by Boards

The Board must have a Local Resolution process and a designated Complaints Officer to deal with purchasing complaints and other complaints about the Board's own actions and decisions.

The Board's designated Complaints Manager is Mrs Liz Fitzpatrick, Patient/Client Services Manager, supported by Mr Michael Cruikshanks, Patient/Client Services Officer and Mrs Michele Clawson, Patient/Client Services Support Officer.

The primary objective of Local Resolution is to provide the fullest possible opportunity for investigation and resolution of the complaint, as quickly as is sensible in the circumstances. The emphasis is on complaints being dealt with quickly and, wherever possible, by those on the spot. The intention of Local Resolution is that it should be open, fair, flexible, and conciliatory. The complainant should be given the opportunity to understand all possible options for pursuing the complaint and the consequences of following any of these.

The process should encourage communication on all sides. The aim should be to resolve a complaint during this stage to the satisfaction of the complainant while being fair to staff. Rigid, bureaucratic, and legalistic approaches should be avoided at all stages of the procedure, but particularly during Local Resolution.

All complaints, whether oral or written, should receive a positive and full response, free of jargon. The aim should be to satisfy the complainant that their concerns have been heeded, and offering an apology and explanation as appropriate, referring to any remedial action that is to follow.

In the context of Local Resolution for the Board, for example, a member of staff from a relevant Directorate such as Public Health and Nursing, Social Services or Planning and Contracting may respond directly to a complainant about a purchasing decision. The Board's Complaints Department should, however, be made aware of the nature of the complaint and response.

The HPSS Executive Complaints Guidance states that:

"All written complaints must receive a response in writing from the Chief Executive. Some oral complaints are sufficiently serious, or difficult to resolve, that they should be recorded in writing by the Complaints Officer. These complaints should also receive a written response from the Chief Executive".

4.4 Independent Review of Complaints about Purchasing Decisions by Boards

The Board must appoint at least one or more of its non-executive directors to act as a convenor for the Independent Review of complaints about the Board. The emphasis is on the independence of the Review and the involvement of lay and independent people. This is in marked contrast to previous procedures. The Board's two non-executive Convenors are currently Mr Alex Coleman, who is the lead Convenor and Mrs Lillian Ievers. They are supported by a number of Consultancy Convenors that have been recruited by the Board. The Board will nominate independent lay chairpersons to link with the convenor and to chair panels, when established. The third member of each panel will be another independent lay person nominated by the Board. Panels may criticise the way in which a purchasing decision has been reached

but where a purchasing decision has been taken properly and reasonably, panels will not be able to suggest an alternative decision.

5. Receipt of Complaints

5.1 Complaints received orally should be dealt with by staff promptly, sympathetically and constructively. Such complaints should be dealt with according to the principles of Local Resolution and should be resolved immediately or within two days of receipt.

5.2 Oral complaints which cannot be resolved to the complainant's satisfaction should be referred to the Board's Complaints Department.

5.3 These complaints should be acknowledged by the renewing member of the Complaints Department within two working days except where it is possible to resolve the complaint fully within five working days.

5.4 Complaints received through the Private Office of the DHSSPS (ie Ministers Cases and Private Office Enquiries) will be forwarded to the Board's Complaints Department which will arrange for an acknowledgement and the preparation of a response. When the reply is ready it will be signed by the Chief Executive.

5.5 Complaints addressed directly to the Board Chairman or Chief Executive, such as those from Members of Parliament or District Councillors, will be dealt with as in 5.4 above.

5.6 Complaints received from members of the public and others not specified above, will be forwarded to the Board's Complaints Department who will arrange for an acknowledgement and the preparation of a response from the Chief Executive.

5.7 In all cases complaints will receive an acknowledgement within two working days, and a full investigation and resolution sought within twenty working days, except in those instances as outlined in para 5.3 above.

5.8 In all cases written responses to complaints will be under the signature of the Chief Executive.

5.9 Where a complaint is received by the Board in error, the receiving member of the Complaints Department should ensure that it is passed immediately to the correct body, after consulting with the complainant and provided that the complainant wishes this to be done. The complainant and the body concerned should both then be advised in writing.

6. Request to Convene a Panel

6.1 **Boards are responsible for Independent Review arrangements for unresolved complaints concerning Trusts, family health services practitioners, including GP fundholders and the independent sector in addition to complaints about purchasing decisions. (See Appendices 1 and 2).**

6.2 Complainants who remain dissatisfied with the response to their complaint may request an Independent Review Panel to review their complaint, within 28 days from the completion of the Local Resolution process.

6.3 The request will be forwarded to the Complaints Department, which will arrange for acknowledgement and onward transmission to the Convenor.

6.4 The Convenor will, if appropriate, and after consultation with the lay chairperson and an appropriate health and social care professional, seek advice from at least two independent clinical, social work, nursing or other as appropriate, assessors to advise the panel.

6.5 The Independent Review Panel will comprise a lay chairperson, a Board Convenor and a third lay person.

6.6 The Independent Review Panel will be constituted and act within the guidance contained in the HPSS Executive Guidance 1996.

7. Time Limits/Performance Targets

7.1 These are outlined in Appendix 3.

8. **NI Commissioner for Complaints**

8.1 All papers relating to both the Local Resolution and Independent Review investigations will be made available to the Commissioner where such a case has been referred by the complainant to the Commissioner for investigation.

9. **Family Health Services**

9.1 If requested by a complainant and/or a practitioner, the Board's Complaints Department, in consultation with both parties and the Family Health Services Unit, shall arrange for a lay conciliator to facilitate Local Resolution for family health services complaints.

9.2 Complainants dissatisfied with the outcome of the Local Resolution process involving family health services may request the Board Convenor to establish an Independent Review Panel.

9.3 The Convenor will proceed as in section 6.0 above.

10. **Complaints Monitoring**

10.1 The operation and effectiveness of the complaints procedure will be monitored continuously and information provided to Board Directors on a regular basis about the number and type of complaints received and their outcomes.

10.2 Copies of all letters of complaint, final replies and, if appropriate, interim responses from Provider Trusts, will be forwarded to the Board's Complaints Department. Such correspondence shall relate to complaints made by Board residents in respect of all services purchased by the Board.

10.3 Separate arrangements exist concerning the monitoring of complaints regarding family health services practitioners.

11. **Role of HSS Council**

Advice should be made available at all stages of the complaints procedure about the role of the HSS Council in giving individuals advice and support on making complaints.

Pro&Guid/MH

Independent REVIEW

What Happens?

EHSSB

If you are dissatisfied

Some people are dissatisfied with the final reply to their complaint from a Board, Trust, Family Health Service Practitioner (family doctor, dentist, pharmacist, optician) or the independent care sector (eg a nursing home proprietor). You may then ask the Board for an ***Independent Review*** of your complaint within ***twenty-eight days*** from having received your final reply.

A request for a review of your complaint should be made to a person specially appointed by the Board known as a ***Convenor***. This request can be made orally or in writing and should set out your remaining grievances and why you are still dissatisfied. If your request is made orally, the *Convenor* will need a statement, which you are prepared to agree and sign, outlining your outstanding concerns. It is important that the Convenor obtains this statement as quickly as possible before starting his/her inquiries.

complaint

You may wish to seek help, for example, from the ***Eastern Health and Social Services Council*** in drawing up this statement.

(Information on how to contact the Council and its role is given at the back of this leaflet).

Correspondence should be addressed to the Convenor at the Eastern Health and Social Services Board, Champion House, 12/22 Linenhall Street, Belfast BT2 8BS. ***The Convenor's Office*** is based at the Board, ***Telephone 9055 3751 or 9055 3765.***

What happens next?

- Your request for an Independent Review will be acknowledged in writing within two working days;

- ***PLEASE REMEMBER*** there is no automatic right to an Independent Review.

Your complaint will not be reviewed by a panel if you have commenced or intend to make a legal claim in relation to the matters complained of. Similarly, if the matters complained of are the subject of disciplinary investigation, a panel will not be set up.

- The Convenor will decide, in consultation with an ***Independent Lay Chairperson*** (also specially appointed by the Board), whether:

complaint

- The Board/Trust/practitioner can take any further action to satisfy you;
- the Board/Trust/practitioner has already taken all practical action (and therefore setting up a panel would add no further value to the process);
- To set up an ***Independent Review Panel.***

You may complain to the NI Commissioner for Complaints (Ombudsman) about a Convenor's decision not to set up an Independent Review Panel. Details on how to contact the Ombudsman are given later in this leaflet.

The independent review panel

The purpose of an Independent Review Panel is to consider the complaint according to the terms of reference which will be drawn up by the Convenor. The panel will investigate the facts of the case, taking into account the views of both sides. It will set out its conclusion, with appropriate comments and suggestions, in a written report.

The panel will be composed of three members appointed by the Board:

- an independent lay chairperson;
- a convenor;
- an independent lay person.

Where the complaint raises medical or other professional issues, the panel will also be advised by at least two appropriate independent ***Clinical Assessors*** appointed by the Board.

complaint

You may be asked to meet with members of the panel or provide them with further information during their consideration of your complaint. Meetings will be conducted as informally and flexibly as possible. None of the parties involved may be legally represented, however you are entitled to be supported at all times by a person of your choosing. This could be an adviser, say from the Health and Social Services Council, who may speak on your behalf, if you so wish.

When the panel has completed its business, you will be sent a copy of its final report. The report will also be forwarded to a limited number of others, including any persons named in the complaint or interviewed by the panel.

Following receipt of the panel's report, the Chief Executive of the organisation complained about must write to you informing you of any action being taken as a result of the panel's recommendations. You have a right to take your grievance to the Commissioner for Complaints should you remain dissatisfied.

complaint

Timescales

The timescales for the Independent Review process are as follows:

Acknowledgement by Convenor of request for Independent Review	2 working days of receipt
Decision by Convenor to set up panel, or not	20 **(10)** working days of receipt of request
Appointment of panel members	20 **(10)** working days of decision by Convenor to establish a panel
Final report of panel	60 **(40)** working days of formal appointment of panel and assessors
Response to complainant by Board/Trust	20 **(5)** working days of receipt of panel's report

(Timescales for complaints involving family health services practitioners are indicated in brackets).

What if you are still unhappy?

If you remain unhappy with the final report of the Independent Review Panel, or with the response made to its recommendations by the Board or Trust involved, you may ask the Commissioner for Complaints (the Ombudsman) to investigate your case. He may also investigate a complaint about a decision not to set up an Independent Review Panel. Although you have the right to approach the Ombudsman at any time, he will not usually take on a case unless it has first been through the complaints procedure.

For the first time, the Ombudsman is able to investigate complaints about clinical judgement and services provided by health service GPs, dentists, pharmacists and opticians.

complain

Your Ombudsman

His address is:

NI Commissioner for Complaints
33 Wellington Place
Belfast BT1 6HN

Tel: 9023 3821

Please remember

The Eastern Health and Social Services Council

Throughout this complaints investigation you also have a right to seek the help of your local Health and Social Services Council.

The Council is an Independent body set up to represent your interest in health and social services. They are willing to assist you at any stage of your complaint by providing advice and support.

They can be contacted at:

EHSSC
1st Floor McKelvey House
25-27 Wellington Place
Belfast
BT1 6GQ
Tel: 9032 1230

complain

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

COMPLAINTS
IN
HEALTH AND SOCIAL CARE

Standards & Guidelines for Resolution & Learning

1 April 2009

SUMMARY

Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning replaces the existing HPSS Complaints Procedure 1996 and provides a streamlined process that applies equally to all health and social care (HSC) organisations. As such it provides a simple, consistent approach for staff who handle complaints and for people raising complaints across all health and social care services.

The standards and guidelines have been developed in conjunction with HSC organisations, following public consultation. They reflect the changing culture across health and social care with an increasing emphasis on the promotion of safety and quality and the need to be open, to learn and take action in order to reduce the risk of recurrence.

The changes to the new HSC complaints procedure include:

- the removal of Independent Review;
- the introduction of Standards for Complaints Handling;
- the introduction of an “Unacceptable Actions” policy for handling unreasonable, vexatious or abusive complainants; and
- clarity on the application of the Children Order Representations and Complaints Procedure.

This new single tier process also aims to provide:

- a strengthened, more robust, local resolution stage;
- an enhanced role for commissioners in monitoring, performance management and learning; and
- improved arrangements for driving forward quality improvements across the HSC.

The new process recognises that there will be times when local resolution will fail. Where this happens the complainant will be advised of their right to refer their complaint to the NI Commissioner of Complaints (the Ombudsman).

The guidelines for resolution and learning provide HSC organisations with detailed, yet flexible, complaints handling arrangements designed to:

- provide effective local resolution;
- improve accessibility;
- clarify the options for pursuing a complaint;
- promote the use and availability of support services, including advocacy;
- provide a well defined process of investigation;
- promote the use of a range of investigative techniques;
- promote the use of a range of options for successful resolution, such as the use of independent experts, lay persons and conciliation;
- resolve complaints more quickly;
- provide flexibility in relation to target response times;
- provide an appropriate and proportionate response;
- provide clear lines of responsibility and accountability;
- improve record keeping, reporting and monitoring; and
- increase opportunities for shared learning.

The standards for complaints handling are designed to assist HSC organisations in monitoring the effectiveness of their complaints handling arrangements locally and build public confidence in the process.

These new arrangements are effective from 1 April 2009.

Definitions of Key Terms

Throughout the standards and guidelines the following terms have the meanings set out below:

complaint	means “an expression of dissatisfaction that requires a response”
complainant	means an existing or former patient, client, resident, family, representative or carer (or whoever has raised the complaint)
Chief Executive	means the Chief Executive of the HSC organisation
Complaints Manager	means the person nominated by an HSC organisation to handle complaints
Family Practitioner Service (FPS)	means family doctors, dentists, pharmacists and opticians
honest broker	this is the term used to describe HSC Board’s role in FPS complaints
HSC Board	means the Health and Social Care Board
HSC organisation	means a HSC organisation which commissions or provides health and social care services and for the purpose of this guidance includes the HSC Board, HSC Trusts, the Northern Ireland Ambulance Service (NIAS), Family Practitioner Services, Out-of Hours Services, pilot scheme providers
the Ombudsman	The NI Commissioner for Complaints

out-of hours services	means immediate necessary treatment provided by FPS 6.00 pm to 8.00 am Monday – Friday, weekends and local holidays
PCC	means the Patient and Client Council
pilot scheme	refers to personal dental services provided by an HSC Trust
pilot scheme complaints procedure	means a complaint s procedure established by the pilot scheme
practice-based complaints procedure	means a FPS complaints procedure established within the terms of the relevant regulations
registered provider	person carrying on or managing the establishment or agency
RQIA	means the Regulation, Quality & Improvement Authority: the regulatory body responsible for regulating, inspecting and monitoring the standard and quality of health and social care services provision provided by independent and statutory bodies in Northern Ireland
registered establishments and agencies	for example, residential care homes, nursing homes, children's homes, independent clinics/ hospitals, nursing agencies, etc. registered with and regulated by RQIA
regulated sector	means registered establishments and agencies
senior person (designated)	means the person designated to take responsibility for delivering the organisation's complaints process e.g. a Director in the HSC

	Trust
service user	means a patient, client, resident, carer, visitor or any other person accessing HSC services
special agency	means the NI Blood Transfusion Agency

SECTION 1 - INTRODUCTION

Purpose of the Guidance

1.1 This guidance sets out how HSC organisations should deal with complaints raised by people who use or are waiting to use their services. It replaces existing guidance and provides a streamlined complaints process which applies equally to all HSC organisations, including the HSC Board, HSC Trusts, the NI Blood Transfusion Service, Family Practitioner Services (FPS), Out of Hours services, pilot schemes and HSC prison healthcare. As such, it provides a simple, consistent approach for staff who handle complaints and for people raising complaints across all health and social care services.

1.2 This guidance aims to promote an organisational culture in health and social care that fosters openness and transparency for the benefit of all who use it or work in it. It is designed to provide ease of access, simplicity and a supportive and open process which results in a speedy, fair and, where possible, local resolution. The procedure provides the opportunity to put things right for service users as well as improving services. Dealing with those who have made complaints provides an opportunity to re-establish a positive relationship with the complainant and to develop an understanding of their concerns and needs.

Local resolution

1.3 The purpose of local resolution is to provide an opportunity for the complainant and the organisation to attempt a prompt and fair resolution of the complaint.

1.4 HSC organisations should work closely with service users to find an early resolution to complaints. Every opportunity should be taken to resolve complaints as close to the source as possible, through discussion and

negotiation. Where possible, complaints should be dealt with immediately. Where this is not possible, local resolution should be completed within 20 working days of receipt of a complaint (10 working days within FPS settings).

1.5 Local procedures should be easily accessible, open, fair, flexible and conciliatory and should encourage communication on all sides. They should include a well-defined process for investigating and resolving complaints. Complainants must be advised of their right to refer their complaint to the NI Commissioner for Complaints (the Ombudsman) if they remain dissatisfied with the outcome of the complaints procedure.

Principles of an effective complaints procedure

1.6 *Complaints in HSC* has been developed around four key principles:

- openness and accessibility – flexible options for pursuing a complaint and effective support for those wishing to do so;
- responsiveness – providing an appropriate and proportionate response;
- fairness and independence – emphasising early resolution in order to minimise strain and distress for all; and
- learning and improvement – ensuring complaints are viewed as a positive opportunity to learn and improve services.

Learning

1.7 Effective complaints handling is an important aspect of clinical and social care governance arrangements and, as such, will help organisations to continue to improve the quality of their services and safeguard high standards of care and treatment. Increased efforts should be made to promote a more positive culture of complaints handling by highlighting the added value of complaints within health and social care and making the process more acceptable/amenable to all.

1.8 Complaints are seen as a significant source of learning within health and social care and provide opportunities to improve:

- outcomes for services users;
- the quality of services; and
- service user experiences.

1.9 How HSC organisations handle complaints is an indicator of how responsive they are to the concerns of service users. An increase in the number of complaints is not in itself a reason for thinking the service is deteriorating. The important point is to handle complaints well, take appropriate action and feed the lessons learnt into quality improvement.

What the guidance covers

1.10 *Complaints in HSC* deals with complaints about care or treatment, or about issues relating to the provision of health and social care. Complaints may, therefore, be raised about services provided by, for example:

- The Health and Social Care Board (HSC Board)
    - commissioning and purchasing decisions (for individuals)
- Family Practitioner Services
- Health and Social Care (HSC) Trusts
    - hospital and community services
    - registered establishments and agencies where the care is funded by the HSC
    - HSC funded staff or facilities in private pay beds
    - HSC prison healthcare
- the Northern Ireland Blood Transfusion Service (NIBTS)

1.11 *Complaints in HSC* may be used to investigate a complaint about any aspect of an application to obtain access to health or social care records for deceased persons under the Access to Health Records (NI) Order 1993 as an alternative to making an application to the courts.

What the guidance does not cover

1.12 *Complaints in HSC* does **not** deal with complaints about:

- private care and treatment or services including private dental care[1] or privately supplied spectacles; or
- services not provided or funded by the HSC, for example, provision of private medical reports.

1.13 Complaints may be raised within an organisation which that organisation needs to address, but which do not fall within the scope of the HSC Complaints Procedure. When this occurs, the HSC organisation should ensure that there are other processes in place to deal with these concerns. For example:

- staff grievances;
- an investigation under the disciplinary procedure;
- an investigation by one of the professional regulatory bodies;
- services commissioned by the HSC Board ;
- a request for information under Freedom of Information;
- access to records under the Data Protection Act 1998;
- an independent inquiry;
- a criminal investigation;
- the Children Order Representations and Complaints Procedure;
- protection of vulnerable adults ;
- child protection procedures;
- coroner's cases;
- legal action.

1.14 Complaints received that appear to indicate the need for referral under any of the processes listed above should be immediately passed to the

[1] The Dental Complaints Service deals with private dental and mixed health service and private dental complaints and can be contacted via the General Dental Council at http://www.gdc-uk.org/

Complaints Manager for onward transmission to the appropriate department. If any aspect of the complaint is not covered by the referral it will be investigated under the HSC Complaints Procedure. In these circumstances, investigation under the HSC Complaints Procedure will only be taken forward if it does not, or will not, compromise or prejudice the matter under investigation under any other process. The complainant must be informed of the need for referral.

Staff Grievances

1.15 HSC organisations should have separate procedures for handling staff grievances. Staff may, however, complain about the way they have been dealt with under the HSC Complaints Procedure and provided they have exhausted the local grievance procedure, may take the matter up with the Ombudsman. Family practitioners may also complain to the Ombudsman about the way they have been dealt with under the complaints procedure.

Disciplinary Procedure

1.16 The HSC Complaints Procedure is concerned only with resolving complaints and learning lessons for improving services. It is not for investigating disciplinary matters though these can be investigated by the HSC organisation and may be referred to a professional regulatory body (see paragraph 1.20 below). The purpose of the complaints procedure is not to apportion blame, but to investigate complaints with the aim of satisfying complainants whilst being fair to staff.

1.17 Where a decision is made to embark upon a disciplinary investigation, action under the complaints procedure on any matter which is the subject of that investigation must cease. Where there are aspects of the complaint not covered by the disciplinary investigation, they may continue to be dealt with under the complaints procedure.

1.18 The Chief Executive (or designated senior person) must advise the complainant in writing that a disciplinary investigation is under way, that they may be asked to take part in that process and that any aspect of the complaint not covered by the referral will be investigated under the HSC Complaints Procedure.

1.19 In drafting these letters, the overall consideration must be to ensure that when the investigation has moved into the disciplinary procedure, the complainant is not left feeling that their complaint has only been partially dealt with.

Investigation by a Professional Regulatory Body

1.20 A similar approach to that outlined above should be adopted in a case referred to a professional regulatory body (Annexe 3). The Chief Executive (or designated senior person) must inform the complainant in writing of the referral. This should include an indication that any information obtained during the complaints investigation may need to be passed to the regulatory body. The letter should also explain how any other aspect of the complaint not covered by the referral to the regulatory body will be investigated under the HSC Complaints Procedure.

Services Commissioned by the HSC Board

1.21 Complaints about the HSC Board's purchasing decisions may be made by, or on behalf of any individual personally affected by a purchasing decision taken by the HSC Board. The HSC Complaints Procedure may not deal with complaints about the merits of a decision where the HSC Board has acted properly and within its legal responsibilities. Where general concerns about commissioning issues are raised with the HSC Board a full explanation of the

HSC Board's policy should be provided. These issues should not, however, be dealt with under the HSC Complaints Procedure.

Access to Information

1.22 Although use and disclosure of service user information may be necessary in the course of handling a complaint, the complainant, or indeed any other person, may at any time make a request for information which may, or may not, be related to the complaint. Such requests should be dealt with separately under the procedures set down by the relevant HSC organisation for dealing with requests for information under the Freedom of Information Act 2000 and requests for access to health or social care records under the Data Protection Act 1998.

Independent Inquiries and Criminal Investigation

1.23 Where an independent inquiry into a serious incident or a criminal investigation is initiated, the Chief Executive (or designated senior person) should immediately advise the complainant of this in writing. As the HSC Complaints Procedure cannot deal with matters subject to any such investigation, consideration of those parts of the original complaint must cease until the other investigation is concluded.

1.24 When the independent inquiry or criminal investigation has concluded, consideration of that part of the original complaint on which action was suspended can recommence if there are outstanding matters which remain to be dealt with.

Children Order Representations and Complaints Procedure

1.25 Arrangements for complaints raised under the Children Order Representations and Complaints Procedure are outlined in Annexe 15. The

HSC Board and HSC Trusts should familiarise themselves with Part IV of, and paragraph 6 of Schedule 5 to, the Children (NI) Order 1995.

Protection of Vulnerable Adults

1.26 Where it is apparent that a complaint relates to abuse, exploitation or neglect of a vulnerable adult then the regional *Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance*[2] (*Sept 2006*) and the associated *Protocol for Joint Investigation of Alleged or Suspected Cases of Abuse of Vulnerable Adults* should be activated by contacting the Adult Protection Co-ordinator at the relevant HSC Trust[3]. The HSC Complaints Procedure should be suspended pending the outcome of the safeguarding vulnerable adults' investigation and the complainant advised accordingly. When the safeguarding vulnerable adults' investigation has concluded, consideration of that part of the original complaint on which action was suspended can recommence if there are outstanding matters which remain to be dealt with.

Child Protection Procedures

1.27 Dissatisfaction with the process or about decisions made in relation to a Child Protection enquiry should be dealt with through the Child Protection Registration Appeals Process. *The Area Child Protection Committees' (ACPC) Regional Policy and Procedure (April 2005)*[4] outlines the criteria for appeal under that procedure. These include:

- ACPC procedures in respect of the case conference were not followed;
- information presented at the case conference was inaccurate; incomplete or inadequately considered in the decision making process;
- the threshold for registration/deregistration was not met;

[2] http://www.dhsspsni.gov.uk/ssi/safeguarding_vulnerable_adults.pdf
[3] Information about and contact details for HSC Trusts can be accessed at: http://www.hscni.net/index.php?link=services
[4] http://www.dhsspsni.gov.uk/acpcregionalstrategy.pdf

- the category for registration was not correct.

Coroner's Cases

1.28 With the agreement of the Coroner's Office, where there are aspects of the complaint not covered by the Coroner's investigation they will continue to be dealt with under the complaints procedure. Once the Coroner's investigation has concluded, any issues that are outstanding in relation to the matters considered by the Coroner can then be dealt with under the complaints procedure.

Legal Action

1.29 Even if a complainant's initial communication is through a solicitor's letter it should not be inferred that the complainant has decided to take formal legal action.

1.30 If the complainant has either instigated formal legal action, or advised that he or she intends to do so, the complaints process should cease. The Chief Executive (or designated senior person) should advise the complainant and any person named in the complaint of this decision in writing.

1.31 It is not the intention of the HSC Complaints Procedure to deny someone the opportunity to pursue a complaint if the person subsequently decides **not to take legal action**. If he/she then wishes to pursue their complaint through the complaints process the investigation of their complaint should commence or resume. However, any matter that has been through the legal process to completion cannot then be investigated under the HSC complaints procedure.

SECTION 2 - MAKING A COMPLAINT

What is a complaint?

2.1 A complaint is "**an expression of dissatisfaction that requires a response**". Complainants may not always use the word "complaint". They may offer a comment or suggestion that can be extremely helpful. It is important to recognise those comments that are really complaints and need to be handled as such.

Promoting access

2.2 Service users should be made aware of their right to complain and given the opportunity to understand all possible options for pursuing a complaint. Complainants must, where appropriate, have the support they need to articulate their concerns and successfully navigate the system. They must also be advised on the types of help available through front-line staff, the Complaints Manager and the Patient and Client Council (PCC). HSC organisations should promote and encourage more open and flexible access to the complaints procedure and other less formal avenues in an effort to address barriers to access. Standard 2: *Accessibility* provides the criteria by which organisations should operate (Annexe 1 refers).

Who can complain?

2.3 Any person can complain about any matter connected with the provision of HSC services. Complaints may be made by:

- a patient or client;
- former patients, clients or visitors using HSC services and facilities;
- someone acting on behalf of existing or former patients or clients, providing they have obtained the patient's or client's consent;
- parents (or persons with parental responsibility) on behalf of a child; and

- any appropriate person in respect of a patient or client unable by reason of physical or mental capacity to make the complaint himself or who has died e.g. the next of kin.

Consent

2.4 Complaints by a third party should be made with the written consent of the individual concerned. There will be situations where it is not possible to obtain consent, such as:

- where the individual is a child and not of sufficient age or understanding to make a complaint on their own behalf;
- where the individual is incapable (for example, rendered unconscious due to an accident; judgement impaired by learning disability, mental illness, brain injury or serious communication problems);
- where the subject of the complaint is deceased.

2.5 Where a person is unable to act for him/herself, his/her consent shall not be required.

2.6 The Complaints Manager, in discussion with the Chief Executive (or senior person), will determine whether the complainant has sufficient interest to act as a representative. The question of whether a complainant is suitable to make representation depends, in particular, on the need to respect the confidentiality of the patient or client. If it is determined that a person is not suitable to act as a representative, the Chief Executive (or senior person) must provide information in writing to the person outlining the reasons the decision has been taken. More information on consent can be found in the DHSSPS' good practice in consent guidance[5].

[5] http://www.dhsspsni.gov.uk/public_health_consent

2.7 Third party complainants who wish to pursue their own concerns can bring these to the HSC organisation without compromising the identity of the patient/ client. The HSC organisation must consider the matter, investigate and address, as fully as possible, any identified concerns. A response will be provided to the third party on any issues which it is possible to address without breaching the patient's/ client's confidentiality.

Confidentiality

2.8 HSC staff should be aware of their legal and ethical duty to protect the confidentiality of the service user's information. The legal requirements are set out in the Data Protection Act 1998 and the Human Rights Act 1998. The common law duty of confidence must also be observed. Ethical guidance is provided by the respective professional bodies. A service user's consent is required if their personal information is to be disclosed but more detailed information can be found in the HSC guidance entitled *Code of Practice on Protecting the Confidentiality of Service User Information*.[6]

2.9 It is not necessary to obtain the service user's express consent to the use of their personal information to investigate a complaint. Even so, it is good practice to explain to the service user that information from his/her health or social services records may need to be disclosed to the people investigating the complaint, but only if they have a demonstrable need to know and for the purposes of investigating. If the service user objects to this, it should be explained to him/her that this could compromise the investigation and his/her hopes of a satisfactory outcome to the complaint. The service user's wishes should always be respected, unless there is an overriding public interest in continuing with the matter.

[6] http://www.dhsspsni.gov.uk/confidentiality-consultation-cop.pdf

Third Party Confidence

2.10 The duty of confidence applies equally to third parties who have given information or who are referred to in the service user's records. Particular care must be taken where the service user's records contain information provided in confidence, by, or about, a third party who is not a health or social services professional. Only that information which is relevant to the complaint should be considered for disclosure, and then only to those *within* the HSC who have a demonstrable need to know in connection with the complaint investigation. Third party information must not be disclosed to the service user unless the person who provided the information has expressly consented to the disclosure.

2.11 Disclosure of information provided by a third party outside the HSC also requires the express consent of the third party. If the third party objects, then it can only be disclosed where there is an overriding public interest in doing so.

Use of Anonymised Information

2.12 Where anonymised information about a patient/client and/or third parties would suffice, identifiable information should be omitted. Anonymising information does not of itself remove the legal duty of confidence but, where all reasonable steps are taken to ensure that the recipient is unable to trace the patient/client or third party identity, it may be passed on where justified by the complaint investigation. Where a patient/client or third party has expressly refused permission to use information, then it can only be used where there is an overriding public interest in doing so.

How can complaints be made?

2.13 Complaints may be made verbally or in writing and should also be accepted via any other method, for example, the telephone or electronically. The complainant should be asked to put the complaint in writing, or assisted to do so. It is helpful to establish at the outset what the complainant wants to achieve to avoid confusion or dissatisfaction and subsequent letters of complaint. HSC organisations should be mindful of technological advances and consider local arrangements to ensure there is no breach of patient/client confidentiality.

2.14 Complaints may be made to any member of staff - for example receptionists, clinical or care staff. In many cases complaints are made orally and front-line staff may either resolve the complaint "on the spot" or pass it to the Complaints Manager. It is important that front-line staff are trained and supported to respond sensitively to the comments and concerns raised and are able to distinguish those issues which would be better referred elsewhere. Front line staff should familiarise themselves with the Equality Good Practice Reviews' principles for dealing with and managing complaints[7].

Options for pursuing a complaint

2.15 Some complainants may prefer to make their initial complaint to someone within the relevant organisation who has not been involved in the care provided. In these circumstances, they should be advised to address their complaint to the Complaints Manager, an appropriate senior person or, if they prefer, in writing to the Chief Executive. All HSC organisations have

[7] Guidance Note – Implementing the Equality Good Practice Reviews (January 2004) http://www.dhsspsni.gov.uk/eq-gprs-circ-hssps-29jan04.pdf

named Complaints Managers. The following paragraphs outline the options available to complainants who want to raise complaints in relation to:

- Family Practitioner Services; and
- Registered Establishments and Agencies.

Family Practitioner Services (family doctors, dentists, pharmacists, opticians)

2.16 All Family Practitioner Services (FPS) are required to have in place a practice-based complaints procedure for handling complaints. The practice-based complaints procedure forms part of the local resolution mechanism for settling complaints. A patient may approach any member of staff with a complaint about the service or treatment he/she has received.

2.17 Alternatively, the complainant has the right to lodge his/her complaint with the HSC Board's Complaints Manager if he/she does not feel able to approach immediate staff.

2.18 Where requested, the HSC Board will act as "honest broker" in the resolution of a complaint. The objective for the HSC Board should be, wherever possible, to restore the trust between the patient and the practitioner/practice staff. This will involve an element of mediation on the part of the HSC Board or the offer of conciliation services where they are appropriate. The HSC Board's Complaints Manager should seek - with the complainant's agreement - to involve the FPS Complaints Manager as much as possible in resolving the issues. The HSC Board's Complaints Manager is also available to practice staff for support and advice.

2.19 The HSC Board has a responsibility to record and monitor the outcome of those complaints lodged with them.

2.20 The HSC Board will provide support and advice to FPS in relation to the resolution of complaints. It will also appoint independent experts, lay persons or conciliation services, where appropriate.

2.21 Complainants must be advised of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the practice-based complaints procedure.

Regulated Establishments and Agencies

2.22 All regulated establishments and agencies must operate a complaints procedure that meets the requirements of applicable Regulations, relevant Minimum Standards and the HSC Complaints Procedure. This includes, publicising the arrangements for dealing with complaints, ensuring that any complaint made under the complaints procedure is investigated, making sure that time limits for investigation are adhered to and complainants are advised of outcomes of the investigation. Complainants must also be advised of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the HSC Complaints Procedure.

2.23 Complaints may be made by service users or by persons acting on their behalf providing they have obtained the service user's consent. Complainants should be encouraged to raise their concerns, at the outset, with the registered provider. The registered provider is required by legislation to ensure the complaint is fully investigated.

2.24 Individuals placed in a regulated establishment or who have their service provided by a regulated agency may, if they prefer, raise their concerns through the HSC Trust that has commissioned the care on their behalf. The HSC Trust that has commissioned the care has a

continuing duty of care to the service user and should participate in local resolution as necessary.

2.25 Where complaints are raised with the HSC Trust, the Trust must establish the nature of the complaint and consider how best to proceed. For example, the complaint may be about an aspect of the "care plan" and can, therefore, only be fully dealt with by the Trust. The complaint may also trigger the need for an investigation under child protection or protection of vulnerable adults procedures or indeed, might highlight non-compliance with statutory requirements. It is not the intention to operate parallel complaints procedures, however, if the RQIA is notified of a breach of regulations or associated standards it will review the matter and take whatever appropriate action is required. It is important, therefore, that Trusts work closely with the registered providers, other professionals and the RQIA to enable appropriate decisions to be made.

2.26 HSC Trusts must assure themselves that regulated establishments and agencies which deliver care on their behalf are effective and responsive in their handling of complaints. Service users may approach the Ombudsman if they remain dissatisfied. It is possible that referrals to the Ombudsman where complaints are dealt with directly by the registered provider without HSC Trust participation in local resolution will be referred to the HSC Trust by the Ombudsman for action.

2.27 Copies of all correspondence relating to regulated sector complaints should be retained. RQIA will use this information to monitor all regulated services including those services commissioned by the HSC Trust.

2.28 In due course, these arrangements will also apply to other services which will be regulated by RQIA, including Fostering Agencies and Voluntary Adoption Agencies.

What information should be included in the complaint?

2.29 A complaint need not be long or detailed, but it should include:

- contact details;
- who or what is being complained about, including the names of staff if known;
- where and when the events of the complaint happened; and
- where possible, what remedy is being sought – e.g. an apology or an explanation or changes to services.

Supporting complainants and staff

2.30 Advice and assistance is available to complainants and staff at any stage in the complaints process from the Complaints Manager. Independent advice and support for complainants is available from the PCC (Annexe 6 refers). Independent advocacy and specialist advocacy services are also available (Annexe 7 refers). Standard 4: *Supporting complainants and staff* provides the criteria by which organisations should operate (Annexe 1 refers).

What are the timescales for making a complaint?

2.31 A complaint should be made as soon as possible after the action giving rise to it, normally within six months of the event. HSC organisations should encourage those who wish to complain to do so as soon as possible after the event. Investigation is likely to be most effective when memories are fresh.

2.32 If a complainant was not aware that there was cause for complaint, the complaint should normally be made within **six months** of their becoming

aware of the cause for complaint, or within **twelve months** of the date of the event, whichever is the earlier.

2.33 There is discretion for the Complaints Manager to extend this time limit where it would be unreasonable in the circumstances of a particular case for the complaint to have been made earlier and where it is still possible to investigate the facts of the case. This discretion should be used with sensitivity. The complainant should be advised that with the passage of time the investigation and response will be based largely on a review of records.

2.34 In any case where a Complaints Manager has decided not to investigate a complaint on the grounds that it was not made within the time limit, the complainant can request the Ombudsman to consider it. The complainant should be advised of the options available to him/her to pursue this further.

2.35 The Complaints Manager must consider the content of complaints that fall outside the time limit in order to identify any potential risk to public or patient safety and, where appropriate, the need to investigate the complaint if it is in the public's interest to do so or refer to the relevant regulatory body.

SECTION 3 - HANDLING COMPLAINTS

Accountability

3.1 Accountability for the handling and consideration of complaints rests with the Chief Executive (or Clinical Governance Lead in FPS settings). The HSC organisation must designate a senior person within the organisation to take responsibility for the local complaints procedure and to ensure compliance with the regulations and that action is taken in light of the outcome of any investigation. In the case of HSC Trusts, a Director should be designated (or a Clinical Governance Lead in FPS setting). All staff must be aware of, and comply with, the requirements of the complaints procedure. These arrangements will ensure the integration of complaints management into the organisation's governance arrangements. Standard 1: *Accountability* provides the criteria by which organisations should operate (Annexe 1 refers).

3.2 Where care or treatment is provided by an independent provider, for example residential or nursing home care, the commissioning body must ensure that the contract includes entitlement, by the HSC organisation, to any and all documentation relating to the care of service users and a provision to comply with the requirements of the HSC Complaints Procedure.

Performance Management

3.3 Complaints provide a rich source of information and should be considered a vital part of the HSC organisation's performance management strategy. HSC organisations need to be able to demonstrate that positive action has been taken as a result of complaints and that learning from complaints is embedded in the organisation's governance and risk management arrangements.

3.4 Complaints should be used to inform and improve. HSC organisations should aim for continuous change and improvement in their performance as a result of complaints. Where something has gone wrong or fallen below standard the organisation has the opportunity to improve and avoid a recurrence. By making sure that lessons from complaints are taken on board and followed up appropriately, services and performance can be greatly improved for the future.

Co-operation

3.5 Local arrangements must be such as to ensure that a full and comprehensive response is given to a complainant and to that end there is all necessary co-operation in the handling and consideration of complaints between:

- HSC organisations;
- Regulatory authorities e.g. professional bodies, DHSSPS Pharmaceutical Inspectorate;
- NI Commissioner for Complaints (the Ombudsman); and
- The Regulation and Quality Improvement Authority (RQIA).

3.6 This general duty to co-operate includes answering questions, providing information and attending any meeting reasonably requested by those investigating the complaint.

Complaints Manager

3.7 HSC organisations must have a designated Complaints Manager of appropriate authority and standing who is readily accessible to both the public and members of staff. While it is not essential that this title be used, it is nevertheless important that the person with the role is easily identifiable to service users. The Complaints Manager is responsible for co-ordinating the

local complaints arrangements and managing the process and is supported in his/her role by the designated senior person. The Complaints Manager should:

- deal with complaints referred by front-line staff;
- be easily identifiable to service users;
- be available to complainants who do not wish to raise their concerns with those directly involved in their care;
- advise and support vulnerable adults;
- consider all complaints received and identify and appropriately refer those falling outside the remit of the complaints procedure;
- provide support to staff to respond to complaints and be aware of the role of the Medical and Dental Defence organisations to assist staff;
- have access to all relevant records (including personal medical records);
- take account of any corroborative evidence available relating to the complaint e.g. witness to a particular event;
- identify training needs associated with the complaints procedure and ensure these are met;
- ensure all issues are addressed in the draft response, taking account of information obtained from reports received and providing a layman's interpretation to otherwise complex reports;
- compile a summary of complaints received, actions taken and lessons learnt and maintain records;
- assist the designated senior person in the examination of trends, monitoring the effectiveness of local arrangements and the action taken (or proposed) in terms of service improvement; and
- assist the designated senior person in ensuring compliance with standards, identifying lessons and dissemination of learning in line with the organisation's governance arrangements.

3.8 Complaints Managers should involve the complainant from the outset and seek to determine what they are hoping to achieve from the process. The complainant should be given the opportunity to understand all possible options

for pursuing the complaint and the consequences of following these options. Throughout the process, the Complaints Manager should assess what further action might best resolve the complaint and at each stage keep the complainant informed.

Publicity

3.9 HSC organisations must ensure that the complaints process is well publicised locally. This means that service users should be made aware of:

- their right to complain;
- all possible options for pursuing a complaint, and the types of help available; and
- the support mechanisms that are in place.

3.10 Ready access to information can make a critical difference to the service user's experience of HSC services. Information about services and what to expect, the various stages involved in the complaints process, response targets and independent support and advice should be available. Clear lines of communication are required to ensure complainants know who to communicate with during the lifetime of their complaint. The provision of information will improve attitudes and communication by staff as well as support and advice for complainants.

3.11 Local information should:

- be visible, accessible and easily understood;
- be available in other formats or languages as appropriate;
- be provided free of charge;
- outline the arrangements for handling complaints, how to contact complaints staff, the availability of support services, and what to do if the complainant remains dissatisfied with the outcome of the complaints process.

Training

3.12 All staff should be trained and empowered to deal with complaints as they occur. Appropriately trained staff will recognise the value of the complaints process and, as a result will welcome complaints as a source of learning. Staff have a responsibility to highlight training needs to their line managers. Line managers, in turn, have a responsibility to ensure needs are met to enable the individual to function effectively in their role and HSC organisations have a responsibility to create an environment where learning can take place. It is essential that staff recognise that their initial response can be crucial in establishing the confidence of the complainant.

Actions on receipt of a complaint

3.13 Standard 3: *Receiving Complaints* provides the criteria by which organisations must operate (Annexe 1 refers).

3.14 All complaints received should be treated with equal importance regardless of how they are submitted. Complainants should be encouraged to speak openly and freely about their concerns and should be reassured that whatever they may say will be treated with appropriate confidence and sensitivity. Complainants should be treated courteously and sympathetically and where possible involved in decisions about how their complaint is handled and considered. However received, the first responsibility of staff is to ensure that the service user's immediate care needs are being met. This may require urgent action before any matters relating to the complaint are addressed.

3.15 The involvement of the complainant throughout the consideration of their complaint will provide for a more flexible approach to the resolution of the complaint. Complaints staff should discuss individual cases with complainants at an early stage and an important aspect of the discussion will be about the time it may take to complete the investigation. Early provision of information

and an explanation of what to expect should be provided to the complainant at the outset to avoid disappointment and subsequent letters of complaint. Each complaint must be taken on its own merit and responded to appropriately. It may be appropriate for the entire process of local resolution to be conducted informally. Overall, arrangements should ensure that complaints are dealt with quickly and effectively in an open and non-defensive way.

3.16 Where possible, all complaints should be recorded and discussed with the Complaints Manager in order to identify those that can be resolved immediately, those that will require a formal investigation or those that should be referred outside the HSC Complaints Procedure. Front-line staff will often find the information they gain from complaints useful in improving service quality. This is particularly so for complaints that have been resolved “on the spot” and have not progressed through the formal complaints process. Mechanisms for achieving this are best agreed at organisational level.

Acknowledgement of Complaint

3.17 A complaint should be acknowledged in writing within **2 working days** of receipt. FPS complaints should be acknowledged within 3 working days in line with legislative requirements. (See Legal Framework at Annexe 2) A copy of the complaint and its acknowledgement should be sent to any person subject to complaint unless there are reasonable grounds to believe that to do so would be detrimental to that person’s health or well-being. The acknowledgement letter should always thank the complainant for drawing the matter to the attention of the organisation.

3.18 There should be a statement expressing sympathy or concern over the incident. This is a statement of common courtesy, not an admission of responsibility.

3.19 It is good practice for the acknowledgement to be conciliatory, and indicate that a full response will be provided within **20 working days**. FPS acknowledgement should indicate that a full response will be provided within 10 working days. Where these response timescales are not possible an explanation must be provided to the complainant.

3.20 The acknowledgement should:

- seek to confirm the issues raised in the complaint;
- offer opportunities to discuss issues either with a member of the complaints staff or, if appropriate, a senior member of staff; and
- provide information about the availability of independent support and advice.

3.21 Complaints Managers should provide the complainant with further information about the complaints process. This may include locally produced information leaflets or those provided by the Ombudsman's Office or the RQIA. It is also advisable to include information about the disclosure of patient information at this stage.

Joint Complaints

3.22 Where a complaint relates to the actions of more than one HSC organisation the Complaints Manager should notify the other organisation(s) involved. The complainant's consent must be obtained before sharing the details of the complaint across HSC organisations. In cases of this nature there is a need for co-operation and partnership between the relevant organisations in agreeing how best to approach the investigation and resolution of the complaint. It is possible that the various aspects of the complaint can be divided easily with each organisation able to respond to its own area of responsibility. The complainant must be kept informed and provided with advice about how each aspect of their complaint will be dealt with and by whom.

Out of Area Complaints

3.23 Where the complainant lives in Northern Ireland and the complaint is about events elsewhere, the HSC Board or HSC Trust that commissioned the service or purchased the care for that service user is responsible for co-ordinating the investigation and ensuring that all aspects of the complaint are investigated. HSC contracts must include entitlement, by the HSC organisation, to any and all documentation relating to the care of service users and a provision to comply with the requirements of the HSC Complaints Procedure.

Investigation

3.24 HSC organisations should establish a clear system to ensure an appropriate level of investigation. The purpose of investigation is not only "resolution" but to ascertain what happened, to establish the facts, to learn, to detect misconduct or poor practice and to improve services. Standard 5: *Investigation* provides the criteria by which organisations must operate (Annexe 1 refers).

3.25 An investigation into a complaint may be undertaken by a suitable person appointed by the HSC organisation. Investigations should be conducted in a manner that is supportive to all those involved, without bias and in an impartial and objective manner. The investigation must not be adversarial and must uphold the principles of fairness and consistency. The investigation process is best described as listening, learning and improving. Investigators should be able to seek advice from the Complaints Manager/ senior person, wherever necessary, about the conduct or findings of the investigation. Whoever undertakes the investigation should seek to understand the nature of the complaint and identify any issues not immediately obvious. Complaints must be approached with an open mind, being fair to all parties. The complainant and those identified as the subject of a complaint should be

advised of the process, what will be investigated and what will not, those who will be involved, the roles they will play and the anticipated timescales. All those involved should be kept informed of progress throughout. Those staff involved in the investigation process should familiarise themselves with the Equality Good Practice Reviews' principles for staff undertaking complaints investigation[8].

Assessment of the complaint

3.26 It is unrealistic to suggest that all complaints should be investigated to the same degree or at the same level within the organisation. HSC organisations must ensure that a robust risk assessment process is applied to all complaints to allow serious complaints, such as those involving unsafe practice, to be identified. The use of assessment tools to risk assess and categorise a complaint may be helpful in determining the course of action to take in response. It can help ensure that the process is proportionate to the seriousness of the complaint and the likelihood of recurrence. HSC organisations should refer to the DHSSPS' guidance *How to classify adverse incidents and risks*[9] to assist them in developing processes to assess complaints.

Investigation and resolution

3.27 The HSC organisation should use a range of investigating techniques that are appropriate to the nature of the complaint and to the needs of the complainant. Those responsible for investigation should be empowered to choose the method that they feel is the most appropriate to the circumstances.

[8] Guidance Note – Implementing the Equality Good Practice Reviews
[9] http://www.dhsspsni.gov.uk/ph_how_to_classify_adverse__incidents_and_risk_-_guidance.pdf

3.28 The investigator should establish the facts relating to the complaint and assess the quality of the evidence. Depending on the subject matter and complexity of the investigation the investigator may wish to call upon the services of others. There are a number of options available to assist HSC organisations in the resolution of complaints. These should be considered in line with the assessment of the complaint and also in collaboration with the complainant and include the involvement of:

- senior managers/ professionals at an early stage;
- honest broker;
- independent experts;
- lay persons; or
- conciliators.

3.29 It is not intended that HSC organisations utilise all the options outlined above as not all these will be appropriate in the resolution of the complaint. Rather HSC organisations should consider which option would assist in providing the desired outcome. The HSC Board will provide the necessary support and advice to FPS in relation to access and appointment of these options, where appropriate.

Completion of Investigation

3.30 Once the investigator has reached their conclusion they should prepare the draft report/response. The purpose is to record and explain the conclusions reached after the investigation of the complaint. The Department's *HSC Regional Template and Guidance for Incident Investigation/ Review Reports*[10] will assist HSC organisations in ensuring the completeness and readability of such reports.

[10] http://www.dhsspsni.gov.uk/hsc_sqsd__34-07_guidance.pdf

3.31 Where the complaint involves clinical/ professional issues, the draft response must be shared with the relevant clinicians/ professionals to ensure the factual accuracy and to ensure clinicians/ professionals agree with and support the draft response.

3.32 All correspondence and evidence relating to the investigation should be retained. The Complaints Manager should ensure that a complete record is kept of the handling and consideration of each complaint. Complaints records should be kept separate from health or social care records, subject only to the need to record information which is strictly relevant to the service user's on-going health or care needs.

3.33 HSC organisations should regularly review their investigative processes to ensure the effectiveness of these arrangements locally.

Circumstances that might cause delay

3.34 Some complaints will take longer than others to resolve because of differences in complexity, seriousness and the scale of the investigative work required. Others may be delayed as a result of circumstance, for example, the unavailability of a member of staff or a complainant as a result of holidays, personal or domestic arrangements or bereavement. Delays may also be as a result of the complainant's personal circumstances at a particular time e.g. a period of mental illness, an allegation of physical injury or because a complaint is being investigated under another procedure (as outlined in paragraphs 1.12 to 1.31).

Periods of acute mental illness

3.35 If a service user makes a complaint during an acute phase of mental illness, the Complaints Manager should register the complaint and

consideration should be given to delaying the complaint until his/her condition has improved. A delay such as this will need either the agreement of the complainant or someone who is able to act on his/her behalf including, where appropriate, consultation with any advocate. The decision about whether a complainant is well enough to proceed with the complaint should be made by a multi-disciplinary team, and the Complaints Manager should refer regularly to this team to establish when this point has been reached.

Physical Injury

3.36 Where a complainant is alleging physical injury, a physical examination should be arranged without delay and with the consent of the injured person. Medical staff undertaking the physical examination should clearly report their findings. If a person refuses a physical examination, or if his or her mental state (for example, degree of agitation) makes this impossible, this should be clearly documented.

3.37 Whatever the reason, as soon as it becomes clear that it will not be possible to respond within the target timescales, the Complaints Manager should advise the complainant and provide an explanation with the anticipated timescales. While the emphasis is on a complete response and not the speed of response, the HSC organisation should, nevertheless, monitor complaints that exceed the target timescales to prevent misuse of the arrangements.

Responding to a complaint

3.38 A full investigation of a complaint should normally be completed within 20 working days (10 working days within FPS). Standard 6: *Responding to complaints* provides the criteria by which organisations must operate (Annexe 1 refers).

3.39 Where appropriate, HSC organisations must consider alternative methods of responding to complaints whether through an immediate response from front-line staff, a meeting, or direct action by the Chief Executive (or senior person). It may be appropriate to conduct a meeting in complex cases, in cases where there is serious harm/death of a patient, in cases involving those whose first language is not English, or, for example in cases where the complainant has a learning disability or mental illness. Where complaints have been raised electronically the HSC must obtain a postal address for the purposes of the response to maintain appropriate levels of confidentiality. **Responses should not be made electronically**.

3.40 Where a meeting is scheduled it is more likely to be successful if the complainant knows what to expect and can offer some suggestions towards resolution. Complainants have a right to choose from whom they seek support and should be encouraged to bring a relative or friend to meetings. Where meetings do take place they should be recorded and that record shared with the complainant for comment.

3.41 The Chief Executive (or Clinical Governance Lead) may delegate responsibility for responding to a complaint, where, in the interests of a prompt reply, a designated senior person may undertake the task (or the governance lead within FPS settings). In such circumstances, the arrangements for clinical and social care governance must ensure that the Chief Executive (or Clinical Governance Lead) maintains an overview of the issues raised in complaints (including those FPS complaints lodged with the HSC Board), the responses given and be assured that appropriate organisational learning has taken place. HSC organisations should ensure that the complainant and anyone who is a subject of the complaint understand the findings of the investigation and the recommendations made.

3.42 The response should be clear, accurate, balanced, simple and easy to understand. It should avoid technical terms, but where these must be used to describe a situation, events or condition, an explanation of the term should be provided. The letter should:

- address the concerns expressed by the complainant and show that each element has been fully and fairly investigated;
- include an apology where things have gone wrong;
- report the action taken or proposed to prevent recurrence;
- indicate that a named member of staff is available to clarify any aspect of the letter; and
- advise of their right to take their complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure.

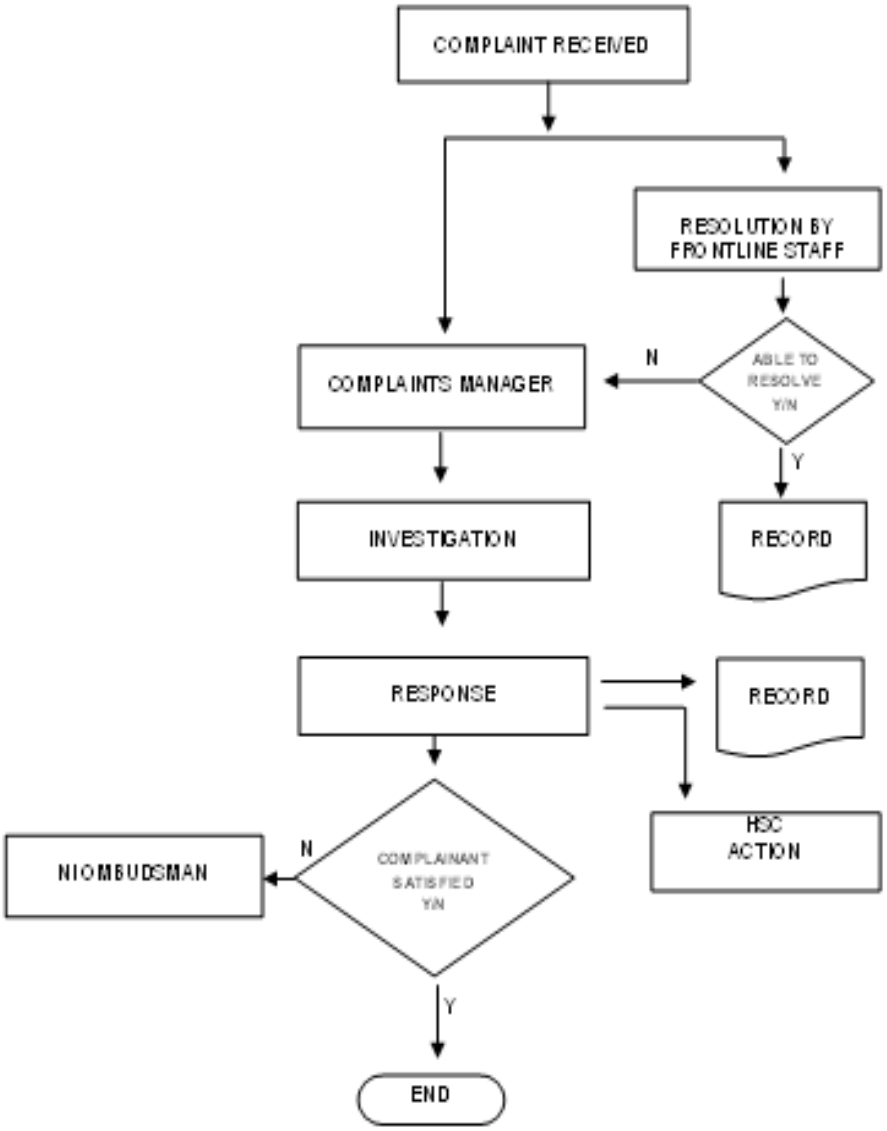
Concluding Local Resolution

3.43 The HSC organisation should offer every opportunity to exhaust local resolution. While the final response should offer an opportunity to clarify the response this should not be for the purposes of delaying “closure”.

3.44 Once the final response has been signed and issued, the Complaints Manager, on behalf of the Chief Executive/Clinical Governance Lead, should liaise with relevant local managers and staff to ensure that all necessary follow-up action has been taken. Arrangements should be made for any outcomes to be monitored to ensure that they are actioned. Where possible, the complainant and those named in the complaint should be informed of any change in system or practice that has resulted from their complaint.

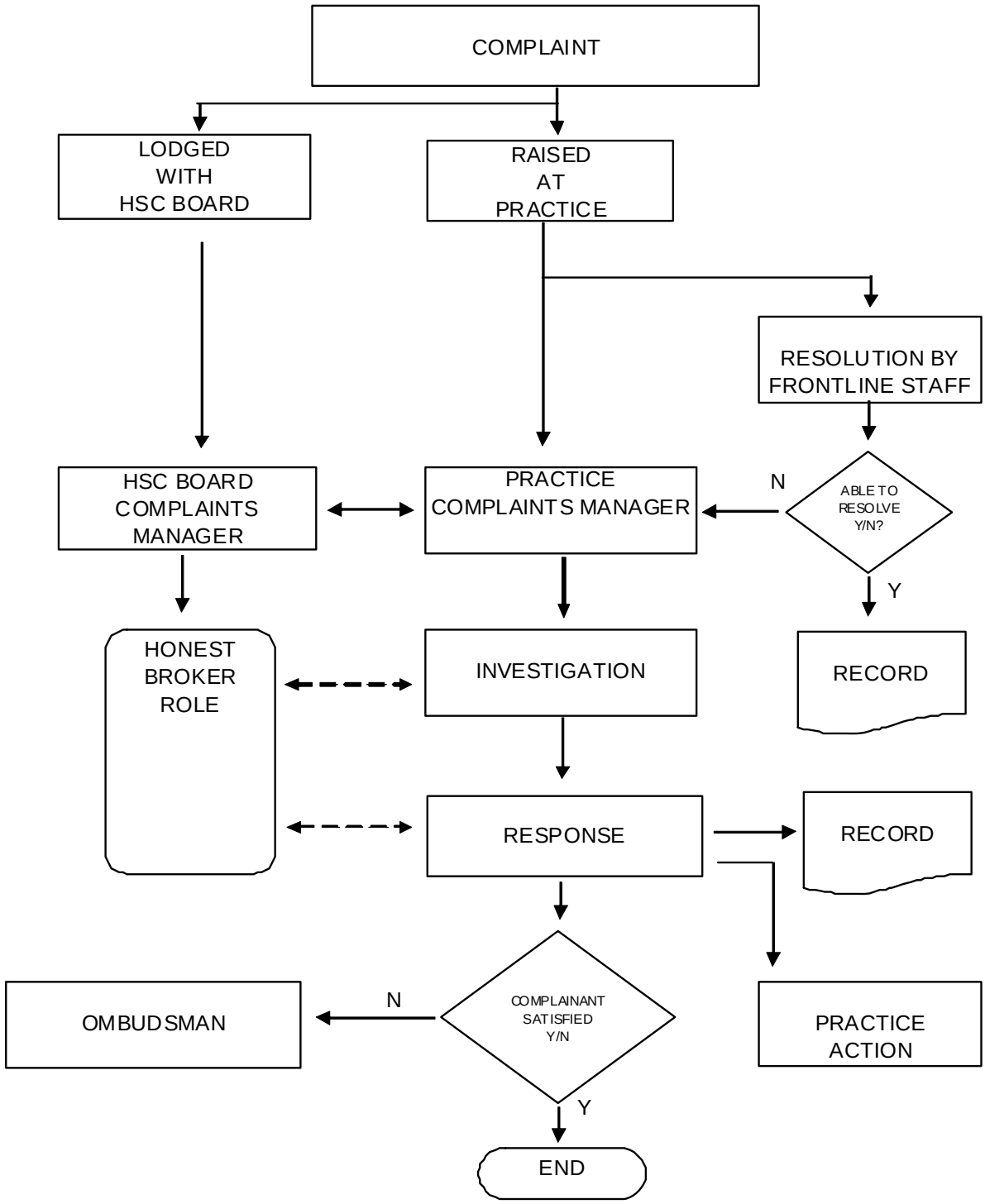
3.45 This completes the HSC Complaints Procedure. Complainants must be advised of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure.

HOSPITAL OR COMMUNITY COMPLAINTS FLOWCHART



MAHI - STM - 097 - 6209

FAMILY PRACTITIONER SERVICE COMPLAINTS FLOWCHART



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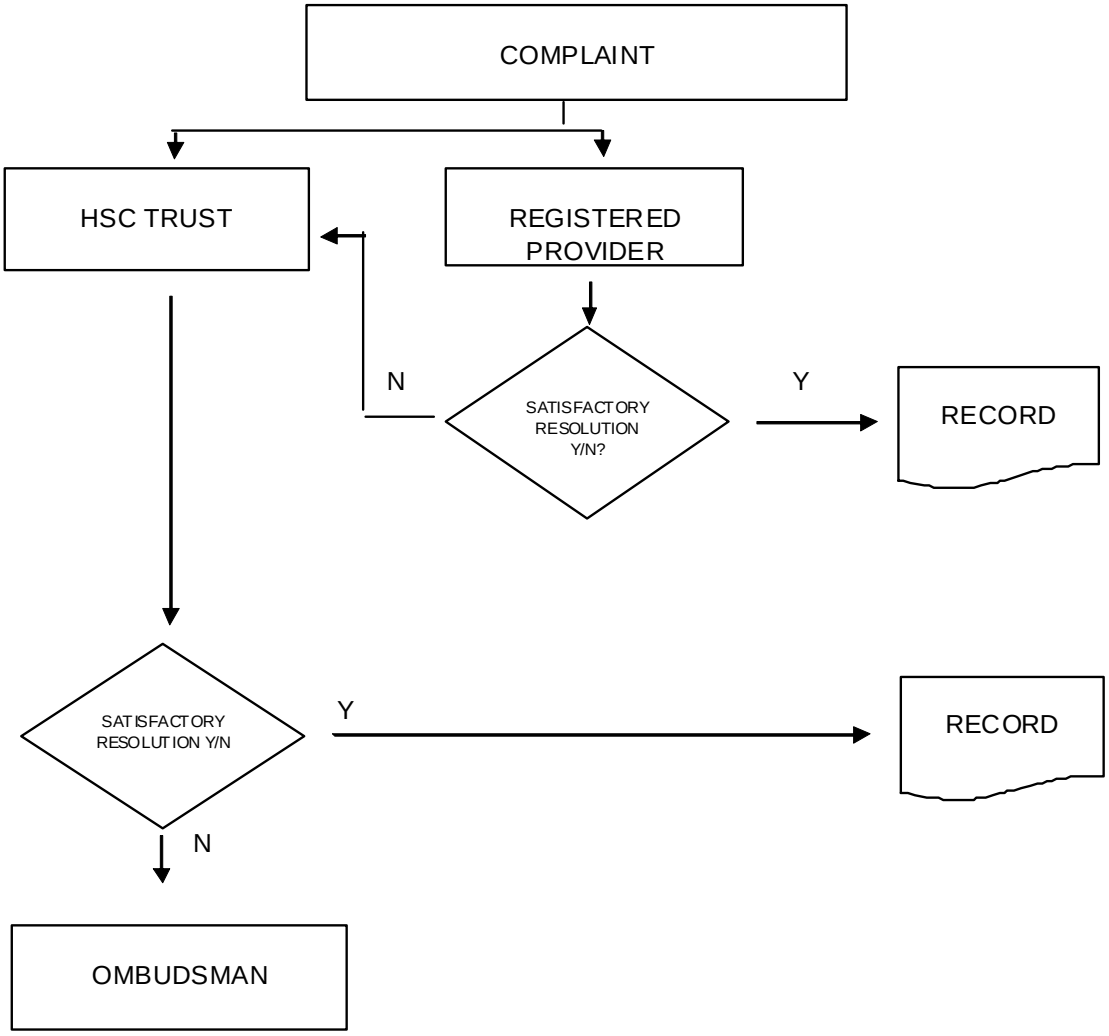
REGISTERED ESTABLISHMENTS & AGENCIES FLOWCHART



SUMMARY OF TARGET TIMESCALES

EVENT	TIMESCALE
Making a complaint	within 6 months of the event, or 6 months after becoming aware of the cause for complaint, but no longer than 12 months from the event
Acknowledgement Family Practitioner Services	within 2 working days* of receipt within 3 working days
Response Family Practitioner Services	within 20 working days within 10 working days

* A working day is any weekday (Monday to Friday) which is not a local or public holiday.

SECTION 4 - LEARNING FROM COMPLAINTS

Reporting & Monitoring

4.1 Each HSC organisation has a legal duty to operate a complaints procedure and is required to monitor how they, or those providing care on their behalf, deal with and respond to complaints. This includes the regular reporting on complaints in line with governance arrangements and monitoring the effectiveness of the procedure locally. The HSC organisation must:

- regularly review its policies and procedures to ensure they are effective;
- monitor the nature and volume of complaints;
- seek feedback from service users and staff to improve services and performance; and
- ensure lessons are learnt from complaints and use these to improve services and performance.

4.2 HSC organisations are also required to keep a record of all complaints received, including copies of all correspondence relating to complaints. HSC organisations must have effective processes in place for identifying and minimising risk, identifying trends, improving quality and safety and ensuring lessons are learnt and shared. HSC organisations must ensure regular and adequate reporting on complaints in line with agreed governance arrangements[11].

4.3 The *Standards for Complaints Handling* (Annexe 1 refers) provide the criteria by which organisations must operate and will assist organisations in monitoring the effectiveness of their complaints-handling arrangements locally. HSC organisations should also involve service users and staff to improve the

[11] Controls Assurance Standard, Risk Management, Criterion 5 http://www.dhsspsni.gov.uk/risk_07_pdf.pdf

quality of services and effectiveness of complaints-handling arrangements locally.[12]

4.4 The HSC must ensure they have the necessary technology/ information systems to record and monitor all complaints. For the purposes of measuring the effectiveness of the procedures, HSC organisations must maintain systems as described below.

The HSC Board

4.5 The HSC Board must maintain an oversight of all Family Practitioner Service and HSC Trust complaints received (including HSC prison healthcare) and be prepared to investigate any patterns or trends of concern or clusters of complaints against individuals, practices, or organisations.

4.6 The HSC Board must provide the Department with quarterly complaints statistics in relation to all FPS and, where appropriate, out-of-hours services.

4.7 The HSC Board must produce an annual report on complaints outlining the number of FPS and, where appropriate, out-of-hours services complaints received, the categories to which the complaints relate and the response times. The annual report should also include the number of FPS complaints in which the HSC Board acted as “honest broker”. Copies should be sent to the PCC, the RQIA, the Ombudsman and the DHSSPS. Reports must not breach patient/ client confidentiality.

HSC Trusts

[12] Circular HSC (SQSD) 29/07: Guidance on Strengthening Personal and Public Involvement in Health and Social Care http://www.dhsspsni.gov.uk/hsc_sqsd_29-07.pdf

4.8 HSC Trusts (including the Northern Ireland Ambulance Service) must provide the Department with quarterly statistical returns on complaints.

4.9 HSC Trusts must provide the HSC Board with quarterly complaints reports outlining the number and type of complaint received, the investigation undertaken and actions as a result including those relating to registered establishments and agencies, the Children Order and, where appropriate, out-of-hours services, pilot schemes and HSC prison healthcare;

4.10 HSC Trusts must produce an annual complaints report to include the number of complaints received, the categories to which the complaints relate, the response times and the learning from complaints. Copies should also be made available to the HSC Board, PCC, RQIA, the Ombudsman and the DHSSPS. Reports must not breach patient/ client confidentiality.

Quarterly reports

4.11 The management boards of the HSC Board and HSC Trusts should receive quarterly reports summarising the categories, emerging trends and the actions taken (or proposed) to prevent recurrence in order to:

- monitor arrangements for local complaints handling;
- consider trends in complaints; and
- consider any lessons that can be learned and shared from complaints and the result in terms of service improvement.

4.12 The HSC Board's quarterly reports to their management board should include a breakdown of complaints received in relation to **all** Family Practitioner Services and, where appropriate, out-of-hours services.

4.13 HSC Trusts' quarterly reports to their management board should include a breakdown of all complaints received including those received by, or on

behalf of, residents in statutory or independent residential care and nursing homes and, where appropriate, out-of-hours services, pilot schemes and HSC prison healthcare.

Family Practitioner Services

4.14 Family Practitioner Services must provide the HSC Board with:

- quarterly complaints statistics outlining the number of complaints received; and
- copies of all written complaints received - within 3 working days of receipt.

Arrangements should ensure that the complainant is aware and agrees to his/her complaint being forwarded to the HSC Board.

4.15 The HSC Board must record and monitor the outcome of all FPS complaints lodged with them.

Other HSC organisations

4.16 All other HSC organisations must publish annually a report on complaints handling. Copies should be sent to the PCC, HSC Board and the DHSSPS. Reports must not breach patient/client confidentiality.

Regulated establishments and agencies

4.17 All regulated establishments and agencies are required to provide RQIA, on request, with a statement containing a summary of complaints made during the proceeding 12 months and the action that was taken in response. RQIA will record and monitor all outcomes and will report on complaints activity within the regulated sector.

DHSSPS

4.18 The DHSSPS will continue to collect statistics on the number, type and response times of complaints made to HSC organisations. A regional breakdown of complaints statistics will be provided via the Departmental website on an annual basis.

Learning

4.17 All HSC organisations are expected to manage complaints effectively, ensuring that appropriate action is taken to address the issues highlighted by complaints and making sure that lessons are learned, to minimise the chance of mistakes recurring. Learning should take place at different levels within the HSC organisation (individual, team and organisational) and the HSC organisation must be able to demonstrate that this is taking place[13].

4.18 Learning is a critical aspect of the HSC Complaints Procedure and provides an opportunity to improve services and contribute to and learn from regional, national and international quality improvement and patient safety initiatives. The HSC, RQIA and Ombudsman must share the intelligence gained through complaints.

4.19 The HSC Board must have in place area-wide procedures for collecting and disseminating the information, themes and good practice derived from complaints ensuring they are used to improve service quality. HSC Trusts and FPS should be encouraged to share learning and seek feedback from service users for further improvement.

[13] The Quality Standards for Health and Social Care, Theme 5 (8.3 (k)) - http://www.dhsspsni.gov.uk/qpi_quality_standards_for_health___social_care.pdf

SECTION 5 - ROLES AND RESPONSIBILITIES

HSC Board

5.1 The HSC Board is required to monitor how they, or those providing care on their behalf, deal with and respond to complaints. This will include monitoring complaints processes, outcomes and service improvements. The S*tandards for Complaints Handling* provides a level against which HSC service performance can be measured (Annexe 1 refers).

5.2 The HSC Board must maintain an oversight of all FPS and HSC Trust complaints received and, where appropriate, out-of-hours services. The HSC Board must be prepared to investigate any patterns or trends of concern or clusters of complaints against individual clinicians/ professionals.

5.3 The HSC Board must have in place area-wide procedures for collecting and disseminating learning and sharing intelligence.

5.4 The HSC Board will provide a vital role in supporting FPS complaints that includes:

- providing support and advice;
- the role of “honest broker” between the complainant and the service provider;
- providing independent experts, lay persons, conciliation services, where appropriate;
- recording and monitoring the outcome of all complaints;
- addressing breaches of contractual arrangements; and
- sharing complaints intelligence with appropriate authorities e.g. the DHSSPS Pharmaceutical Inspectorate.

HSC Organisations

5.5 HSC organisations must:

- make arrangements for the handling and consideration of complaints and publicise these arrangements locally;
- appoint a Complaints Manager with responsibility for co-ordinating the local complaints arrangements and managing the process;
- appoint a senior person to take responsibility for delivering the organisation's complaints process and ensuring that all necessary organisational learning takes place;
- ensure that all staff who provide services on their behalf are aware of, and trained in, the procedures to be followed when dealing with complaints;
- ensure that complainants and staff are supported and made aware of the availability of support services;
- ensure that there is full co-operation between organisations/bodies in the handling and consideration of complaints;
- integrate complaints management into the organisation's clinical and social care governance and risk management arrangements;
- monitor the effectiveness of local complaints handling arrangements;
- have in place area-wide procedures for collecting and disseminating the information, themes and good practice derived from complaints; and
- where appropriate, publish annually a report on complaints handling.

The Regulation and Quality Improvement Authority (RQIA)

5.6 The Regulation and Quality Improvement Authority (RQIA) is an independent non-departmental public body. RQIA is charged with overall responsibility for regulating, inspecting and monitoring the standard and quality of health and social care services provided by independent and statutory bodies in Northern Ireland.

5.7 RQIA has a duty to assess and report on how the HSC and the regulated sector handle complaints in light of the standards and regulations laid down by the DHSSPS. RQIA will assess the effectiveness of local procedures and will use information from complaints to identify wider issues for the purposes of raising standards.

5.8 RQIA has a duty to encourage improvement in the delivery of services and to keep the DHSSPS informed on matters concerning the provision, availability and quality of services.

5.9 RQIA may be contacted at:

9th Floor, Riverside Tower
Lanyon Place
Belfast
BT1 3BT
Tel: 028 90 517500
Fax: 028 90 571501
http://www.rqia.org.uk/home/index.cfm

ANNEXE 1: STANDARDS FOR COMPLAINTS HANDLING

Standards for complaints handling

1. The following standards have been developed to address the variations in the standard of complaints handling across HSC organisations. These will assist organisations in monitoring the effectiveness of their complaints handling arrangements locally and will build public confidence in the process by which their complaint will be handled.

2. These are the standards to which HSC organisations are expected to operate. These standards complement existing Controls Assurance Standards, the Quality Standards for Health and Social Care, the Minimum Standards in relation to registered establishments and agencies and the Standards for Patient and Client Experience[14]. The standards for complaints handling are:

Standard 1: Accountability
Standard 2: Accessibility
Standard 3: Receiving complaints
Standard 4: Supporting complainants and staff
Standard 5: Investigation of complaints
Standard 6: Responding to complaints
Standard 7: Monitoring
Standard 8: Learning

[14] http://www.dhsspsni.gov.uk/improving_the_patient_and_client_experience.pdf

STANDARD 1: ACCOUNTABILITY

HSC organisations will ensure that there are clear lines of accountability for the handling and consideration of complaints.

Rationale:

HSC organisations will demonstrate that they have in place clear accountability structures to ensure the effective and efficient investigation of complaints, to provide a timely response to the complainant and a framework whereby learning from complaints is incorporated into the clinical, social care and organisational governance arrangements.

Criteria:

1. Managerial accountability for complaints within HSC organisations rests with the Chief Executive (or Clinical Governance Lead in FPS settings);
2. HSC organisations must designate a senior person to take responsibility for complaints handling and responsiveness locally;
3. HSC organisations must ensure that complaints are integrated into clinical and social care governance and risk management arrangements;
4. HSC organisations will include complaints handling within its performance management framework and corporate objectives;
5. Each HSC organisation must ensure that the operational Complaints Manager is of appropriate authority and standing and has appropriate support;
6. All staff must be aware of, and comply with, the requirements of the complaints procedure within their area of responsibility;
7. Where applicable, HSC organisations will ensure that independent provider contracts include compliance with the requirements of the HSC Complaints Procedure;

8. Each HSC organisation is responsible for quality assuring its complaints handling arrangements.

STANDARD 2: ACCESSIBILITY

All service users will have open and easy access to the HSC Complaints Procedure and the information required to enable them to complain about any aspect of service.

Rationale:

Those who wish to complain will be treated impartially, in confidence, with sensitivity, dignity and respect and will not be adversely affected because they have found cause to complain. Where possible, arrangements will be made as necessary for the specific needs of those who wish to complain, including provision of interpreting services; information in a variety of formats and languages; at suitable venues; and at suitable times.

Criteria:

1. Arrangements about how to make a complaint are widely publicised, simple and clear and made available in all areas throughout the service;
2. Arrangements for making a complaint are open, flexible and easily accessible to all service users, no matter what their personal situation or ability;
3. Flexible arrangements are in place in order that individual complainants may be suitably accommodated in an environment where they feel comfortable;
4. All staff have appropriate training about the needs of service users, including mental health, disability and equality awareness training.

STANDARD 3: RECEIVING COMPLAINTS

All complaints received will be dealt with appropriately and the process and options for pursuing a complaint will be explained to the complainant.

Rationale:

All complaints are welcomed. Effective complaints handling is an important aspect of the HSC clinical and social care governance arrangements. All complaints, however or wherever received, will be recorded, treated confidentially, taken seriously and dealt with in a timely manner.

Criteria:

1. Flexible arrangements are in place so that complaints can be raised in a variety of ways (e.g. verbally or in writing), and in a way in which the complainant feels comfortable;
2. Complaints from a third party must, where possible, have the written consent of the individual concerned;
3. HSC staff are aware of their legal and ethical duty to protect the confidentiality of service user information;
4. Attempts to resolve complaints are as near to the point of contact as possible, and in accordance with the complainant's wishes;
5. Where possible, the complainant should be involved in decisions about how their complaint is handled and considered;
6. Complaints are appropriately recorded and assessed according to risk in line with agreed governance arrangements;

STANDARD 4: SUPPORTING COMPLAINANTS AND STAFF

HSC organisations will support complainants and staff throughout the complaints process.

Rationale:

The HSC will support service users in making complaints and will encourage feedback through a variety of mechanisms. Information on complaints will outline the process as well as the support services available. Staff will be trained and empowered to deal with complaints as they arise.

Criteria:

1. HSC organisations will ensure the provision of readily available advice and information on how to access support services appropriate to the complainant's needs;
2. The HSC organisation's Complaints Manager will offer assistance in the formulating of a complaint;
3. HSC organisations will promote the use of independent advice and advocacy services;
4. HSC organisations will facilitate, where appropriate, the use of conciliation;
5. HSC organisations will adopt a consistent approach in the application of DHSSPS guidance on responding to unreasonable, vexatious or abusive complainants;
6. HSC organisations will ensure that staff receive training on complaints, appropriate to their needs;
7. HSC organisations will ensure that mechanisms are in place to support staff throughout the complaints process.

STANDARD 5: INVESTIGATION OF COMPLAINTS

All investigations will be conducted promptly, thoroughly, openly, honestly and objectively.

Rationale:

HSC organisations will establish a clear system to ensure an appropriate level of investigation. Not all complaints need to be investigated to the same degree. A thorough, documented investigation will be undertaken, where appropriate, including a review of what happened, how it happened and why it happened. Where there are concerns, the HSC organisation will act appropriately and, where possible, improve practice and ensure lessons are learned.

Criteria

1. Investigations are conducted in line with agreed governance arrangements;
2. Investigations are robust and proportionate and the findings are supported by the evidence;
3. A variety of flexible techniques are used to investigate complaints, dependent on the nature and complexity of the complaint and the needs of the complainant;
4. Independent experts or lay people are involved during the investigation, where identified as being necessary or potentially beneficial and with the complainant's consent;
5. People with appropriate skills, expertise and seniority are involved in the investigation of complaints, according to the substance of the complaint;
6. All HSC providers/ commissioners and regulatory bodies will co-operate, where necessary, in the investigation of complaints;
7. The HSC organisation will investigate and take necessary action, regardless of consent, where a patient/client safety issue is raised;

8. All correspondence and evidence relating to the investigation will be retained in line with relevant information governance requirements;

STANDARD 6: RESPONDING TO COMPLAINTS

All complaints will be responded to as promptly as possible and all issues raised will be addressed.

Rationale:

All complainants have a right to expect their complaint to be dealt with promptly and in an open and honest manner.

Criteria:

1. The timescales for acknowledging and responding to complaints are in line with statutory requirements;
2. Where any delays are anticipated or further time required the HSC organisation will advise the complainant of the reasons and keep them informed of progress;
3. HSC organisations will consider a variety of methods of responding to complaints;
4. Responses will be clear, accurate, balanced, simple, fair and easy to understand. All the issues raised in the complaint will be addressed and, where appropriate, the response will contain an apology;
5. The Chief Executive may delegate responsibility for responding to a complaint where, in the interests of a prompt reply, a designated senior person may undertake this task (or a clinical governance lead in FPS settings);
6. Complainants should be informed, as appropriate, of any change in system or of practice that has resulted from their complaint;
7. Where a complainant remains dissatisfied, he/she should be clearly advised of the options that remain open to them.

STANDARD 7: MONITORING

HSC organisations will monitor the effectiveness of complaints handling and responsiveness.

Rationale:

HSC organisations are required to monitor how they, or those providing care on their behalf, deal with and respond to complaints. Monitoring performance is essential in determining any necessary procedural change that may be required. It will also ensure that organisations have taken account of the issues and incorporated improvements where appropriate.

Criteria:

1. HSC organisations should ensure the regular and adequate reporting on complaints in accordance with agreed governance arrangements;
2. HSC organisations must produce and disseminate, where appropriate, an Annual Report on Complaints;
3. HSC organisations must ensure that they have in place the necessary technology/information system to record and monitor all complaints and outcomes;
4. HSC organisations should have a mechanism to routinely request feedback from service users and staff on the operation of the complaints process;
5. HSC organisations must review the arrangements for complaints handling and responsiveness.

STANDARD 8: LEARNING

HSC organisations will promote a culture of learning from complaints so that, where necessary, services can be improved when complaints are raised.

Rationale:

Complaints are viewed as a significant source of learning within HSC organisations and are an integral aspect of its patient/client safety and quality services ethos. Complaints will help organisations to continue to improve the quality of their services and safeguard high standards of care and treatment. HSC organisations must have effective structures in place for identifying and minimising risk, identifying trends, improving quality and safety and ensuring lessons are learnt and shared.

Criteria:

1. HSC organisations will monitor the nature and volume of complaints so that trends can be identified and acted upon;
2. HSC organisations will ensure there are provisions made within governance arrangements for the identification of learning from complaints and the sharing of learning locally and regionally;
3. Learning will take place at different levels within the HSC (individual, team and organisational);
4. HSC organisations will ensure that they have adequate mechanisms in place for reporting on progress with the implementation of action plans arising from complaints;
5. HSC organisations will incorporate learning arising from any review of findings of an investigation;
6. HSC organisations will contribute to, and learn from, regional, national and international quality improvement and patient safety initiatives;

7. HSC organisations will include learning from complaints within its Annual Report on Complaints, where Annual Reports are required.

ANNEXE 2: LEGAL FRAMEWORK

HPSS Complaints Procedure Regulations:

- The Health and Personal Social Services (General Medical Services Contracts) Regulations (NI) 2004;
- The Health and Personal Social Services General Dental Services Regulations (NI) 1993;
- The General Ophthalmic Services Regulations (NI) 2007;
- The Pharmaceutical Services Regulations (NI) 1997.

Pilot Scheme Directions

- Directions to Health and Social Services Boards concerning the implementation of pilot schemes (personal dental services) (NI) 2008

The Children (NI) Order 1995:

- The Representations Procedure (Children) Regulations (NI) 1996.

HPSS Complaints Procedure Directions:

- The Health and Social Care Complaints Procedure Directions (NI) 2009;
- Directions to the Health and Social Care Board on Procedures for Dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers (NI) 2009

The Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003

- The Residential Care Homes Regulations (NI) 2005;
- The Nursing Homes Regulations (NI) 2005;
- The Independent Health Care Regulations (NI) 2005;
- The Nursing Agencies Regulations (NI) 2005;

- The Adult Placement Agencies Regulations (NI) 2005;
- The Day Care Settings Regulations (NI) 2007;
- The Residential Family Centres Regulations (NI) 2007;
- The Domiciliary Care Agencies Regulations (NI) 2007;

ANNEXE 3: PROFESSIONAL REGULATORY BODIES

General Chiropractic Council (GCC) Chiropractors Phone: 020 7713 5155 www.gcc-uk.org	**Nursing and Midwifery Council (NMC)** Nurses, midwives and specialist community public health nurses Phone: 020 7333 6622 www.nmc-uk.org
General Dental Council (GDC) Dentists, dental therapists, dental hygienists, dental nurses, dental technicians, clinical dental technicians and orthodontic therapists Phone: 020 7887 3800 www.gdc-uk.org	**Royal Pharmaceutical Society of Great Britain (RPSGB)** Pharmacists, pharmacy technicians (on the voluntary register) and pharmacy premises Phone: 020 7735 9141 www.rpsgb.org
General Medical Council (GMC) Doctors Phone: 0845 357 8001 www.gmc-uk.org	**Pharmaceutical Society of Northern Ireland** Pharmacists and pharmacy premises in Northern Ireland Phone: 02890 326927 www.psni.org.uk
General Optical Council (GOC) Opticians Phone: 020 7580 3898 www.optical.org **General Osteopathic Council (GOsC)** Osteopaths Phone: 020 7357 6655 www.osteopathy.org.uk	**Council for Healthcare Regulatory Excellence (CHRE)** aims to protect the public, promote best practice and encourage excellence among the nine regulators of healthcare professionals listed. www.chre.org.uk
Health Professions Council (HPC) Arts therapists, biomedical scientists, chiropodists, podiatrists, clinical scientists, dieticians, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, prosthetists and orthotists, radiographers, speech and language therapists Phone: 020 7582 0866 www.hpc-uk.org	**Northern Ireland Social Care Council (NISCC)** Social care workers, qualified social workers, and social work students on approved degree courses in Northern Ireland Phone: 02890 417600 www.niscc.info

ANNEXE 4: HSC PRISON HEALTHCARE

1. From 1 April 2008 responsibility for HSC prison healthcare was transferred to the DHSSPS. From that date the DHSSPS has delegated responsibility for commissioning those health and social services to the Eastern Health and Social Services Board (EHSSB). From 1 April 2009 this responsibility has transferred to the HSC Board. The South Eastern HSC Trust has responsibility for providing or securing the provision of health and social care services for prisoners.

2. Complaints raised about care or treatment or about issues relating to the provision of prison healthcare will be dealt with under the HSC Complaints Procedure.

ANNEXE 5: THE NI COMMISSIONER FOR COMPLAINTS

1. The NI Commissioner for Complaints (the Ombudsman) can carry out independent investigations into complaints about poor treatment or service or the administrative actions of HSC organisations. If someone has suffered because they have received poor service or treatment or were not treated properly or fairly – and the organisation or practitioner has not put things right where they could have – the Ombudsman may be able to help.

2. The Ombudsman's contact details are:

Mr Tom Frawley
Northern Ireland Ombudsman
Progressive House
33 Wellington Place
Belfast
BT1 6HN

[redacted]

3. Further information can be accessed at:
www.ni-ombudsman.org.uk

ANNEXE 6: THE PATIENT AND CLIENT COUNCIL

1. The Patient and Client Council (PCC) is an independent non-departmental public body established on 1 April 2009 to replace the Health and Social Services Councils. Its functions include:

- representing the interests of the public;
- promoting involvement of the public;
- providing assistance to individuals making or intending to make a complaint; and
- promoting the provision of advice and information to the public about the design, commissioning and delivery of health and social care services.

2. If a person feels unable to deal with a complaint alone, the staff of the PCC can offer a wide range of assistance and support. This assistance may take the form of:

- information on the complaints procedure and advice on how to take a complaint forward;
- discussing a complaint with the complainant and drafting letters;
- making telephone calls on the complainants behalf;
- helping the complainant prepare for meetings and going with them to meetings;
- preparing a complaint to the Ombudsman.
- referral to other agencies, for example, specialist advocacy services;
- help in accessing medical/social services records;

3. All advice, information and assistance with complaints is provided free of charge and is confidential. Further information can be obtained from:

www.patientclientcouncil@hscni.net; or
Freephone 0800 917 0222

ANNEXE 7: ADVOCACY

1. Some people who might wish to complain do not do so because they do not know how, doubt they will be taken seriously, or simply find the prospect too intimidating. Advocacy services are an important way of enabling people to make informed choices. Advocacy helps people have access to information they need, to understand the options available to them, and to make their views and wishes known. Advocacy also provides a preventative service that reduces the likelihood of complaints escalating. Advocacy is not new. People act as advocates every day for their children, for their elderly or disabled relatives and for their friends.

2. Within the HSC sector, advocacy has been available mainly for vulnerable groups, such as people with mental health problems, learning disabilities and older people (including those with dementia). However, people who are normally confident and articulate can feel less able to cope because of illness, anxiety and lack of knowledge and be intimidated by professional attitudes.

3. HSC organisations should encourage the use of advocacy services and ensure complainants are supported from the outset and made aware of the role of advocacy in complaints, including those services provided by the PCC. Advocacy in complaints must be seen to be independent to retain confidence in the complaints process.

ANNEXE 8: CONCILIATION

1. Conciliation is a process of examining and reviewing a complaint with the help of an independent person. The conciliator will assist all concerned to a better understanding of how the complaint has arisen and will aim to prevent the complaint being taken further. He/she will work to ensure that good communication takes place between both parties involved to enable them to resolve the complaint. It may not be appropriate in the majority of cases but it may be helpful in situations:

- where staff or practitioners feel the relationship with the complainant is difficult;
- when trust has broken down between the complainant and the practice/ pharmacy/ HSC organisation and both parties feel it would assist in the resolution of the complaint;
- where it is important, e.g. because of ongoing care issues, to maintain the relationship between the complainant and the practice/ pharmacy/ HSC organisation; or
- when there are misunderstandings with relatives during the treatment of the patient.

2. All discussions and information provided during the process of conciliation are confidential. This allows staff to be open about the events leading to the complaint so that both parties can hear and understand each others' point of view and ask questions.

3. Where a complainant is considered unreasonable, vexatious or abusive under the *Unacceptable Action Policy* (Annexe 14 refers) then conciliation would NOT be an appropriate option.

4. Conciliation is a voluntary process available to both the complainant and those named in the complaint. Either may request conciliation but both must agree to the process being used. In deciding whether conciliation should be offered, consideration must be given to the nature and complexity of the complaint and what attempts have already been made to achieve local resolution. The decision to progress to conciliation must be made with the agreement of both parties. The aim is to resolve difficulties, for example, if there is a breakdown in the relationship between a doctor or practitioner and their patient.

5. Conciliation may be requested by the complainant, the practice/pharmacy or the HSC organisation. In FPS complaints it may be suggested by the HSC Board.

FPS arrangements

6. The Practitioner/ Practice/ Pharmacy Manager should approach the HSC Board Complaints Manager for advice.

7. Where a request for a conciliator is received the HSC Board Complaints Manager will liaise with the relevant FPS lead to consider the best way forward. Where it is considered that conciliation would aid resolution then the HSC Board Complaints Manager will advise the FPS practice/ pharmacy. In some cases the HSC Board may consider an alternative to conciliation, such as, an honest broker.

Agreement by parties involved

8. The FPS Practice/ Pharmacy Manager/ HSC organisation must contact the complainant and discuss the rationale for involving a conciliator and provide an opportunity to allow the complainant to agree to such an approach

and consent to share information. It is important that all parties involved are aware of the confidentiality clause attached to conciliation services. Once agreement is received, the HSC organisation or the HSC Board Complaints Manager (on behalf of FPS) will make the necessary arrangements.

9. Where it has been agreed that the intervention of a conciliator is appropriate, the HSC organisation or HSC Board (on behalf of FPS) should clearly define the remit of the appointment for the purposes of:

- explaining the issue(s) to be resolved;
- ensuring all parties understand what conciliation involves;
- agreeing the timescales;
- agreeing when conciliation has ended; and
- explaining what happens when conciliation ends.

10. The conciliator must advise the practice/pharmacy/ HSC organisation when conciliation has ceased and whether a resolution was reached. No further details should be provided. The practice/pharmacy must then notify the HSC Board of the outcome.

11. Using conciliation does not affect the right of a complainant to pursue their complaint further through the HSC organisation or HSC Board (for FPS) if they are not satisfied. Neither does it preclude the complainant from referring their complaint to the Ombudsman should they remain dissatisfied.

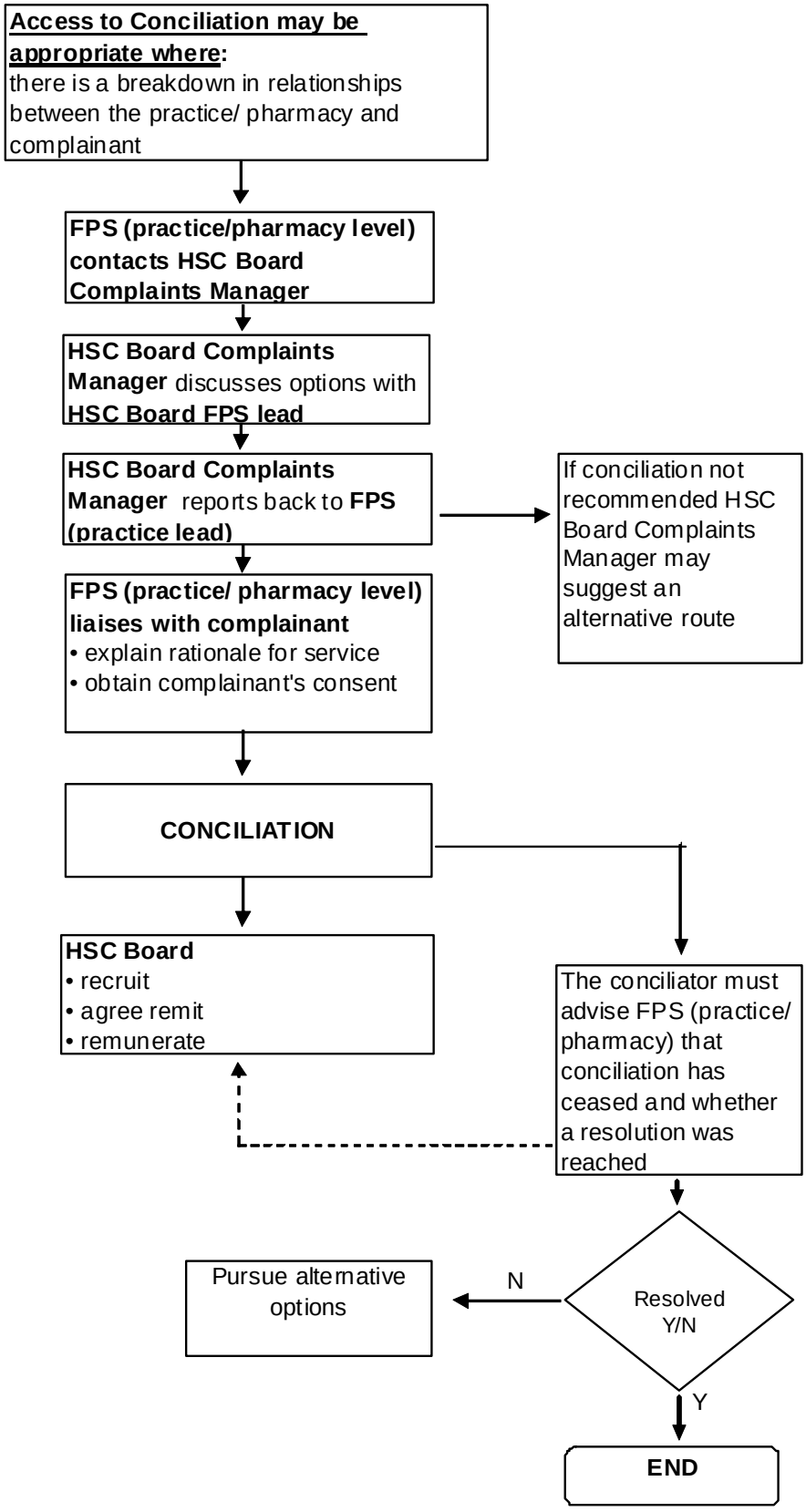
Appointment of conciliators

12. The HSC organisation or HSC Board (on behalf of FPS) is responsible for communicating with, ascertaining the availability of and formally appointing an appropriate conciliation service. In addition it is responsible for all other arrangements, including remuneration.

Monitoring

13. The HSC Board will monitor the effectiveness and usage of conciliation arrangements within HSC Trusts and FPS.

Conciliation – FPS Access



ANNEXE 9: INDEPENDENT EXPERTS

1. The use of an Independent Expert in the resolution of a complaint may be requested by the complainant, the practice/pharmacy or the HSC organisation. In FPS complaints it can also be suggested by the HSC Board. In deciding whether independent advice should be offered, consideration must be given, in collaboration with the complainant, to the nature and complexity of the complaint and any attempts at resolution. Input will not be required in every complaint but it may be considered beneficial where the complaint:

- cannot be resolved locally;
- indicates a risk to public or patient safety;
- could give rise to a serious breakdown in relationships, threaten public confidence in services or damage reputation;
- to give an independent perspective on clinical issues.

FPS arrangements

2. The Practitioner/ Practice/ Pharmacy Manager should approach the HSC Board Complaints Manager for advice.

3. Where a request for an independent expert is received the HSC Board Complaints Manager will liaise with the relevant FPS lead to consider the best way forward. Where it is considered that independent expert advice would aid resolution then the HSC Board Complaints Manager will advise the FPS practice. In some cases the HSC Board may consider an alternative to an Independent Expert.

Agreement and consent

4. The FPS Practice / Pharmacy Manager/ HSC organisation must contact the complainant and discuss the rationale for involving an Independent Expert

and provide an opportunity to allow the complainant to agree to such an approach and consent to share information. Once received, the HSC organisation or the HSC Board Complaints Manager (on behalf of FPS) will make the necessary arrangements.

5. The HSC organisation may decide to involve an Independent Expert in a complaint without the complainant's consent, outside the complaints procedure, for the purposes of obtaining assurances regarding health and social care practice.

6. Where it has been agreed that an Independent Expert will be involved the practice/ pharmacy/ HSC organisation should clearly define the remit of the appointment for the purposes of:

- explaining and agreeing the issue(s) to be reviewed;
- ensuring all parties understand the focus of the issue(s);
- agreeing the timescales;
- agreeing to the provision of a final report; and
- explaining what happens when this process is complete.

7. The Independent Expert's findings/ report will be forwarded to the practice/pharmacy/ HSC organisation. A summary of the findings should be made available by the practice/ pharmacy/ HSC organisation to:

- the complainant; and
- the HSC Board (for FPS only).

8. The letter of response to the complainant is the responsibility of the practice/ pharmacy/ HSC organisation.

Appointment of Independent Experts

9. The HSC organisation or HSC Board (on behalf of FPS) is responsible for communicating with, ascertaining the availability of and formally appointing an appropriate Independent Expert. In addition, it is responsible for all other arrangements, including remuneration and indemnity.

10. Independent Experts must be impartial, objective and independent of any parties to the complaint. Independent Experts should be recruited from another Local Commissioning group (LCG) area to ensure this impartiality (and in certain circumstance may be recruited from outside Northern Ireland).

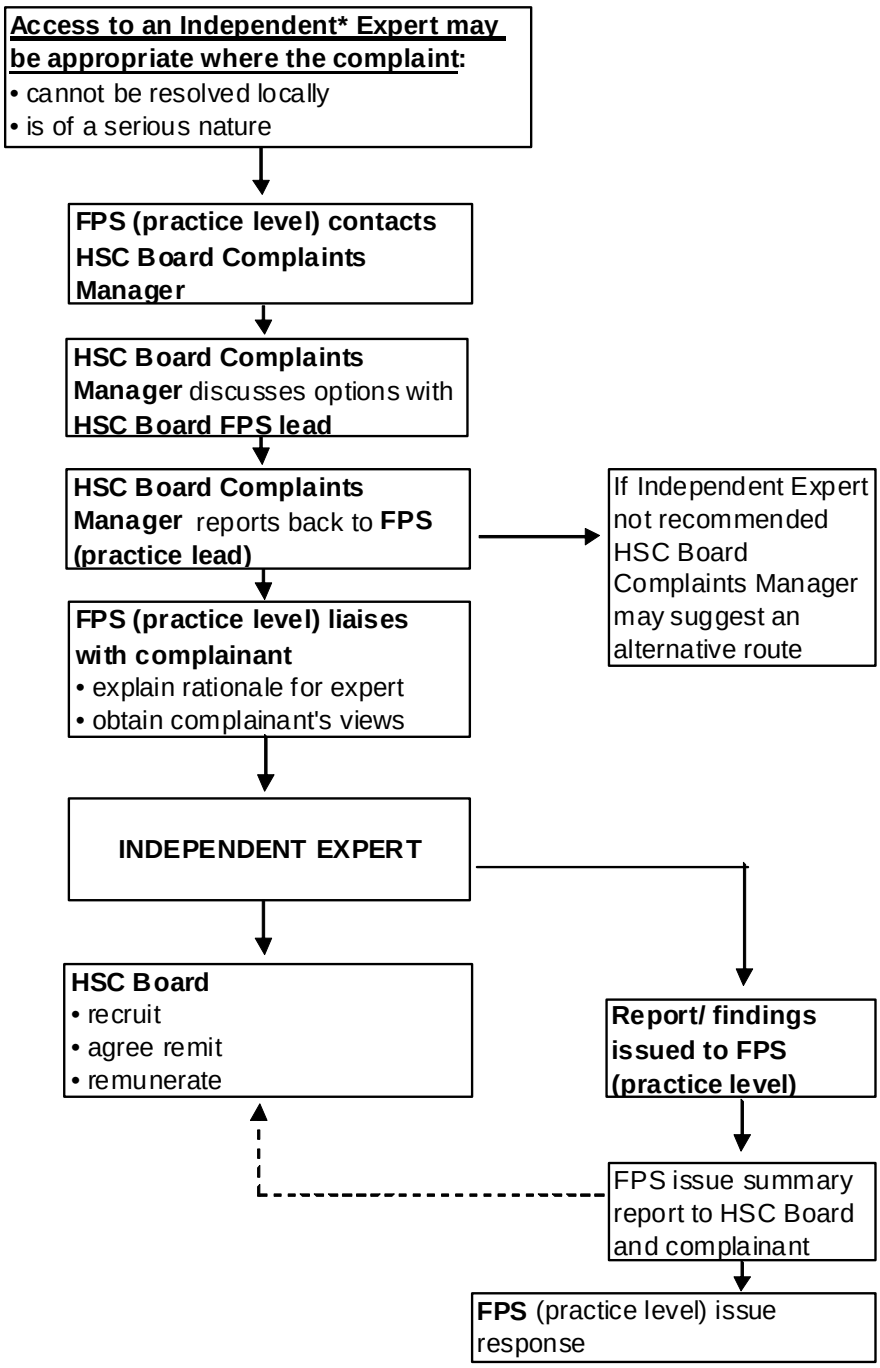
Monitoring

12. The HSC Board will monitor the effectiveness and usage of Independent Expert arrangements within HSC Trusts and FPS including the implementation of any recommendations in FPS.

13. A flowchart outlining the process for FPS is shown overleaf.

MAHI - STM - 097 - 6247

Independent Experts - FPS Access



* definition of "Independent" = an Independent Expert must be recruited from another LCG area (and in certain circumstances outside Northern Ireland) and must have no connection with any of the parties to the complaint to avoid calling into question their objectivity and independence.

ANNEXE 10: LAY PERSONS

1. Lay persons may be beneficial in providing an independent perspective of non-clinical/ technical issues within the local resolution process. Lay persons are NOT intended to act as advocates, conciliators or investigators. Neither do they act on behalf of the provider or the complainant. The lay person's involvement is to help bring about a resolution to the complaint and to provide assurances that the action taken was reasonable and proportionate to the issues raised. For example, the lay person could accompany the investigator during the investigation process where the complainant is considered unreasonable (Annexe 14 refers).

2. Input from a lay person may be valuable to test key issues that are part of the complaint, such as:

- communication issues;
- quality of written documents;
- attitudes and relationships;
- access arrangements (appointment systems).

3. It is essential that both the provider and the complainant have agreed to the involvement of a lay person.

4. Lay persons should have appropriate training in relation to the HSC complaints procedure and have the necessary independence and communication skills.

FPS arrangements

5. The Practitioner/ Practice Manager should approach the HSC Board Complaints Manager for advice.

6. Where a request for a lay person is received the HSC Board Complaints Manager will liaise with the relevant FPS lead to consider the best way forward. Where it is considered that a lay person's involvement would aid resolution then the HSC Board Complaints Manager will advise the FPS practice. In some cases the HSC Board may consider an alternative to a lay person.

Agreement and consent

7. The FPS Practice/ Pharmacy Manager/ HSC organisation must contact the complainant and discuss the rationale for involving a lay person and provide an opportunity to allow the complainant to agree to such an approach and consent to share information. Once received, the HSC organisation/ HSC Board Complaints Manager (on behalf of FPS) will make the necessary arrangements.

8. Where it has been agreed that a lay person will be involved the practice/ pharmacy, HSC organisation should clearly define the remit of the appointment for the purposes of:

- explaining the issue(s) to be resolved;
- ensuring all parties understand the focus of the issue(s);
- ensuring all parties understand what lay person involvement means;
- agreeing the timescales;
- agreeing to the provision of a final report, and
- explaining what happens when this process is complete.

9. The lay person's findings/ report will be forwarded to the practice/ pharmacy/ HSC organisation. A summary should be made available by the practice/ pharmacy/ HSC organisation to:

- the complainant; and
- the HSC Board (for FPS only).

10. The letter of response to the complainant is the responsibility of the practice/ pharmacy/ HSC organisation.

Appointment of lay persons

11. The HSC organisation of HSC Board (on behalf of FPS) is responsible for communicating with, ascertaining the availability of and formally appointing an appropriate lay person. In addition it is responsible for all other arrangements, including training, performance management and remuneration.

Monitoring

12. The HSC Board will monitor the effectiveness and usage of lay person arrangements within HSC Trusts and FPS.

ANNEXE 12: HONEST BROKER ROLE

1. “Honest broker” is the term used to describe the role of the HSC Board Complaints Manager in supporting and advising FPS on the handling of complaints. The complainant or the practice/ pharmacy can ask the HSC Board to act in this role at any point in the complaints process.

2. It is not an alternative to local resolution. Neither is it an opportunity for the HSC Board to take over an investigation. Rather it is about facilitating communications and building relationships between the practice/ pharmacy and the complainant. The honest broker will act as an intermediary and is available to both the complainant or practice/ pharmacy staff throughout the complaints process. For example, the honest broker may:

- provide advice to both the complainant and the practice/pharmacy;
- act as a link between both parties and/ or negotiate with them; and
- facilitate and attend meetings between both parties.

3. Paragraphs 2.16 to 2.20 outline the options available to complainants when pursuing FPS complaints. This includes an option to lodge their complaint directly with the HSC Board. Where the complainant contacts the HSC Board the Complaints Manager will explain the options available to resolve the complaint:

- that the complaint can be copied to the relevant practice/ pharmacy for investigation, resolution and response; or
- that the HSC Board can act as honest broker between the complainant and the practice/ pharmacy.

4. FPS co-operation in complaints of this type is essential for the role of honest broker to effectively assist in the successful local resolution of

complaints. FPS will be asked for their agreement should the complainant prefer the HSC Board's involvement.

5. Where the HSC Board Complaints Manager has been asked to act as honest broker he/she will:

- act as intermediary between the complainant and the practice/ pharmacy;
- make arrangements for independent expert advice, conciliation, lay person assistance, where appropriate; and
- ensure the complainant is informed about the progress of the practice/ pharmacy complaint.

6. Whichever process is used it is important to note that the practice/ pharmacy are responsible for the investigation and the response. The HSC Board Complaints Manager, however, must ensure that:

- a written response is provided by the practice/ pharmacy to the complainant and any other person subject to the complaint;
- the written response is provided within 10 working days of receipt of complaint and where this is not possible that the complainant is informed; and
- the response notifies the complainant of their right to refer their complaint to the Ombudsman should they remain dissatisfied with the outcome of the complaints procedure.

7. The complainant may contact the HSC Board Complaints Manager for further advice and support.

ANNEXE 13: VULNERABLE ADULTS

Definition of vulnerable adult

1. For the purposes of "Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance" the term "vulnerable adult" is defined as: *a person aged 18 years or over who is, or may be, in need of community care services* ***or*** *is resident in a continuing care facility by reason of mental or other disability, age or illness* ***or*** *who is, or may be, unable to take care of him or herself* ***or*** *unable to protect him or herself against significant harm or exploitation.*[15]

2. Adults who "may be eligible for community care services" are those whose independence and well being would be at risk if they did not receive appropriate health and social care support. They include adults with physical, sensory and mental impairments and learning disabilities, howsoever those impairments have arisen; e.g. whether present from birth or due to advancing age, chronic illness or injury. They also include informal carers, family and friends who provide personal assistance and care to adults on an unpaid basis.

3. Making a complaint about health and social care can be intimidating, especially for people with mental health problems, learning disabilities or for those who are old or frail. HSC organisations should have consistent, explicit arrangements in place for advising and supporting vulnerable adults including signposting to independent advice and specialist advocacy services.

[15] Law Commission for England and Wales (1995) Mental Incapacity, Report No.231 London: HMSO – definition of "vulnerable adult" adopted by the HSC Regional Adult Protection Forum

Reportable offences and allegations of abuse

4. Very careful consideration must be given to complaints alleging offences that could be reportable to the police, and there should be explicit policies about the arrangements for such reporting. Where it is apparent that a complaint relates to abuse, exploitation or neglect then the regional *Safeguarding Vulnerable Adults Policy and Procedural Guidance (Sept 2006)* and the associated *Protocol for Joint Investigation of Alleged or Suspected Cases of Abuse of Vulnerable Adults* should be activated (see paragraph 1.26).

ANNEXE 14: UNREASONABLE, VEXATIOUS OR ABUSIVE COMPLAINANTS

1. HSC staff must be trained to respond with patience and empathy to the needs of people who make a complaint, but there will be times when there is nothing further that can reasonably be done to assist them. Where this is the case and further communications would place inappropriate demands on HSC staff and resources, consideration may need to be given to classifying the person making a complaint as an unreasonable, demanding or persistent complainant.

2. In determining arrangements for handling such complainants, staff need to:

- ensure that the complaints procedure has been correctly implemented as far as possible and that no material element of a complaint is overlooked or inadequately addressed;
- appreciate that even habitual complainants may have grievances which contain some substance;
- ensure a fair approach; and
- be able to identify the stage at which a complainant has become habitual.

3. The following *Unacceptable Actions Policy*[16] should only be used as a last resort after all reasonable measures have been taken to resolve the complaint.

[16] Unacceptable Actions Policy based on best practice guidelines issued by the Scottish Public Services Ombudsman

Unacceptable Actions Policy

4. This policy sets out the approach to those complainants whose actions or behaviour HSC organisations consider unacceptable. The aims of the policy are:

- to make it clear to all complainants, both at initial contact and throughout their dealings with the organisation, what the HSC organisation can or cannot do in relation to their complaint. In doing so, the HSC organisation aims to be open and not raise hopes or expectations that cannot be met;
- to deal fairly, honestly, consistently and appropriately with all complainants, including those whose actions are considered unacceptable. All complainants have the right to be heard, understood and respected. HSC staff have the same rights.
- to provide a service that is accessible to all complainants. However, HSC organisations retain the right, where it considers complainants' actions to be unacceptable, to restrict or change access to the service;
- to ensure that other complainants and HSC staff do not suffer any disadvantage from complainants who act in an unacceptable manner.

Defining Unacceptable Actions

5. People may act out of character in times of trouble or distress. There may have been upsetting or distressing circumstances leading up to a complaint. HSC organisations do not view behaviour as unacceptable just because a complainant is assertive or determined. In fact, it is accepted that being persistent can be a positive advantage when pursuing a complaint. However, the actions of complainants who are angry, demanding or persistent may result in unreasonable demands on the HSC organisation or unacceptable behaviour towards HSC staff. It is these actions that HSC organisations consider

unacceptable and aim to manage under this policy. These unacceptable actions are grouped under the following headings:

Aggressive or abusive behaviour

6. Violence is not restricted to acts of aggression that may result in physical harm. It also includes behaviour or language (whether verbal or written) that may cause staff to feel afraid, threatened or abused. Examples of behaviours grouped under this heading include threats, physical violence, personal verbal abuse, derogatory remarks and rudeness. HSC organisations also consider that inflammatory statements and unsubstantiated allegations can be abusive behaviour.

7. HSC organisations expect its staff to be treated courteously and with respect. Violence or abuse towards staff is unacceptable and a Zero Tolerance[17] approach must be adopted. HSC staff understand the difference between aggression and anger. The anger felt by many complainants involves the subject matter of their complaint. However, it is not acceptable when anger escalates into aggression directed towards HSC staff.

Unreasonable demands

8. Complainants may make what the HSC consider unreasonable demands through the amount of information they seek, the nature and scale of service they expect or the number of approaches they make. What amounts to unreasonable demands will always depend on the circumstances surrounding the behaviour and the seriousness of the issues raised by the complainant. Examples of actions grouped under this heading include demanding responses within an unreasonable timescale, insisting on seeing or speaking

[17] www.dhsspsni.gov.uk/zerotolerance.pdf

to a particular member of staff, continual phone calls or letters, repeatedly changing the substance of the complaint or raising unrelated concerns.

9. HSC organisations consider these demands as unacceptable and unreasonable if they start to impact substantially on the work of the organisation, such as taking up an excessive amount of staff time to the disadvantage of other complainants or functions.

Unreasonable persistence

10. It is recognised that some complainants will not or cannot accept that the HSC organisation is unable to assist them further or provide a level of service other than that provided already. Complainants may persist in disagreeing with the action or decision taken in relation to their complaint or contact the organisation persistently about the same issue. Examples of actions grouped under this heading include persistent refusal to accept a decision made in relation to a complaint, persistent refusal to accept explanations relating to what the HSC organisation can or cannot do and continuing to pursue a complaint without presenting any new information. The way in which these complainants approach the HSC organisation may be entirely reasonable, but it is their persistent behaviour in continuing to do so that is not.

11. HSC organisations consider the actions of persistent complainants to be unacceptable when they take up what the HSC organisation regards as being a disproportionate amount of time and resources.

Managing Unacceptable Actions

12. There are relatively few complainants whose actions a HSC organisation consider unacceptable. How the organisation manages these depends on their

nature and extent. If it adversely affects the organisation's ability to do its work and provide a service to others, it may need to restrict complainant contact with the organisation in order to manage the unacceptable action. The HSC organisation will do this in a way, wherever possible, that allows a complaint to progress to completion through the complaints process. The organisation may restrict contact in person, by telephone, fax, letter or electronically or by any combination of these. The organisation will try to maintain at least one form of contact. In extreme situations, the organisation will tell the complainant in writing that their name is on a "no contact" list. This means that they may restrict contact with the organisation to either written communication or through a third party.

13. The threat or use of physical violence, verbal abuse or harassment towards HSC staff is likely to result in the ending of all direct contact with the complainant. All incidents of verbal and physical abuse will be reported to the police.

14. HSC organisations do not deal with correspondence (letter, fax or electronic) that is abusive to staff or contains allegations that lack substantive evidence. When this happens the HSC organisation will tell the complainant that it considers their language offensive, unnecessary and unhelpful. The HSC organisation will ask them to stop using such language and state that it will not respond to their correspondence if they do not stop. The HSC organisation may require future contact to be through a third party.

15. HSC staff will end telephone calls if the caller is considered aggressive, abusive or offensive. The staff member taking the call has the right to make this decision, tell the caller that the behaviour is unacceptable and end the call if the behaviour does not stop.

16. Where a complainant repeatedly phones, visits the organisation, sends irrelevant documents or raises the same issues, the HSC organisation may decide to:

- only take telephone calls from the complainant at set times on set days or put an arrangement in place for only one member of staff to deal with calls or correspondence from the complainant in the future;
- require the complainant to make an appointment to see a named member of staff before visiting the organisation or that the complainant contacts the organisation in writing only;
- return the documents to the complainant or, in extreme cases, advise the complainant that further irrelevant documents will be destroyed;
- take other action that the HSC organisation considers appropriate. The HSC organisation will, however, tell the complainant what action it is taking and why.

17. Where a complainant continues to correspond on a wide range of issues and the action is considered excessive, then the complainant is told that only a certain number of issues will be considered in a given period and asked to limit or focus their requests accordingly.

18. Complainant action may be considered unreasonably persistent if all internal review mechanisms have been exhausted and the complainant continues to dispute the HSC organisation’s decision relating to their complaint. The complainant is told that no future phone calls will be accepted or interviews granted concerning this complaint. Any future contact by the complainant on this issue must be in writing. Future correspondence is read and filed, but only acknowledged or responded to if the complainant provides significant new information relating to the complaint.

Deciding to restrict complainant contact

19. HSC staff who directly experience aggressive or abusive behaviour from a complainant have the authority to deal immediately with that behaviour in a manner they consider appropriate to the situation in line with this policy. With the exception of such immediate decisions taken at the time of an incident, decisions to restrict contact with the organisation are only taken after careful consideration of the situation by a more senior member of staff. Wherever possible, the HSC organisation will give the complainant the opportunity to modify their behaviour or action before a decision is taken. Complainants are told in writing why a decision has been made to restrict future contact, the restricted contact arrangements and, if relevant, the length of time that these restrictions will be in place.

Appealing a decision to restrict contact

20. A complainant can appeal a decision to restrict contact. A senior member of staff who was not involved in the original decision considers the appeal. They advise the complainant in writing that either the restricted contact arrangements still apply or a different course of action has been agreed.

Recording and reviewing a decision to restrict contact

21. The HSC organisation will record all incidents of unacceptable actions by complainants. Where it is decided to restrict complainant contact, an entry noting this is made in the relevant file and on appropriate computer records. A decision to restrict complainant contact may be reconsidered if the complainant demonstrates a more acceptable approach. A senior member of staff will review the status of all complainants with restricted contact arrangements on a regular basis.

ANNEXE 15: CHILDREN ORDER REPRESENTATIONS AND COMPLAINTS PROCEDURE

1. Under the Children (NI) Order 1995 (the Order) HSC Trusts are statutorily required to establish a procedure for considering:

- any representations (including any complaint) made to it about the discharge of its functions under Part IV of, and paragraph 4 of Schedule 5 to, the Order, and
- matters in relation to children accommodated by voluntary organisations and privately run children's homes, and
- those personal social services to children provided under the Adoption Order (NI) 1987.

2. HSC Trusts functions are outlined in Article 45 of, and paragraph 6 of Schedule 5 to, the Order and in the Representations Procedure (Children) Regulations (NI) 1996.

3. Departmental guidance on the establishment and implementation of such a procedure is included at Chapter 12 of the Children Order Guidance and Regulations, Volume 4 (a flowchart to aid decision making is attached).

4. The HSC Board and HSC Trusts should familiarise themselves with these requirements.

CHILDREN ORDER REPRESENTATIONS AND COMPLAINTS PROCEDURE

1. Complaint: Does it fit the definition of a Children Order complaint as below?

"…Any representation (including any complaint) made to the Trust … about the discharge of any of its functions under Part IV of the Order in relation to the child."
(Children (NI) Order 1995, Article 45(3))

OR

"A written or oral expression of dissatisfaction or disquiet in relation to an individual child about the Trust's exercise of its functions under Part IV of, and para 6 of Schedule 5 to, the Children Order."
(Guidance & Regulations – Vol. 4, Para 12.5 – DHSS)

If **YES** to **EITHER** of above

If **NO** to **EITHER** of above → Progress via HSC Complaints Procedure

2. Does it meet the criteria of what may be complained about under Children Order?

"… about Trust support for families and their children under Part IV of the Order."
(Vol. 4, Para 12.8)

a. Day care;
b. Services to support children within family home;
c. Accommodation of a child;
d. After care;
e. Decisions relating to the placement of a child;
f. The management or handling of a child's case (in respect of Part IV services);
g. Process involved in decision making (in respect of Part IV services);
h. Denial of a (Part IV) service;
i. Exemptions to usual fostering limit;
j. Matters affecting a group of children (receiving a Part IV service);
k. Issues concerning a child subject to Adoption Services.

If **YES** to **ANY** of above

If **NO** to **ALL** of above → Progress via HSC Complaints Procedure

3. <u>Complainant</u>: Does he/she fit the definition of a Children Order complainant?

a. **Any child** who is being looked after by the Trust;

b. **Any child** who is not being looked after by the Trust, but is in need;

c. A parent **of his**;

d. Any person who is not a parent of his but who has **parental responsibility for him**;

e. Any Trust foster parent;

f. Such other person as the Trust considers has a sufficient interest in **the child's welfare** to warrant his representations being considered by the Trust, i.e.

- the person who had the day to day care of the child within the past two years;
- the child's Guardian ad Litem;
- the person is a relative of the child (as defined by Children Order, Article 2(2));
- The person is a significant adult in the child's life, and where possible, this is confirmed by the child;
- a friend;
- a teacher;
- a general practitioner.
  (Children (NI) Order 1995 Article 45(3))

If **<u>YES</u>** to **ANY** of above → **Progress via Children Order Procedure**

If **<u>NO</u>** to **ALL** of above → Progress via HSC Complaints Procedure

<u>NB</u>: In order for a complaint to be eligible to be considered under the Children Order Procedure, the answer to 1 <u>and</u> 2 <u>and</u> 3 MUST all be YES.

Consent: *The (Trust) should always check with the child (subject to his understanding) that a complaint submitted reflects his views and that he wishes the person submitting the complaint to act on his behalf.* (Where it is decided that the person submitting the complaint is not acting on the child's behalf, that person may still be eligible to have the complaint considered).

Department of Health

An Roinn Sláinte

Männystrie O Poustie

www.health-ni.gov.uk

GUIDANCE IN RELATION TO THE

HEALTH AND SOCIAL CARE COMPLAINTS PROCEDURE

Revised April 2019

REVISIONS TO HSC COMPLAINTS PROCEDURE

Title	Update/Action	Date Effective
Guidance in relation to the Health and Social Care Complaints Procedure	Introduced in place of: Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning	01 April 2019
Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning	Introduced in place of: (HPSS) Complaints Procedure 1996	01 April 2009
Health and Personal Social Services (HPSS) Complaints Procedure 1996	Revoked and replaced with new Guidance	31 March 2009

AMENDMENTS TO COMPLAINTS DIRECTIONS

Directions	Details	Date Effective
Directions to the Regional Business Services Organisation on Procedures for dealing with Health and Social Care Complaints	The **BSO Directions** were amended for the first time at: • Paragraph 2 (Interpretation) of the principal Directions (a) update to Northern Ireland Public Services Ombudsman • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and • Paragraph 7(4) where paragraph 7(4A) was added	01 April 2019

Directions	Details	Date Effective
	in regard to SAIs.	
Directions to the Regional Agency for Public Health and Social Well-Being on Procedures for Dealing with Health and Social Care Complaints	The **PHA Directions** were amended for the first time at: • Paragraph 2 (Interpretation) of the principal Directions (a) update to Northern Ireland Public Services Ombudsman • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and • Paragraph 7(4) where paragraph 7(4A) was added in regard to SAIs. • Paragraph 7 (No investigation of complaint) of the principal Directions—the definition of vulnerable adults policy or procedures was updated to adult safeguarding procedures or protocol	01 April 2019
Directions to the Health and Social Care Board on procedures for dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers	The **HSC Board Directions** were amended for the third time at: • Paragraph 2 (Interpretation) of the principal Directions (a) update to Northern Ireland Public Services Ombudsman • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No	01 April 2019

Directions	Details	Date Effective
	investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and • Paragraph 7(4) where paragraph 7(4A) was added in regard to SAIs. • Paragraph 7 (No investigation of complaint) of the principal Directions—the definition of vulnerable adults policy or procedures was updated to adult safeguarding procedures or protocol • Paragraph 12 (Referring a complaint) of the principal Directions, for sub-paragraph (5)(b) substitute(b) The HSC Board Complaints Manager acts impartially as "honest broker" to the complainant and Practice/Practitioner in the resolution of the complaint.	
Health and Social Care Complaints Procedure Directions	The **Main Directions** were amended for the second time at: • Paragraph 2 (Interpretation) of the principal Directions (a) update to Northern Ireland Public Services Ombudsman • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and • Paragraph 7(4) where	01 April 2019

Directions	Details	Date Effective
	paragraph 7(4A) was added in regard to SAIs. • Paragraph 7 (No investigation of complaint) of the principal Directions—update to adult safeguarding procedures or protocol • Paragraph 12 (Referring a complaint) of the principal Directions, for sub-paragraph (5)(b) substitute(b) The HSC Board Complaints Manager acts impartially as "honest broker" to the complainant and Practice/Practitioner in the resolution of the complaint. • Paragraph 14 (Response) of the principal Directions omit sub-paragraph (7).	
Complaints about Family Health Services Practitioners and Pilot Scheme Providers **(Amendment)** Directions (Northern Ireland) 2013	The **HSC Board Directions** were amended for the second time in regard to the handling of complaints under paragraph 12(5)(b) at: • Paragraph 18(c) (Response) was amended to include sub-paragraph 18(c)(i) to respond to the complainant within 20 days when the HSC Board has been asked to act as 'honest broker'; and • Sub-paragraph 18(c) (ii) to respond to the complainant within 10 days in all other cases.	02 September 2013 **2013 N0. 12**
Health and Social Care Complaints Procedure Directions **(Amendment)** (Northern Ireland) 2009	The **Main Directions** were amended for the first time at: • Paragraph 2	02 September 2013 **2013 N0. 11**

Directions	Details	Date Effective
	(Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and • Paragraph 7(4) where paragraph 7(4A) was added in regard to SAIs.	
Directions to the Regional Business Services Organisation on Procedures for dealing with Health and Social Care Complaints	The Directions were introduced. Known as **BSO Directions**	26 July 2010
Directions to the Regional Agency for Public Health and Social Well-Being on Procedures for Dealing with Health and Social Care Complaints	The Directions were introduced. Known as **PHA Directions**	26 July 2010
Amendment Directions to the Health and Social Care Board on procedures for dealing with complaints about Family Health Services Practitioners and Pilot Scheme Providers	The **HSC Board Directions** were amended for the first time in respect to monitoring and the requirement by the Family Practitioner Services or pilot scheme provider to obtain consent from the complainant was removed at: Paragraph 21(2)(a) in regards to what the practitioner must send to the HSC Board and the timescale: and Paragraph 21(2) (b) in regards the practitioner sending the HSC Board quarterly complaints.	01 October 2009
Directions to the Health and Social Care Board on procedures for dealing with complaints about Family	The Directions were introduced. Known as **HSC Board Directions**	01 April 2009

Directions	Details	Date Effective
Health Services Practitioners and Pilot Scheme Providers		
Health and Social Care Complaints Procedure Directions (Northern Ireland) 2009	The Directions were introduced. Known as **Main Directions**	01 April 2009

BACKGROUND

The HSC Complaints Procedure*, 'Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning'* was developed and published in 2009*.* It replaced the former Health and Personal Social Services (HPSS) Complaints Procedure 1996 and provided a streamlined health and social care (HSC) complaints process that applies equally to all HSC organisations. As such it presented a simple, consistent approach and set out complaints handling procedures with clear standards and guidance for both HSC staff who handle complaints and for the public who may wish to raise a complaint across all HSC services.

The HSC Complaints Procedure (published 2009) was developed in conjunction with HSC organisations and publically consulted on before being finalised and published. It reflected the changing culture across HSC services and demonstrated an increased emphasis regarding the promotion of and need for **safety and quality** in service provision as well as the need to be open and transparent; and to learn from complaints and take action in order to reduce the risk of recurrence.

The key principles remain unchanged however this document follows a review and refresh of the HSC Complaints Procedure in order to bring it up to date for 2019. Any changes or improvements in complaints handling across the HSC are set out in detail. The document has been renamed the '*Guidance in relation to the Health and Social Care Complaints Procedure' or 'HSC Complaints Procedure'* for short. Updates include the:

- details on the new government department name introduced under the Departments Northern Ireland Act 2016[1];
- details of the role of the Northern Ireland Public Services Ombudsman (NIPSO) known as 'the Ombudsman' further to changes introduced under the Public Services Ombudsman Act (Northern Ireland) 2016[2];
- removal of the restriction on providing electronic responses to complainants;
- removal of the ability for HSC staff to complain to the Ombudsman about the way they have been dealt with under the Complaints Guidance;
- clarity on the role and remit of the honest broker in complaints handling;
- updated information on complaints about Independent Sector Providers (ISPs); and
- process for dealing with complaints and serious adverse incidents that are subject to legal proceedings.

This single tier process aims to provide:

- a strengthened, more robust, local resolution stage;
- an enhanced role for commissioners in monitoring, performance management and learning;
- improved arrangements for driving forward quality improvements across the HSC; and
- improved arrangements for the delivery of responses to complainants.

[1] Departments Northern Ireland Act 2016: http://www.legislation.gov.uk/nia/2016/5/section/1/enacted
[2] Public Services Ombudsman Act (Northern Ireland) 2016: http://www.legislation.gov.uk/nia/2016/4/enacted

The HSC Complaints Procedure presents HSC organisations with detailed, yet flexible, complaints handling arrangements designed to:

- provide effective local resolution and learning;
- improve accessibility;
- clarify the options for pursuing a complaint;
- promote the use and availability of support services, including advocacy;
- provide a well-defined process of investigation;
- promote the use of a range of investigative techniques;
- promote the use of a range of options for successful resolution, such as the use of independent experts, lay persons and conciliation;
- resolve complaints quickly and efficiently;
- provide flexibility in relation to target response times;
- provide an appropriate and proportionate response within reasonable and agreed timescales;
- provide clear lines of responsibility and accountability;
- improve record keeping, reporting and monitoring; and
- increase opportunities for shared learning across the region.

The standards for complaints handling are designed to assist HSC organisations in monitoring the effectiveness of their complaints handling arrangements locally and build public confidence in the process. The eight specific standards of HSC are:

Standard 1: Accountability
Standard 2: Accessibility
Standard 3: Receiving complaints
Standard 4: Supporting complainants and staff
Standard 5: Investigation of complaints
Standard 6: Responding to complaints
Standard 7: Monitoring
Standard 8: Learning

More details on each of the standards are provided in Annex 1 of this document.

It is recognised that sometimes, and even in despite of the best efforts of all concerned, there will be occasions when local resolution fails. Where this happens the complainant will be advised of their right to refer their complaint to the Ombudsman. The HSC Organisation also reserves the right to refer complaints to the Ombudsman.

This revised guidance in relation to the HSC Complaints Procedure is effective from 01 April 2019. It will be known as *'Guidance in relation to the Health and Social Care Complaints Procedure'*.

SECTION 1 – INTRODUCTION

Purpose of the HSC Complaints Procedure

1.1 This document is an updated version of the HSC Complaints Procedure which was first published in 2009 and sets out how HSC organisations should deal with complaints raised by people who use or are waiting to use their services. It replaces any previous or existing guidance with effect from 01 April 2019 and continues to provide a streamlined complaints process which applies equally to all HSC organisations, including the HSC Board, HSC Trusts, Business Services Organisation (BSO), Public Health Agency (PHA), NI Blood Transfusion Service (NIBTS), Family Practitioner Services (FPS), Out of Hours services pilot schemes and HSC prison healthcare. As such, it presents a simple, consistent approach for both HSC staff who handle complaints and for the public who may wish to raise a complaint across all HSC services.

1.2 The HSC Complaints Procedure continues to promote an organisational culture in health and social care that fosters openness and transparency for the benefit of all who use it or work in it. It is designed to provide ease of access, simplicity and a supportive and open process which results in a speedy, fair and, where possible, local resolution. The HSC Complaints Procedure provides the opportunity to put things right for service users as well as learning from the experience and improving the safety and quality of services. Dealing with those who have made complaints delivers an opportunity to re-establish a positive relationship with the complainant and to develop an understanding of their concerns and needs.

Local resolution

1.3 The purpose of local resolution is to enable the complainant and the organisation to attempt a prompt and fair resolution of the complaint.

1.4 HSC organisations should work closely with service users to find an early resolution to complaints. Every opportunity should be taken to resolve complaints as close to the source as possible, through discussion and negotiation. Where possible, complaints should be dealt with immediately. Where this is not possible, local resolution should be completed within 20 working days of receipt of a complaint (10

working days within FPS settings). The expectations of service users should be managed by HSC staff and any difficulties identified in being able to resolve a complaint within 20 days by local resolution should be communicated to the service user immediately.

1.5 Local procedures should be easily accessible, open, fair, flexible and conciliatory and should encourage communication on all sides. They should include a well-defined process for investigating and resolving complaints. Complainants must be advised of their right and be signposted to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the HSC Complaints Procedure.

Principles of an effective Complaints Procedure

1.6 The HSC Complaints Procedure has been developed around four key principles:

- **openness and accessibility** – flexible options for pursuing a complaint and effective support for those wishing to do so;
- **responsiveness** – providing an appropriate and proportionate response;
- **fairness and independence** – emphasising early resolution in order to minimise strain and distress for all; and
- **learning and improvement** – ensuring complaints are viewed as a positive opportunity to learn and improve services.

Learning

1.7 Effective complaints handling is an important aspect of clinical and social care governance arrangements. Lessons learned during the complaints resolution process will assist organisations to make changes to improve the quality of their services and safeguard high standards of care and treatment. Increased efforts should be made to promote a more positive culture of not just resolving complaints but also learning from them. Furthermore, by highlighting the potential added value of complaints and subsequent quality and safety improvements made within HSC organisations the process becomes more acceptable and amenable to all.

1.8 Complaints are seen as a significant source of learning within health and social care and provide opportunities to improve:

- outcomes for services users;
- the quality of services; and
- service user experiences.

1.9 How HSC organisations handle complaints is an indicator of how responsive they are to the concerns of service users and/or their representatives. An increase in the number of complaints is not in itself a reason for thinking the service is deteriorating. The important point is to handle complaints well, take appropriate action and use the lessons learned to improve quality and safety.

What the HSC Complaints Procedure covers

1.10 The HSC Complaints Procedure deals with complaints about care or treatment, or about issues relating to the provision of health and social care. Complaints may, therefore, be raised about services provided by, for example:

- HSC Board
  - commissioning and purchasing decisions (for individuals)
- HSC Trusts
  - hospital and community services
  - registered establishments and agencies where the care is funded by the HSC
  - HSC funded staff or facilities in private pay beds
  - HSC prison healthcare
- Business services organisation (BSO)
  - services provided relevant to health and social care
- Public Health agency (PHA)
- Northern Ireland Blood Transfusion Service (NIBTS)
- Family practitioner Services (FPS)

1.11 The HSC Complaints Procedure may be used to investigate a complaint about any aspect of an application to obtain access to health or social care records for deceased patients under the Access to Health Records (NI) Order 1993[3] as an alternative to making an application to the courts.

[3] Access to Health Records (NI) Order 1993 applies only to records created since 30 May 1994.

What the HSC Complaints Procedure does not cover

1.12 Complaints about private care and treatment or service; which includes private dental care[4] or privately supplied spectacles are not dealt with in this guidance. In addition those services which are not provided or funded by the HSC, for example, provision of private medical reports are also not covered under the HSC Complaints Procedure.

1.13 Complaints may be raised within an HSC organisation which need to be addressed, but the complaint or aspects of it may not fall within the scope of the HSC Complaints Procedure. When this occurs, the HSC organisation should ensure that there are other processes in place which can be referred to in order to deal with these concerns. For example:

- staff grievances
- an investigation under the disciplinary procedure
- an investigation by one of the professional regulatory bodies
- services commissioned by the HSC Board
- requests for information under Freedom of Information or access to records under the General Data Protection Regulation (GDPR)
- independent inquiries and criminal investigations
- the Children Order Representations and Complaints Procedure
- adult safeguarding
- child protection procedures
- Coroners cases
- legal action
- Serious Adverse Incidents (SAIs)
- Whistleblowing[5]

[4] The Dental Complaints Service deals with private dental and mixed health service and private dental complaints and can be contacted via the General Dental Council at http://www.gdc-uk.org/
[5] Public Interest Disclosure (Northern Ireland) Order 1998

1.14 Complaints received that appear to indicate the need for referral under any of the processes listed above should be immediately transferred to the Complaints Manager for onward transmission to the appropriate department. Where a complaint is referred to any of these other processes it will be the responsibility of the officers involved to ensure that information is given to complainants on the reason for the referral; how the new process operates; their expectations for involvement in the process; anticipated timescales and the named officer/organisation the complainant can contact for ongoing communication. If any aspect of the complaint is not covered by the referral it will continue to be investigated under the HSC Complaints Procedure. In these circumstances, investigation will only be taken forward if it does not, or will not, compromise or prejudice the matter being investigated under any other process.

Staff Grievances

1.15 HSC organisations should have separate procedures for handling staff grievances.

Disciplinary Procedure

1.16 Disciplinary matters are not covered under the HSC Complaints Procedure. Its purpose is to focus on resolving complaints and learning lessons for improving HSC services. It is not for investigating disciplinary matters though these can be investigated by the HSC organisation and may be referred to a Professional Regulatory Body (see paragraph 1.20 below). The purpose of the HSC Complaints Procedure is not to apportion blame, but to investigate complaints with the aim of satisfying complainants whilst being fair to staff.

1.17 Where a decision is made to embark upon a disciplinary investigation, action under the HSC Complaints Procedure on any matter which is the subject of that investigation must cease. Where there are aspects of the complaint <u>not</u> covered by the disciplinary investigation, they may continue to be dealt with under the HSC Complaints Procedure.

1.18 The Chief Executive (or designated senior person[6]) must advise the complainant in writing that an investigation is being dealt with under appropriate Trust staff procedures. They also need to be informed that they may be asked to take part in the process and that any aspect of the complaint not covered by the investigation will continue to be investigated under the HSC Complaints Procedure.

1.19 In drafting these letters, the overall consideration must be to ensure that when investigation is required the complainant is not left feeling that their complaint has only been partially dealt with.

Investigation by a Professional Regulatory Body

1.20 A similar approach to that outlined above should be adopted in a case referred to a professional regulatory body (Annex 3). The Chief Executive (or designated senior person) must inform the complainant in writing of the referral. This should include an indication that any information obtained during the complaints investigation may need to be passed to the regulatory body. The letter should also explain how any other aspect of the complaint not covered by the referral to the regulatory body will be investigated under the HSC Complaints Procedure.

Services Commissioned by the HSC Board

1.21 Complaints about the HSC Board's commissioning decisions regarding purchasing of services may be made by, on or on behalf of any individual personally affected by a commissioning decision taken by the HSC Board. The HSC Complaints Procedure may not deal with complaints about the merits of a decision where the HSC Board has acted properly and within its legal responsibilities. Where general concerns about commissioning issues are raised with the HSC Board a full explanation of the HSC Board's policy should be provided. These issues should not, however, be dealt with under the HSC Complaints Procedure.

[6] A designated Senior Person should be a Director (or Nominee)

Requests for Information/Access to Records

1.22 Although use and disclosure of service user information may be necessary in the course of handling a complaint, the complainant, or indeed any other person, may at any time make a request for information which may, or may not, be related to the complaint. Such requests should be dealt with separately under the procedures set down by the relevant HSC organisation for dealing with requests for information under the Freedom of Information Act 2000[7] and requests for access to health or social care records under the General Data Protection Regulation (GDPR)[8].

Independent Inquiries and Criminal Investigations

1.23 Where an independent inquiry into a serious incident or a criminal investigation is initiated, the Chief Executive (or designated senior person) should immediately advise the complainant of this in writing. As the HSC Complaints Procedure cannot deal with matters subject to any such investigation, consideration of those parts of the original complaint must cease until the other investigation is concluded.

1.24 When the independent inquiry or criminal investigation has concluded, consideration of that part of the original complaint on which action was suspended may recommence if there are outstanding matters remaining to be considered under the HSC Complaints procedure.

Children Order Representations and Complaints Procedure

1.25 Arrangements for complaints raised under the Children Order Representations and Complaints Procedure are outlined in Annex 15. The HSC Board and HSC Trusts should familiarise themselves with Part IV of, and paragraph 6 of Schedule 5 to, the Children (NI) Order 1995[9].

[7] Freedom of Information Act 2000: http://www.legislation.gov.uk/ukpga/2000/36/contents
[8] General Data Protection Regulation (GDPR): https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr
[9] Children (NI) Order 1995: http://www.legislation.gov.uk/nisi/1995/755/contents

Adult Safeguarding

1.26 Where it is apparent that a complaint relates to abuse, exploitation or neglect of an adult at risk of harm then the regional '*Adult Safeguarding Operational Procedures*' (September 2016[10]) and the associated *'Protocol for Joint Investigation of Adult Safeguarding Cases'* (August 2016[11]) should be activated by contacting the Adult Protection Gateway Service at the relevant HSC Trust[12]. The HSC Complaints Procedure should be suspended pending the outcome of the adult safeguarding investigation and the complainant advised accordingly. However, if there are aspects of the complaint that do not cause the aforementioned Operational Procedures and associated Protocol to be activated, then these should continue to be investigated under the HSC Complaints Procedure. However, only those aspects of the complaint not falling within the scope of the safeguarding investigation will continue via the HSC Complaints Procedure.

Child Protection Procedures

1.27 Any complaint about individual agencies should be investigated through that agency's complaints procedure. Appeals which relate to decisions about placing a child's name on the Child Protection Register should be dealt with through the Child Protection Registration Appeals Process. The Safeguarding Board for Northern Ireland (SBNI) Child Protection procedures manual outlines the criteria for appeal under that procedure. These include when the:

- ACPC procedures in respect of the case conference were not followed;
- information presented at the case conference was inaccurate; incomplete or inadequately considered in the decision making process;
- threshold for registration/deregistration was not met;
- category for registration was not correct.

[10] Adult Safeguarding Operational Procedures: http://www.hscboard.hscni.net/download/PUBLICATIONS/SAFEGUARDING%20VULNERABLE%20ADULTS/guidance_and_protocols/Adult-Safeguarding-Operational-Procedures.pdf
[11] Protocol for Joint Investigation of Adult Safeguarding Cases: http://www.hscboard.hscni.net/download/PUBLICATIONS/SAFEGUARDING%20VULNERABLE%20ADULTS/guidance_and_protocols/Protocol-for-joint-investigation-of-adult-safeguarding-cases.pdf
[12] Information about and contact details for HSC Trusts can be accessed at the following link - https://www.nidirect.gov.uk/articles/who-contact-if-you-suspect-abuse-exploitation-or-neglect

Coroners Cases

1.28 With the agreement of the Coroner's Office, where there are aspects of the complaint not covered by the Coroners investigation they will continue to be dealt with under the HSC Complaints Procedure. Once the Coroners investigation has concluded, any issues that are outstanding in relation to the matters considered by the Coroner may then be dealt with under the HSC Complaints Procedure.

Legal Action

1.29 Even if a complainant's initial communication is through a solicitor's letter it should not be inferred that the complainant has decided to take formal legal action.

1.30 If the complainant has either instigated formal legal action, or advised that he or she intends to do so, the complaints process should cease. The Chief Executive (or designated senior person) should advise the complainant and any person/member of staff named in the complaint of this decision in writing. However, those aspects of the complaint not falling within the scope of the legal investigation will continue via the HSC Complaints Procedure.

1.31 It is not the intention of the HSC Complaints Procedure to deny someone the opportunity to pursue a complaint if the person subsequently decides **not to take legal action**. If he/she then wishes to continue with their complaint via the HSC Complaints Procedure and requests this, the investigation of their complaint should commence or resume. However, any matter that has been through the legal process to completion cannot also be investigated under the HSC Complaints Procedure.

Serious Adverse Incidents (SAI)

1.32 Complaints may indicate the need for a Serious Adverse Incident (SAI) investigation. When this occurs, the Chief Executive (or designated senior person), must advise the complainant and any person/staff member named in the complaint in writing that an SAI investigation is under way. They must also indicate to all concerned that the HSC Complaints Procedure may still continue during the SAI investigation. However, only those aspects of the complaint not falling within the scope of the SAI investigation will continue via the HSC Complaints Procedure.

1.33 The overall consideration must be to ensure that when the investigation is through the SAI process, the complainant is not left feeling that their complaint has only been partially dealt with.

SECTION 2 – MAKING A COMPLAINT

What is a complaint?

2.1 A complaint is "**an expression of dissatisfaction that requires a response**". Complainants may not always use the word "complaint". They may offer a comment or suggestion that can be extremely helpful. It is important to recognise those comments that are actually complaints and therefore need to be handled as such.

Promoting access

2.2 Standard 2: *Accessibility* provides the criteria by which organisations should operate (Annex 1 refers). Service users should be made aware of their right to complain and given the opportunity to understand all possible options for pursuing a complaint. Complainants must, where appropriate, have the support they need to articulate their concerns and successfully navigate the system. They must also be advised on the types of help available, for example, through front-line staff, the Complaints Manager and the Patient and Client Council (PCC). HSC organisations should promote and encourage more open and flexible access to the HSC Complaints Procedure and other less formal avenues in an effort to address barriers to access.

Who can complain?

2.3 Any person can complain about any matter connected with the provision of HSC services. Complaints may be made by:

- a patient or client;
- former patients, clients or visitors using HSC services and facilities;
- someone acting on behalf of existing or former patients or clients, providing they have obtained the patient's or client's consent;
- parents (or persons with parental responsibility) on behalf of a child; and
- any appropriate person in respect of a patient or client unable by reason of physical or mental capacity to make the complaint himself or who has died e.g. the next of kin.

Consent

2.4 Complaints by a third party should be made with the written consent of the individual concerned. There will be situations where it is not possible to obtain consent, such as when the:

- individual is a child and not of sufficient age or understanding to make a complaint on their own behalf;
- individual is incapable (for example, rendered unconscious due to an accident; judgement impaired as a result of a learning disability, mental illness, brain injury or serious communication problems);
- subject of the complaint is deceased; and
- delay in the provision of consent may result in a delay in the resolution of the complaint.

2.5 Where a person is unable to act for him/herself, his/her consent shall not be required.

2.6 The Complaints Manager, in discussion with the Chief Executive (or designated senior person), will determine whether the complainant has sufficient interest to act as a representative. The question of whether a complainant is suitable to make representation depends, in particular, on the need to respect the confidentiality of the patient or client. If it is determined that a person is not suitable to act as a representative, the Chief Executive (or designated senior person) must provide them with information in writing outlining the reasons the decision has been taken. More information on consent can be found in the DoH good practice in consent guidance[13].

2.7 Third party complainants who wish to pursue their own concerns can bring these to the HSC organisation without compromising the identity of the patient/client. The HSC organisation must consider the matter then investigate and address the issue and any concerns identified fully. A response will be provided to the third party on any issues which may be addressed without breaching patient/client confidentiality.

[13] https://www.health-ni.gov.uk/articles/consent-examination-treatment-or-care

Confidentiality

2.8 HSC staff should be aware of their legal and ethical duty to protect the confidentiality of the service user's information. The legal requirements are set out in the General Data Protection Regulations (GDPR) which controls how personal information is used by organisations, businesses or the government. Additional requirements are detailed in the Human Rights Act 1998 (HRA) which requires public authorities to act in a way which is compatible with the list in the European Convention on Human Rights (the Convention). The Common Law Duty of Confidentiality must also be observed. Ethical guidance is provided by the respective professional bodies. A service user's consent is required if their personal information is to be disclosed. More detailed information can be found in the DoH guidance entitled *Code of Practice on Protecting the Confidentiality of Service User Information* [14]published January 2012.

2.9 It is not necessary to obtain the service user's express consent to the use of their personal information to investigate a complaint. Even so, it is good practice to explain to the service user that information from his/her health and/or social care records may need to be disclosed to the complaint investigators, but only if they have a demonstrable need to know and for the purposes of investigating. If the service user objects to this, it should be explained to him/her that non-disclosure could compromise the investigation and his/her hopes of a satisfactory outcome to the complaint. The service user's wishes should always be respected, unless there is an overriding public interest in continuing with the matter.

Third Party Confidence

2.10 The duty of confidence applies equally to third parties who have given information or who are referred to in the service user's records. Particular care must be taken where the service user's records contain information provided in confidence, by, or about, a third party who is not a health or social care professional. Only

[14] DoH Code of Practice: https://www.health-ni.gov.uk/publications/dhssps-code-practice-protecting-confidentiality-service-user-information

information which is relevant to the complaint should be considered for disclosure, and then only to those *within* the HSC who have a demonstrable 'need to know' in connection with the complaint investigation. Third party information must not be disclosed to the service user unless the person who provided the information has expressly consented to the disclosure.

2.11 Disclosure of information provided by a third party outside the HSC also requires express consent. If the third party objects, then information they provided can only be disclosed where there is an overriding public interest in doing so.

Use of Anonymised Information

2.12 Where anonymised information about a patient/client and/or third parties would suffice for investigation of the complaint, identifiable information should be omitted. Anonymising information does not of itself remove the legal duty of confidence but, where all reasonable steps are taken to ensure that the recipient is unable to trace the patient/client or third party identity, it may be passed on where justified by the complaint investigation. Where a patient/client or third party has expressly refused permission to use certain information, then it can only be used where there is an overriding public interest in doing so.

How can complaints be made?

2.13 Complaints may be made in a variety of formats including verbally, written or electronic. Should a verbal complaint be made the complainant should be asked to formalise their complaint in writing. If the complainant is unable to put their complaint in writing then Trust staff or the Patient Client Council can provide assistance. It is helpful to establish at the outset what the complainant wants to achieve in order to avoid confusion or dissatisfaction and subsequent complaints. HSC organisations should be mindful of technological advances specifically in regard to email communications and must adhere to their relevant Information Technology (IT) policies and procedures. Complaints Managers should also consider local arrangements to ensure there is no breach of patient/client confidentiality in the management of information surrounding complaints.

2.14 Complaints may be made to any member of staff, for example receptionists, clinical or care staff. In many cases complaints are made orally and front-line staff may either resolve the complaint "on the spot" or pass it to the Complaints Manager. It is important that front-line staff receive the appropriate complaints handling training including refresher training according to extant local procedures. They must also be supported to respond sensitively to the comments and concerns raised and be able to distinguish those issues which would be better referred elsewhere for more detailed investigation. Front line staff should familiarise themselves with Section 75 of the Northern Ireland Act 1998 which changed the practices of government and public authorities so that equality of opportunity and good relations are central to policy making, policy implementation, policy review and service delivery[15]. (See Flowchart page 50)

Options for pursuing a complaint

2.15 Some complainants may prefer to make their initial complaint to someone within the relevant organisation who has not been involved in the care provided. In these circumstances, they should be advised to address their complaint to the Complaints Manager, an appropriate senior person or, if they prefer, to the Chief Executive. All HSC organisations have named Complaints Managers. The following paragraphs outline the options available to complainants who want to raise complaints in relation to:

- Family Practitioner Services;
- Regulated Establishments and Agencies; and
- Independent Sector Providers.

Family Practitioner Services (family doctors, dentists, pharmacists, opticians)

2.16 Family Practitioner Services (FPS) are required to have in place a practice-based complaints procedure which forms part of the local resolution mechanism for settling complaints. A patient may approach any member of staff with a complaint about the service or treatment he/she has received.

[15] Section 75 of the Northern Ireland Act 1998
https://www.legislation.gov.uk/ukpga/1998/47/section/75

2.17 Alternatively, the complainant has the right to lodge his/her complaint with the HSC Board's Complaints Manager if he/she does not feel able to approach immediate staff (see flowchart page 51).

2.18 Where requested, the HSC Board will act impartially as "honest broker" to the complainant and Practice/Practitioner in either the resolution of a complaint or by assisting all parties in reaching a position of understanding. The objective for the HSC Board should be, wherever possible, to restore the trust between the patient and the Practice/Practitioner staff. This will involve an element of mediation on the part of the HSC Board or the offer of conciliation services where they are appropriate. The HSC Board's Complaints Manager should seek with the complainant's agreement to involve the FPS Complaints Manager as much as possible in resolving the issues. The HSC Board's Complaints Manager is also available to Practice/Practitioner staff for support and advice.

2.19 The HSC Board has a responsibility to record and monitor the outcome of complaints lodged with them.

2.20 The HSC Board will provide support and advice to FPS in relation to the resolution of complaints. It will also appoint Independent Experts, Lay Persons or Conciliation Services, where appropriate.

2.21 Complainants must be advised of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the practice-based complaints procedure.

Regulated Establishments and Agencies

2.22 All regulated establishments and agencies[16] must operate a complaints procedure that meets the requirements of applicable Regulations, relevant Minimum Standards and the HSC Complaints Procedure. This includes:

- Effectively publicising the arrangements for dealing with complaints and ensuring service users, clients and families are aware of such arrangements;
- Ensuring that any complaint made under the complaints procedure is investigated;
- Ensuring that time limits for investigations are adhered to;
- Advising complainants regarding the outcomes of the investigation; and
- Maintaining a record of learning from complaints that is available for inspection.

2.23 Complainants must also be advised of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the HSC Complaints Procedure. It is for the Ombudsman to determine whether or not a case falls within that office's jurisdiction.

2.24 Complaints may be made by service users or persons acting on their behalf providing they have obtained the service user's consent. Complaints relating to contracted services provided by the registered provider or agency may be received directly by the service provider or by the contracting Trust. Complainants should be encouraged to raise their concerns, at the outset, with the registered provider or agency. The registered provider is required by legislation to ensure the complaint is fully investigated. The general principle in the first instance would be that the registered provider or agency investigates and responds directly to the complainant.

2.25 However, individuals placed in a regulated establishment or who have their service provided by a regulated agency may, if they prefer, raise their concerns through the HSC Trust that commissioned the care on their behalf (see flowchart on page 52) as the commissioning Trust has a continuing duty of care to the service user and should participate in local resolution as necessary.

[16] Residential and nursing homes as well as Voluntary Adoption Agencies are examples of regulated establishments and agencies.

2.26 Where complaints are raised with the HSC Trust, the Trust must establish the nature of the complaint and consider how best to proceed. For example, the complaint may be about an aspect of the "care plan" and can, therefore, only be fully dealt with by the Trust. The complaint may also trigger the need for an investigation under child protection or protection of vulnerable adults' procedures or indeed, might highlight non-compliance with statutory requirements. It is not the intention to operate parallel complaints procedures, however, if the RQIA is notified of a breach of regulations or associated standards it will review the matter and take whatever appropriate action is required. It is important, therefore, that Trusts work closely with the registered providers, other professionals and the RQIA to enable appropriate decisions to be made.

2.27 HSC Trusts must assure themselves that regulated establishments and agencies that deliver care on their behalf are effective and responsive in complaints handling. Service users may approach the Ombudsman if they remain dissatisfied. It is possible that referrals to the Ombudsman where complaints are dealt with directly by the registered provider without HSC Trust participation in local resolution will be referred to the HSC Trust by the Ombudsman for action.

2.28 Copies of all correspondence relating to regulated sector complaints should be retained. The RQIA will use this information to monitor all regulated services including those services commissioned by the HSC Trust.

2.29 Voluntary Adoption Agencies became regulated by the RQIA in 2010 and in due course, these arrangements will extend to Fostering Agencies services which will also be regulated by the RQIA.

Independent Sector Providers

2.30 This section of the guidance has been developed for use in complaints against Independent Service Providers (ISP) in contract with HSC Trusts. Complaints against regulated establishments and agencies, such as, residential and nursing homes should be handled in accordance with paragraphs 2.22 to 2.28 above. On occasions HSC organisations contract with ISPs to provide services for patients/clients. An example where this may be the case is in the maintenance of waiting lists for elective forms of treatment.

2.31 Such contracts are agreed and managed by HSC Trusts and procured in accordance with public procurement law. ISPs may have their own premises or may be permitted to use Trust premises, equipment and facilities.

2.32 Trusts must be assured that ISPs with which they contract have appropriate governance arrangements in place for the effective handling, management and monitoring of all complaints. This should include the appointment of designated officers of suitable seniority to take responsibility for the management of the in-house complaints handling procedures, the investigation of complaints and the production of leaflets, or other literature (available and accessible to patients/clients) that outline the provider's complaints procedure.

2.33 Complaints relating to contracted services provided by ISPs may be received directly by the ISP or by the contracting Trust. The general principle in the first instance would be that the ISP investigates and responds directly to the complainant. Independent Sector Providers are required to notify Trusts of any complaints received without delay and in any event within 72 hours. Trusts can then determine how they wish the complaints to be investigated (see flowchart on page 53).

2.34 Where complaints are raised directly with the Trust, it must establish the nature of the complaint and consider how best to proceed. The Trust may simply refer the complaint to the ISP for investigation, resolution and response or it may decide to investigate the complaint itself where it raises serious concerns or where the Trust deems it in the public interest to do so. This may also be considered preferable should the Trust premises and/or staff have been involved (see flowchart on page 53).

2.35 In all cases, appropriate communication should be made with the complainant to inform them which organisation is leading the investigation into their complaint.

2.36 In complaints investigated by the ISP:

- A written response will be provided by the ISP to the complainant and copied to the Trust;

- Where there is a delay in responding within the target timescales the complainant will be informed and where possible provided with a revised date for conclusion of the investigation; and

- The letter of response must advise the complainant that they may progress their complaint to the Trust for further consideration if they remain dissatisfied. The Trust will then determine whether the complaint warrants further investigation and, if so, will confirm who should be responsible for conducting it. The Trust will work closely with the ISP to enable appropriate decisions to be made.

2.37 The complainant must also be informed of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure.

2.38 It is possible that referrals to the Ombudsman, where complaints are dealt with directly by the ISP without Trust participation in local resolution, will be referred to the Trust by the Ombudsman for action.

2.39 Trusts should have agreed arrangements in place to ensure that ISPs regularly provide information relating to all complaints received and responded to directly by them. This information should be made available to the Trust for monitoring purposes. The ISP must keep a record of complaints, the subsequent investigation and its outcome and any action taken as a result. This record must be submitted to the Trust no longer than 10 working days after the end of each quarter for complaints closed in the period. This should include details of the number, source and type(s) of complaint, action taken and outcome of investigation.

2.40 The ISP should also indicate if the learning from complaints has been disseminated to all relevant staff. The ISP must review their complaints procedure on an annual basis and in this annual review shall include a review of the outcome of any complaints investigations during the preceding year to ensure that where necessary any changes to practice and procedure are implemented. This annual review must be available for inspection by Trust staff on request.

What information should be included in the complaint?

2.41 A complaint need not be long or detailed, but it should include:

- contact details;
- who or what is being complained about, including the names of staff if known;
- where and when the events of the complaint happened; and
- where possible, what remedy is being sought – e.g. an apology or an explanation or changes to services.

2.42 Standard 4: *Supporting complainants and staff* provides the criteria by which organisations should operate (Annex 1 refers). Advice and assistance is available to complainants and staff at any stage in the complaints process from the Complaints Manager. Independent advice and support for complainants is available from the PCC (detailed in Section 5 – Roles and responsibilities). Independent advocacy and specialist advocacy services are also available (Annex 7 refers).

What are the timescales for making a complaint?

2.43 A complaint should be made as soon as possible after the action giving rise to it, normally within six months of the event. HSC organisations should encourage those who wish to complain to do so as soon as possible after the event. Investigation is likely to be most effective when memories are fresh and the relevant evidence such as records of treatment will be easier to source.

2.44 If a complainant was not aware that there was potential cause for complaint, the complaint should normally be made within **six months** of their becoming aware of the cause for complaint, or within **twelve months** of the date of the event, whichever is the earlier.

2.45 There is discretion for the Complaints Manager to extend this time limit where it would be unreasonable in the circumstances of a particular case for the complaint to have been made earlier and where it is still possible to investigate the facts of the case. This discretion should be used with sensitivity and impartiality. The complainant should be advised that with the passage of time the investigation and response will be based largely on a review of records.

2.46 In any case where a Complaints Manager has decided not to investigate a complaint on the grounds that it was not made within the time limit, the complainant can request the Ombudsman to consider it. The complainant should be advised of the options available to pursue this further.

2.47 The Complaints Manager must consider the content of complaints that fall outside the time limit in order to identify any potential risk to public or patient safety and, where appropriate, the need to investigate the complaint if it is in the public's interest to do so or refer to the relevant regulatory body.

SECTION 3 – HANDLING COMPLAINTS

Accountability

3.1 Standard 1: *Accountability* provides the criteria by which organisations should operate (Annex 1 refers). Accountability for the handling and consideration of complaints rests with the Chief Executive (or Clinical Governance Lead in FPS settings). The HSC organisation must designate a senior person within the organisation:

- to take responsibility for the local complaints procedure;
- to ensure compliance with the regulations; and
- to ensure that action is taken in light of the outcome of any investigation.

In the case of HSC Trusts, a Director (or a Clinical Governance Lead in FPS setting) should be designated. All staff must be aware of, and comply with, the requirements of the complaints procedure. These arrangements will ensure the integration of complaints management into the organisation's governance arrangements.

3.2 Where care or treatment is provided by an independent provider, for example residential or nursing home care, the commissioning body must ensure that the contract includes entitlement, by the HSC organisation, to any and all documentation relating to the care of service users and a provision to comply with the requirements of the HSC Complaints Procedure.

Performance Management

3.3 Complaints provide a rich source of information and learning from complaints should be considered a vital part of the HSC organisation's performance management strategy. HSC organisations need to be able to demonstrate that positive action has been taken as a result of complaints and that learning from complaints is embedded in the organisation's governance and risk management arrangements.

3.4 Complaints should be used to inform and improve the standard of service provision. HSC organisations should aim for continuous change and improvement in their performance as a result of complaints. Where something has gone wrong or

fallen below standard the organisation has the opportunity to improve and avoid a recurrence. By making sure that lessons from complaints are taken on board and followed up appropriately, services and performance can be greatly improved for the future.

Co-operation

3.5 Local arrangements must ensure that a full and comprehensive response is given to a complainant and that there is the necessary co-operation in the handling and consideration of complaints between:

- HSC organisations;
- Regulatory authorities e.g. professional bodies, DOH, Medicines Regulatory Group (MRG);
- The Ombudsman; and
- The RQIA.

3.6 This general duty to co-operate includes answering questions, providing information and attending any meeting reasonably requested by those investigating the complaint.

Complaints Manager

3.7 HSC organisations must appoint:

- A senior person within the organisation to ensure compliance with the relevant Complaints Directions[17] and to ensure that action is taken in light of the outcome of any investigation; and
- A Complaints Manager to co-ordinate the local complaints arrangements and manage the process.

[17] DoH Complaints Directions: https://www.health-ni.gov.uk/publications/hsc-complaints-directions

3.8 The Complaints Manager or whoever is designated on their behalf must be readily accessible to both the public and members of staff. The Complaints Manager should:

- deal with complaints referred by front-line staff;
- be easily identifiable to service users;
- be available to complainants who do not wish to raise their concerns with those directly involved in their care;
- provide advice and support to vulnerable adults;
- consider all complaints received and identify and appropriately refer those falling outside the remit of the complaints procedure;
- provide support to staff to respond to complaints;
- be aware of and advise on the role of the Medical Defence Organisations (MDOs)[18] to assist staff requiring professional indemnity[19];
- have access to all relevant records (including personal medical records);
- take account of all evidence available relating to the complaint e.g. witness to a particular event;
- identify training needs associated with the complaints procedure and ensure those needs are met;
- ensure all issues are addressed in the draft response, taking account of information obtained from reports received and providing a layman's interpretation to otherwise complex reports;
- compile a summary of complaints received, actions taken and lessons learnt;
- maintain and appropriately store records;
- assist the designated senior person in the examination of trends, monitoring the effectiveness of local arrangements and the action taken (or proposed) in terms of service improvement; and

[18] There are 3 MDOs, the Medical Defence Union (MDU), Medical and Dental Defence Union of Scotland (MDDUS), and Medical Protection Society (MPS).
[19] Since 16 July 2014 and the introduction of the Health Care and Associated Professions (Indemnity Arrangements) Order 2014, all registered healthcare professionals are legally required to have adequate and appropriate insurance or indemnity to cover the different aspects of their practice in the UK.

- assist the designated senior person in ensuring compliance with standards, identifying lessons and dissemination of learning in line with the organisation's governance arrangements.

3.9 Complaints Managers should involve the complainant from the outset and seek to determine what they are hoping to achieve from the process. The complainant should be given the opportunity to understand all possible options available in seeking complaint resolution. Throughout the process, the Complaints Manager should assess what further action might best resolve the complaint and at each stage keep the complainant informed.

Publicity

3.10 HSC organisations must ensure that the complaints process is well publicised locally. This means that service users should be made aware of:

- their right to complain;
- all possible options for pursuing a complaint, and the types of help available; and
- the support mechanisms that are in place.

3.11 Ready access to information can make a critical difference to the service user's experience of HSC services. Information about services and what to expect, the various stages involved in the complaints process, response targets and independent support and advice should be available. Clear lines of communication are required to ensure complainants know who to communicate with during the lifetime of their complaint. The provision of information will improve attitudes and communication by staff as well as support and advice for complainants.

3.12 Local information should:

- be visible, accessible and easily understood;
- be available in other formats or languages as appropriate;
- be provided free of charge; and
- outline the arrangements for handling complaints, how to contact complaints staff, the availability of support services, and what to do if the complainant remains dissatisfied with the outcome of the complaints process.

Training

3.13 All staff should be trained and empowered to deal with complaints as they occur. Appropriately trained staff will recognise the value of the complaints process and, as a result will welcome complaints as a source of learning. HSC staff have a responsibility to highlight training needs to their line managers. Line managers, in turn, have a responsibility to ensure needs are met to enable the individual to function effectively in their role and HSC organisations have a responsibility to create an environment where learning can take place. It is essential that staff recognise that their initial response can be crucial in establishing the confidence of the complainant.

Actions on receipt of a complaint

3.14 Standard 3: *Receiving Complaints* provides the criteria by which organisations must operate (Annex 1 refers).

3.15 All complaints received should be treated with equal importance regardless of how they are submitted. Complainants should be encouraged to speak openly and freely about their concerns and should be reassured that whatever they may say will be treated with appropriate confidence and sensitivity. Complainants should be treated courteously and sympathetically and where possible involved in decisions about how their complaint is handled and considered. The first responsibility of staff is to ensure that the service user's immediate care needs are being met. This may require urgent action before any matters relating to the complaint are addressed.

3.16 The involvement of the complainant throughout the consideration of their complaint will provide for a more flexible approach to the resolution of the complaint. Complaints staff should discuss individual cases with complainants at an early stage and an important aspect of the discussion will be about the time it may take to complete the investigation especially if it is likely to exceed the 20 working day target for any reason. Early provision of information and an explanation of what to expect should be provided to the complainant at the outset to avoid disappointment and subsequent letters of complaint. Each complaint must be taken on its own merit and responded to accordingly. It may be appropriate for the entire process of local

resolution to be conducted informally. Overall, arrangements should ensure that complaints are dealt with quickly and effectively in an open and non-defensive way.

3.17 Where possible, all complaints should be registered and discussed with the Complaints Manager in order to identify those that can be resolved immediately, those that require formal investigation, or those that should be investigated and managed outside of the HSC Complaints Procedure by other means. Front-line staff will often find the information they gain from complaints useful in improving service quality. This is particularly so for complaints that have been resolved "on the spot" and have not progressed through the formal HSC Complaints procedure. Mechanisms for achieving this are best agreed at organisational level.

Acknowledgement of Complaint

3.18 A complaint should be acknowledged in writing within **2 working days** of receipt. FPS complaints should be acknowledged within **3 working days** in line with legislative requirements (see Legal Framework at Annex 2). The acknowledgement letter should always thank the complainant for drawing the matter to the attention of the organisation. A copy of the complaint and its acknowledgement should be sent to any person involved in the complaint unless there are reasonable grounds to believe that to do so would be detrimental to that person's health or well-being.

3.19 There should be a statement expressing sympathy or concern regarding the issue that led to a complaint being made. This is a statement of common courtesy, not an admission of responsibility.

3.20 It is good practice for the acknowledgement letter to be conciliatory, and indicate that a full response will be provided within **20 working days**. FPS acknowledgement should indicate that a full response will be provided within **10 working days**. As soon as the HSC organisation becomes aware that the relevant response timescale is not achievable they must provide the complainant with an explanation. The complainant must be updated every 20 working days on the progress of their complaint by the most appropriate means. All contact with the complainant must be recorded by the HSC organisation.

3.21 The acknowledgement should:

- seek to confirm the issues raised in the complaint;
- offer opportunities to discuss issues either with a member of the complaints staff or, if appropriate, a senior member of staff; and
- provide information about the availability of independent support and advice.

3.22 Complaints Managers should provide the complainant with further information about the complaints process. This may include locally produced information leaflets or those provided by the Ombudsman's Office or the RQIA. It is also advisable to include information about the disclosure of patient information at this stage.

Joint Complaints

3.23 Where a complaint relates to the actions of more than one HSC organisation the Complaints Manager should notify any other organisations involved. The complainant's consent must be obtained before sharing the details of the complaint across HSC organisations. In cases of this nature there is a need for co-operation and partnership between the relevant organisations in agreeing how best to approach the investigation and resolution of the complaint. It is possible that the various aspects of the complaint can be divided easily with each organisation able to respond to its own area of responsibility. The complainant must be kept informed and provided with advice about how each aspect of their complaint will be dealt with and by whom.

Out of Area Complaints

3.24 Where the complainant lives in Northern Ireland and the complaint is about events elsewhere, the HSC Board or HSC Trust that commissioned the service or purchased the care for that service user is responsible for co-ordinating the investigation and ensuring that all aspects of the complaint are investigated. HSC contracts must include entitlement, by the HSC organisation, to any and all documentation relating to the care of service users and a provision to comply with the requirements of the HSC Complaints Procedure.

Investigation

3.25 Standard 5: *Investigation* provides the criteria by which organisations must operate (Annex 1 refers). HSC organisations should establish a clear system to ensure an appropriate level of investigation. The purpose of investigation is not only "resolution" but also to:

- ascertain what happened or what was perceived to have happened;
- establish the facts;
- learn lessons;
- detect misconduct or poor practice; and
- improve services and performance.

3.26 An investigation into a complaint may be undertaken by a suitable person appointed by the HSC organisation. Investigations should be conducted in a manner that is supportive to all those involved, without bias and in an impartial and objective manner. The investigation must uphold the principles of fairness and consistency. The investigation process is best described as listening, learning and improving. Investigators should be able to seek advice from the Complaints Manager/senior person, wherever necessary, about the conduct or findings of the investigation.

3.27 Whoever undertakes the investigation should seek to understand the nature of the complaint and identify any issues not immediately obvious. Complaints must be approached with an open mind, being fair to all parties. The complainant and those identified as the subject of a complaint should be advised of the process, what will and will not be investigated, those who will be involved, the roles they will play and the anticipated timescales. Everyone involved should be kept informed of progress throughout. Staff involved in the investigation process should familiarise themselves with Section 75 of the Northern Ireland Act 1998.

Assessment of the complaint

3.28 It is unrealistic to suggest that all complaints should be investigated to the same degree or at the same level. HSC organisations must ensure that a robust risk assessment process is applied to all complaints to allow serious complaints, such as those involving unsafe practice, to be identified. The use of assessment tools to risk assess and categorise a complaint may be helpful in determining the course of action to take in response. It can help ensure that the process is proportionate to the seriousness of the complaint and the likelihood of recurrence.

Investigation and resolution

3.29 The HSC organisation should use a range of investigating techniques that are appropriate to the nature of the complaint and to the needs of the complainant. Those responsible for investigation should be empowered to choose the method that they feel is the most appropriate to the circumstances.

3.30 The investigator should establish the facts relating to the complaint and assess the quality of the evidence. Depending on the subject matter and complexity of the investigation the investigator may wish to call upon the services of others. There are a number of options available to assist HSC organisations in the resolution of complaints. These should be considered in line with the assessment of the complaint and also in collaboration with the complainant and include the involvement of:

- senior managers/professionals at an early stage;
- honest broker;
- independent experts;
- lay persons; and
- conciliators.

3.31 It is not intended that HSC organisations utilise all the options outlined above as not all these will be appropriate in the resolution of the complaint. Rather HSC organisations should consider which option would assist in providing the desired outcome. The HSC Board will provide the necessary support and advice to FPS in relation to access and appointment of these options, where appropriate.

Completion of Investigation

3.32 Once the investigator has reached their conclusion they should prepare the draft report/response. The purpose is to record and explain the conclusions reached after the investigation of the complaint. The Department's *HSC Regional Template and Guidance for Incident Investigation/ Review Reports*[20] will assist HSC organisations in ensuring the completeness and readability of such reports.

3.33 Where the complaint involves clinical/ professional issues, the draft response must be shared with the relevant clinicians/ professionals to ensure the factual accuracy and to ensure clinicians/ professionals agree with and support the draft response.

3.34 All correspondence and evidence relating to the investigation should be retained. The Complaints Manager should ensure that a complete record is kept of the handling and consideration of each complaint. Complaints records should be kept separate from health or social care records, subject only to the need to record information which is strictly relevant to the service user's on-going health or care needs.

3.35 HSC organisations should regularly review their investigative processes to ensure the effectiveness of these arrangements locally.

[20] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2034-07_0.pdf

Circumstances that might cause delay

3.36 Some complaints will take longer than others to resolve because of differences in complexity, seriousness and the scale of the investigative work required. Others may be delayed as a result of circumstance, for example, the unavailability of a member of staff or a complainant as a result of holidays, personal or domestic arrangements or bereavement. Delays may also be as a result of the complainant's personal circumstances at a particular time e.g. a period of mental illness, an allegation of physical injury or because a complaint is being investigated under another procedure (as outlined in paragraphs 1.12 to 1.14).

Periods of acute mental illness

3.37 If a service user makes a complaint during an acute phase of mental illness, the Complaints Manager should register the complaint and consideration should be given to delaying the complaint until his/her condition has improved. A delay such as this will need either the agreement of the complainant or someone who is able to act on his/her behalf including, where appropriate, consultation with any advocate. The decision about whether a complainant is well enough to proceed with the complaint should be made by a multi-disciplinary team, and the Complaints Manager should refer regularly to this team to establish when this point has been reached.

Physical Injury

3.38 Where a complainant is alleging physical injury, a physical examination should be arranged without delay and with the consent of the injured person. Medical staff undertaking the physical examination should clearly report their findings. If a person refuses a physical examination, or if his or her mental state (for example, degree of agitation) makes this impossible, this should be clearly documented.

3.39 Whatever the reason, as soon as it becomes clear that it will not be possible to respond within the target timescales, the Complaints Manager should advise the complainant and provide an explanation with the anticipated timescales. While the emphasis is on a complete response and not the speed of response, the HSC

organisation should, nevertheless, monitor complaints that exceed the target timescales to prevent misuse of the arrangements. The complainant must also be updated every 20 working days on the progress of their complaint by the most appropriate means. All contact with the complainant must be recorded by the HSC organisation.

Responding to a complaint

3.40 Standard 6: *Responding to complaints* provides the criteria by which organisations must operate (Annex 1 refers). A response must be sent to the complainant within **20 working days of receipt** of the complaint (**10 working days within FPS**) or, where that is not possible, the complainant must be advised of the delay (as per paragraph 3.39 above).

3.41 Where appropriate, HSC organisations must consider alternative methods of responding to complaints whether through an immediate response from front-line staff, a meeting, or direct action by the Chief Executive (or senior person). It may be appropriate to conduct a meeting in complex cases, in cases where there is serious harm/death of a patient, in cases involving those whose first language is not English, or, for example in cases where the complainant has a learning disability or mental illness. Where complaints have been raised electronically the HSC may reply electronically whilst ensuring they adhere to the relevant Information Technology (IT) policies and procedures and maintain appropriate levels of confidentiality according to Trust policies and procedures**.**

3.42 Where a meeting is scheduled it is more likely to be successful if the complainant knows what to expect and can offer some suggestions towards resolution. Complainants have a right to choose from whom they seek support and should be encouraged to bring a relative or friend to meetings. Where meetings do take place they should be recorded and that record shared with the complainant for comment.

3.43 The Chief Executive (or Clinical Governance Lead) may delegate responsibility for responding to a complaint, where, in the interests of a prompt reply, a designated senior person may undertake the task (or the governance lead within FPS settings). In such circumstances, the arrangements for clinical and social care governance must ensure that the Chief Executive (or Clinical Governance Lead) maintains an overview of the issues raised in complaints (including those FPS complaints lodged with the HSC Board), the responses given and be assured that appropriate organisational learning has taken place. HSC organisations should ensure that the complainant and anyone who is a subject of the complaint understand the findings of the investigation and the recommendations made.

3.44 The response should be clear, accurate, balanced, simple and easy to understand. It should avoid technical terms, but where these must be used to describe a situation, events or condition, an explanation of the term should be provided. The letter should:

- address the concerns expressed by the complainant and show that each element has been fully and fairly investigated;
- include an apology where things have gone wrong;
- report the action taken or proposed to prevent recurrence;
- indicate that a named member of staff is available to clarify any aspect of the letter;
- advise of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure; and
- advise of the availability of the Patient and Client Council to provide assistance in making a submission to the Ombudsman.

Concluding Local Resolution

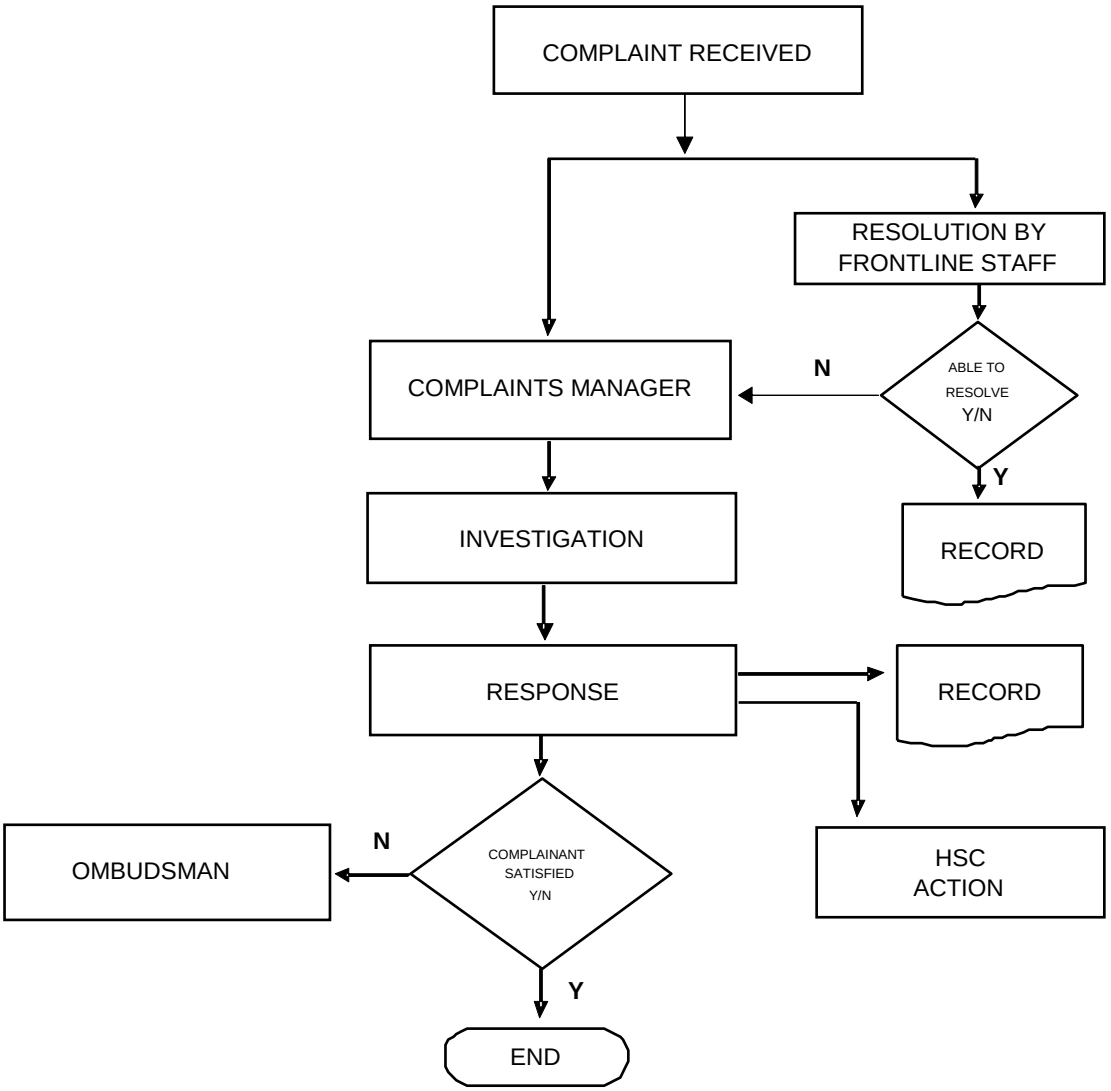
3.45 The HSC organisation should offer every opportunity to exhaust local resolution. While the final response should offer an opportunity to clarify the response this should not be for the purposes of delaying "closure". Complainants should contact the organisation within one month of the organisation's response if they are dissatisfied with the response or require further clarity[21]. There is discretion for the Complaints Manager to extend this time limit where it would be unreasonable in the circumstances for the complainant to have made contact sooner.

3.46 Once the final response has been signed and issued, the Complaints Manager, on behalf of the Chief Executive/Clinical Governance Lead, should liaise with relevant local managers and staff to ensure that all necessary follow-up action has been taken. Arrangements should be made for any outcomes to be monitored to ensure that they are actioned. Where possible, the complainant and those named in the complaint should be informed of any change in system or practice that has resulted from the investigation into their complaint.

3.47 This completes the HSC Complaints Procedure. There is a statutory obligation on all HSC organisations to signpost to the Ombudsman upon completion of the complaints procedure. Please refer to Annex 5 for details on the requirements for signposting.

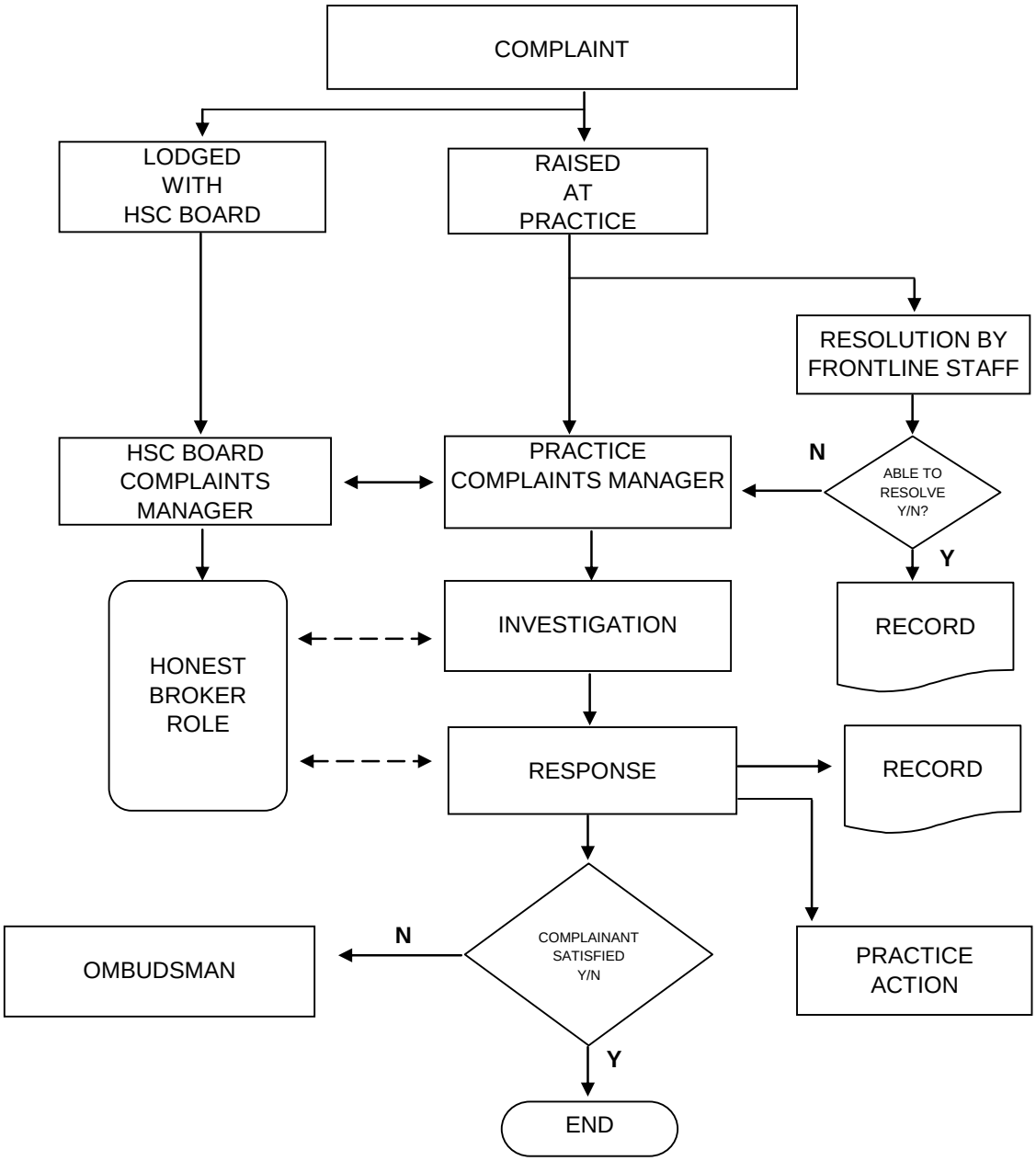
[21]Inserted 5th June 2013 per letter from Director of Safety, Quality & Standards Directorate

HOSPITAL OR COMMUNITY COMPLAINTS FLOWCHART

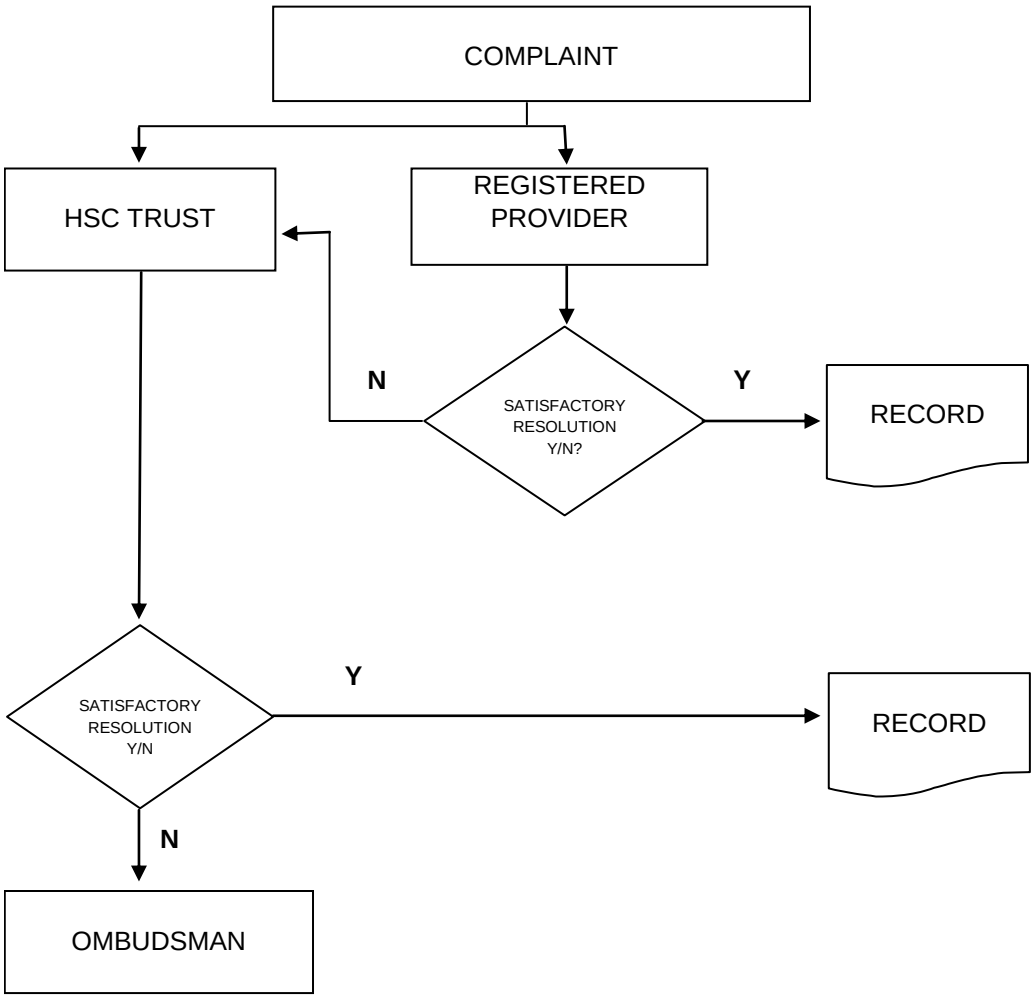


MAHI - STM - 097 - 6316

FAMILY PRACTITIONER SERVICE COMPLAINTS FLOWCHART



REGULATED ESTABLISHMENTS & AGENCIES FLOWCHART
(Services commissioned by HSC)



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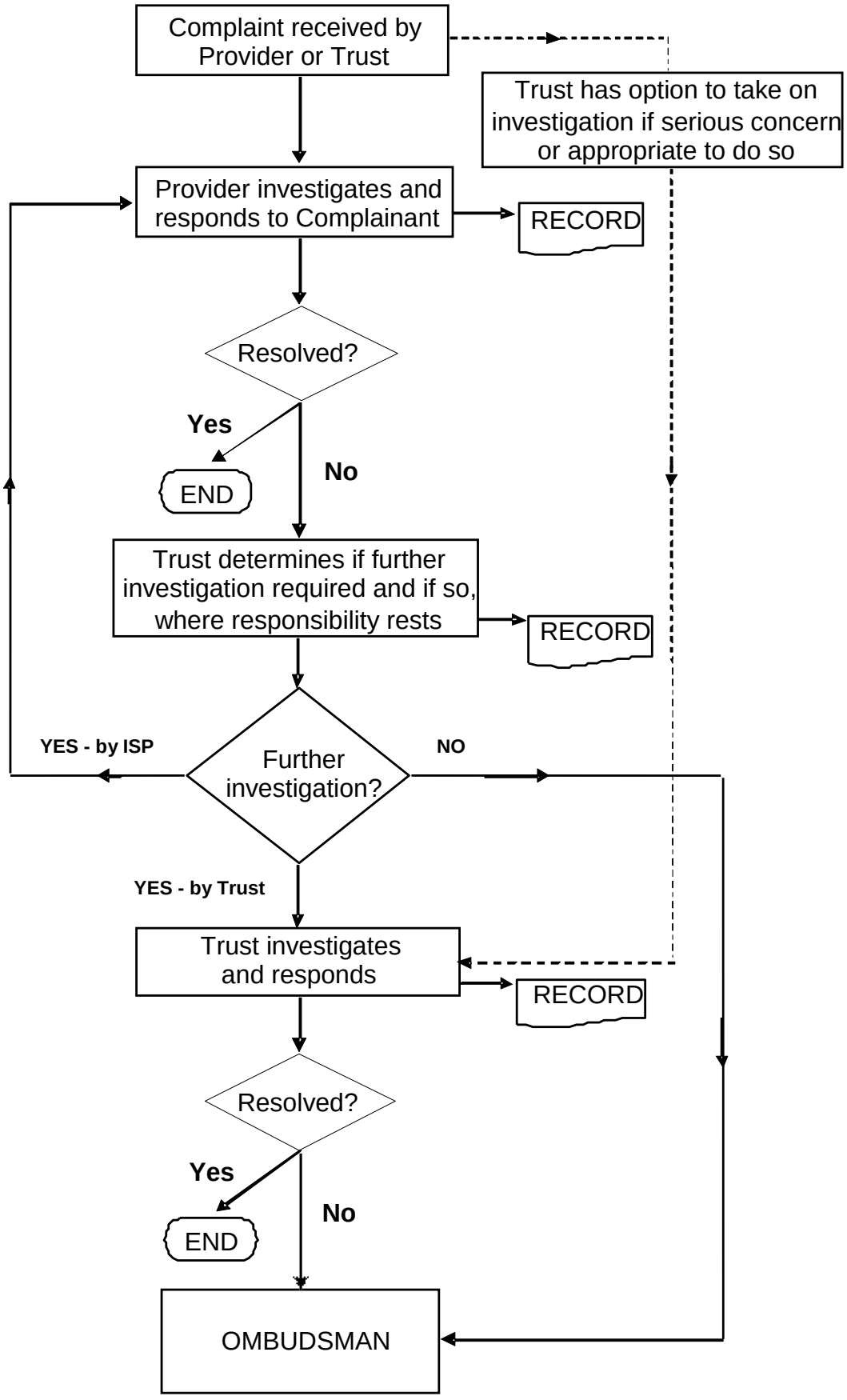
INDEPENDENT SECTOR PROVIDER (ISP) COMPLAINTS FLOWCHART



SUMMARY OF TARGET TIMESCALES

EVENT	TIMESCALE
Making a complaint	within 6 months of the event, or 6 months after becoming aware of the cause for complaint, but no longer than 12 months from the event
Acknowledgement Family Practitioner Services	within 2 working days* of receipt within 3 working days
Response Family Practitioner Services	within 20 working days within 10 working days (20 working days if lodged with HSC Board)
Should complainant wish to seek clarity in relation to response or express continued dissatisfaction	within 1 months of the organisation's response

*** A working day is any weekday (Monday to Friday) which is not a local or public holiday.**

SECTION 4 – LEARNING FROM COMPLAINTS

Reporting and Monitoring

4.1 Each HSC organisation has a legal duty to operate a complaints procedure and is required to monitor how they, or those providing care on their behalf, deal with and respond to complaints. This includes the regular reporting on complaints in line with governance arrangements and monitoring the effectiveness of the procedure locally. The HSC organisation must:

- regularly review its policies and procedures to ensure they are effective;
- monitor the nature and volume of complaints;
- seek feedback from service users and staff to improve services and performance; and
- ensure lessons are learnt from complaints and use these to improve services and performance.

4.2 HSC organisations are also required to keep a record of all complaints received, including copies of all correspondence relating to complaints. HSC organisations must have effective processes in place for identifying and minimising risk, identifying trends, improving quality and safety and ensuring lessons are learnt and shared. HSC organisations must ensure regular and adequate reporting on complaints in line with agreed governance arrangements.

4.3 The *Standards for Complaints Handling* (Annex 1 refers) provide the criteria by which organisations must operate and will assist organisations in monitoring the effectiveness of their complaints handling arrangements locally. HSC organisations should also involve service users and staff to improve the quality of services and effectiveness of complaints handling arrangements locally

4.4 The HSC must ensure they have the necessary technology/information systems to record and monitor all complaints. For the purposes of measuring the effectiveness of the procedures, HSC organisations must maintain systems as described below.

The HSC Board

4.5 The HSC Board must maintain an oversight of all FPS and HSC Trust complaints received (including HSC prison healthcare) and be prepared to analyse any patterns or trends of concern or clusters of complaints against individuals, practices, or organisations.

4.6 The HSC Board must provide the Department with quarterly complaints statistics in relation to all FPS and, where appropriate, out-of-hours services.

4.7 The HSC Board must produce an annual report on complaints outlining the number of FPS and, where appropriate, out-of-hours services complaints received, the categories to which the complaints relate and the response times. The annual report should also include the number of FPS complaints in which the HSC Board acted as "honest broker". Copies should be sent to the PCC, the RQIA, the Ombudsman and the DOH. Reports must not breach patient/ client confidentiality.

HSC Trusts

4.8 All HSC Trusts including the Northern Ireland Ambulance Service (NIAS) must provide the Department with quarterly statistical returns on complaints.

4.9 HSC Trusts must provide their Management Boards and the HSC Board with quarterly complaints reports outlining the number and types of complaints received, the investigation undertaken and actions as a result including those relating to regulated establishments and agencies, and, where appropriate, out-of-hours services, pilot schemes and HSC prison healthcare. The reports must summarise the categories, emerging trends and the actions taken (or proposed) to prevent recurrence in order to:

- monitor arrangements for local complaints handling;
- consider trends in complaints; and
- consider any lessons that can be learned and shared from complaints and the result in terms of service improvement.

4.10 HSC Trusts must also produce an annual complaints report to include the number of complaints received, the categories to which the complaints relate, the response times and the learning from complaints. Copies should also be made available to the HSC Board, PCC, RQIA, the Ombudsman and the DoH. Reports must not breach patient/ client confidentiality.

Quarterly reports

4.11 The management boards of the HSC Board and HSC Trusts should receive quarterly reports summarising the categories, emerging trends and the actions taken (or proposed) to prevent recurrence in order to:

- monitor arrangements for local complaints handling;
- consider trends in complaints; and
- consider any lessons that can be learned and shared from complaints and the result in terms of service improvement.

4.12 The HSC Board's quarterly reports to their management board should include a breakdown of complaints received in relation to **all** Family Practitioner Services and, where appropriate, out-of-hours services.

4.13 HSC Trusts' quarterly reports to their management board should include a breakdown of all complaints received including those received by, or on behalf of, residents in statutory or independent residential care and nursing homes and, where appropriate, out-of-hours services, pilot schemes and HSC prison healthcare.

Family Practitioner Services

4.14 Family Practitioner Services must provide the HSC Board with anonymised copies of all written complaints received and responses provided by the Practice within 3 working days of the response being issued.

4.15 Arrangements should be in place to ensure that the complainant is aware and agrees to his/her complaint being forwarded to the HSC Board.

4.16 The HSC Board must record and monitor the outcome of all FPS complaints lodged with them.

Other HSC organisations

4.17 All other HSC organisations must publish an annual report on complaints handling. Copies should be sent to the PCC, HSC Board and the DoH. Reports must not breach patient/client confidentiality.

Regulated establishments and agencies

4.18 All regulated establishments and agencies are required if requested to provide the RQIA with a statement containing a summary of complaints made during the preceding 12 months and the action that was taken in response. The RQIA will record and monitor all outcomes and will report on complaints activity within the regulated sector.

Department of Health (DoH)

4.19 The DoH will continue to collect statistics on the number, type and response times of complaints made to HSC organisations. A regional breakdown of complaints statistics will be provided via the Departmental website on an annual basis.

Learning

4.20 All HSC organisations are expected to manage complaints effectively, ensuring that appropriate action is taken to address the issues highlighted by complaints and making sure that lessons are learned, to minimise the chance of mistakes recurring and to improve the safety and quality of services. Learning should take place at different levels within the HSC organisation (individual, team and organisational) and the HSC organisation must be able to demonstrate that this is taking place[22].

4.21 Learning is a critical aspect of the HSC Complaints Procedure and provides an opportunity to improve services and contribute to and learn from regional, national and international quality improvement and patient safety initiatives. All HSC organisations, the RQIA and Ombudsman must share the intelligence gained through complaints.

4.22 The HSC Board must have in place regional-wide procedures for collecting and disseminating the information, themes and good practice derived from complaints and must ensure they are used to improve service quality. HSC Trusts and FPS should be encouraged to share learning and seek feedback from service users for further improvement.

[22] The Quality Standards for Health and Social Care, Theme 5 (8.3 (k)) - https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/the-quality-standards-for-health-and-social-care.pdf

SECTION 5 - ROLES AND RESPONSIBILITIES

HSC Board

5.1 The HSC Board is required to monitor how they, or those providing care on their behalf, deal with and respond to complaints. This will include monitoring complaints processes, outcomes and service improvements. The S*tandards for Complaints Handling* provides a level against which HSC service performance can be measured (Annex1 refers).

5.2 The HSC Board must maintain an oversight of all FPS and HSC Trust complaints received and, where appropriate, out-of-hours services. The HSC Board must be prepared to investigate any patterns or trends of concern or clusters of complaints against individual clinicians/ professionals.

5.3 The HSC Board must have in place area-wide procedures for collecting and disseminating learning and sharing intelligence.

5.4 The HSC Board will provide a vital role in supporting FPS complaints that includes:

- providing support and advice;
- the role of “honest broker” between the complainant and the service provider;
- providing independent experts, lay persons, conciliation services, where appropriate;
- recording and monitoring the outcome of all complaints;
- addressing breaches of contractual arrangements; and
- sharing complaints intelligence with appropriate authorities e.g. the DoH Medicines Regulatory Group (MRG).

HSC Organisations

5.5 HSC organisations must:

- make arrangements for the handling and consideration of complaints and publicise these arrangements locally;
- appoint a Complaints Manager with responsibility for co-ordinating the local complaints arrangements and managing the process;
- appoint a senior person to take responsibility for delivering the organisation's complaints process and ensuring that all necessary organisational learning takes place;
- ensure that all staff who provide services on their behalf are aware of, and trained in, the procedures to be followed when dealing with complaints;
- ensure that complainants and staff are supported and made aware of the availability of support services;
- ensure that there is full co-operation between organisations/bodies in the handling and consideration of complaints;
- integrate complaints management into the organisation's clinical and social care governance and risk management arrangements;
- monitor the effectiveness of local complaints handling arrangements;
- have in place area-wide procedures for collecting and disseminating the information, themes and good practice derived from complaints; and
- where appropriate, publish annually a report on complaints handling.

The Patient and Client Council (PCC)

5.6 The PCC is an independent non-departmental public body established on 1 April 2009 to replace the Health and Social Services Councils. Its functions include:

- representing the interests of the public;
- promoting involvement of the public;
- providing assistance to individuals making or intending to make a complaint; and
- promoting the provision of advice and information to the public about the design, commissioning and delivery of health and social care services.

5.7 If a person feels unable to deal with a complaint alone, the staff of the PCC can offer a wide range of assistance and support. This assistance may take the form of:

- information on the complaints procedure and advice on how to take a complaint forward;
- discussing a complaint with the complainant and drafting letters;
- making telephone calls on the complainants behalf;
- helping the complainant prepare for meetings and going with them to meetings;
- preparing a complaint to the Ombudsman;
- referral to other agencies, for example, specialist advocacy services; and
- help in accessing medical/social services records.

5.8 All advice, information and assistance with complaints is provided free of charge and is confidential. Further information can be obtained from: www.patientclientcouncil@hscni.net or Freephone 0800 917 0222

WHO CAN HELP ME RAISE MY COMPLAINT?

You can get practical help to raise your complaint from the Patient and Client Council (PCC).

You can contact a PCC Officer at:

Phone: 0800 917 0222
Email: complaints.pcc@hscni.net

For more information, visit PCC's website:
www.patientclientcouncil.hscni.net

The PCC Complaints Support Service is there to:

- Give you information on how to complain and who to complain to
- Help you write letters of complaint
- Make telephone calls for you about your complaint
- Go with you to meetings about your complaint and make sure your concerns are responded to
- Work with health and social care organisations to improve services as a result of your complaint

WHAT CAN I DO IF I AM NOT SATISFIED WITH THE TRUST'S RESPONSE?

If you are not happy with the trust's response to your complaint, you can contact the Northern Ireland Public Service Ombudsman (NIPSO) at:

Phone: 0800 343 424

Email: nipso@nipso.org.uk

For more information, visit NIPSO's website:
www.nipso.org.uk

ANNEX 1: STANDARDS FOR COMPLAINTS HANDLING

Standards for complaints handling

1. The following standards have been developed to address the variations in the standard of complaints handling across HSC organisations. These will assist organisations in monitoring the effectiveness of their complaints handling arrangements locally and will build public confidence in the process by which their complaint will be handled. These are the standards to which HSC organisations are expected to operate for complaints handling:

STANDARD 1: ACCOUNTABILITY

HSC organisations will ensure that there are clear lines of accountability for the handling and consideration of complaints.

Rationale:

HSC organisations will demonstrate that they have in place clear accountability structures to ensure the effective and efficient investigation of complaints, to provide a timely response to the complainant and a framework whereby learning from complaints is incorporated into the clinical, social care and organisational governance arrangements.

Criteria:

1. Managerial accountability for complaints within HSC organisations rests with the Chief Executive (or Clinical Governance Lead in FPS settings);
2. HSC organisations must designate a senior person to take responsibility for complaints handling and responsiveness locally;
3. HSC organisations must ensure that complaints are integrated into clinical and social care governance and risk management arrangements;
4. HSC organisations will include complaints handling within its performance management framework and corporate objectives;
5. Each HSC organisation must ensure that the operational Complaints Manager is of appropriate authority and standing and has appropriate support;
6. All staff must be aware of, and comply with, the requirements of the complaints procedure within their area of responsibility;
7. Where applicable, HSC organisations will ensure that independent provider contracts include compliance with the requirements of the HSC Complaints Procedure; and
8. Each HSC organisation is responsible for quality assuring its complaints handling arrangements.

STANDARD 2: ACCESSIBILITY

All service users will have open and easy access to the HSC Complaints Procedure and the information required to enable them to complain about any aspect of service.

Rationale:

Those who wish to complain will be treated impartially, in confidence, with sensitivity, dignity and respect and will not be adversely affected because they have found cause to complain. Where possible, arrangements will be made as necessary for the specific needs of those who wish to complain, including provision of interpreting services; information in a variety of formats and languages; at suitable venues; and at suitable times.

Criteria:

1. Arrangements about how to make a complaint are widely publicised, simple and clear and made available in all areas throughout the service;
2. Arrangements for making a complaint are open, flexible and easily accessible to all service users, no matter what their personal situation or ability;
3. Flexible arrangements are in place in order that individual complainants may be suitably accommodated in an environment where they feel comfortable; and
4. All staff have appropriate training about the needs of service users, including mental health, disability and equality awareness training.

STANDARD 3: RECEIVING COMPLAINTS

All complaints received will be dealt with appropriately and the process and options for pursuing a complaint will be explained to the complainant.

Rationale:

All complaints are welcomed. Effective complaints handling is an important aspect of the HSC clinical and social care governance arrangements. All complaints, however or wherever received, will be recorded, treated confidentially, taken seriously and dealt with in a timely manner.

Criteria:

1. Flexible arrangements are in place so that complaints can be raised in a variety of ways (e.g. verbally or in writing), and in a way in which the complainant feels comfortable;
2. Complaints from a third party must, where possible, have the written consent of the individual concerned;
3. HSC staff are aware of their legal and ethical duty to protect the confidentiality of service user information;
4. Attempts to resolve complaints are as near to the point of contact as possible, and in accordance with the complainant's wishes;
5. Where possible, the complainant should be involved in decisions about how their complaint is handled and considered; and
6. Complaints are appropriately recorded and assessed according to risk in line with agreed governance arrangements.

STANDARD 4: SUPPORTING COMPLAINANTS AND STAFF

HSC organisations will support complainants and staff throughout the complaints process.

Rationale:

The HSC will support service users in making complaints and will encourage feedback through a variety of mechanisms. Information on complaints will outline the process as well as the support services available. Staff will be trained and empowered to deal with complaints as they arise.

Criteria:

1. HSC organisations will ensure the provision of readily available advice and information on how to access support services appropriate to the complainant's needs;
2. The HSC organisation's Complaints Manager will offer assistance in the formulating of a complaint;
3. HSC organisations will promote the use of independent advice and advocacy services;
4. HSC organisations will facilitate, where appropriate, the use of conciliation;
5. HSC organisations will adopt a consistent approach in the application of DOH guidance on responding to unreasonable or abusive complainants;
6. HSC organisations will ensure that staff receive training on complaints, appropriate to their needs; and
7. HSC organisations will ensure that mechanisms are in place to support staff throughout the complaints process.

STANDARD 5: INVESTIGATION OF COMPLAINTS

All investigations will be conducted promptly, thoroughly, openly, honestly and objectively.

Rationale:

HSC organisations will establish a clear system to ensure an appropriate level of investigation. Not all complaints need to be investigated to the same degree. A thorough, documented investigation will be undertaken, where appropriate, including a review of what happened, how it happened and why it happened. Where there are concerns, the HSC organisation will act appropriately and, where possible, improve practice and ensure lessons are learned.

Criteria

1. Investigations are conducted in line with agreed governance arrangements;
2. Investigations are robust and proportionate and the findings are supported by the evidence;
3. A variety of flexible techniques are used to investigate complaints, dependent on the nature and complexity of the complaint and the needs of the complainant;
4. Independent experts or lay people are involved during the investigation, where identified as being necessary or potentially beneficial and with the complainant's consent;
5. People with appropriate skills, expertise and seniority are involved in the investigation of complaints, according to the substance of the complaint;
6. All HSC providers/commissioners and regulatory bodies will co-operate, where necessary, in the investigation of complaints;
7. The HSC organisation will investigate and take necessary action, regardless of consent, where a patient/client safety issue is raised; and
8. All correspondence and evidence relating to the investigation will be retained in line with relevant information governance requirements;

STANDARD 6: RESPONDING TO COMPLAINTS

All complaints will be responded to as promptly as possible and all issues raised will be addressed.

Rationale:

All complainants have a right to expect their complaint to be dealt with promptly and in an open and honest manner.

Criteria:

1. The timescales for acknowledging and responding to complaints are in line with statutory requirements;
2. Where any delays are anticipated or further time required the HSC organisation will advise the complainant of the reasons and keep them informed of progress;
3. HSC organisations must consider alternative methods of responding to complaints;
4. Responses will be clear, accurate, balanced, simple, fair and easy to understand. All the issues raised in the complaint will be addressed and, where appropriate, the response will contain an apology;
5. The Chief Executive may delegate responsibility for responding to a complaint where, in the interests of a prompt reply, a designated senior person may undertake this task (or a clinical governance lead in FPS settings);
6. Complainants should be informed, as appropriate, of any change in system or of practice that has resulted from their complaint; and
7. Where a complainant remains dissatisfied, he/she should be clearly advised of the options that remain open to them.

STANDARD 7: MONITORING

HSC organisations will monitor the effectiveness of complaints handling and responsiveness.

Rationale:

HSC organisations are required to monitor how they, or those providing care on their behalf, deal with and respond to complaints. Monitoring performance is essential in determining any necessary procedural change that may be required. It will also ensure that organisations have taken account of the issues and incorporated improvements where appropriate.

Criteria:

1. HSC organisations should ensure the regular and adequate reporting on complaints in accordance with agreed governance arrangements;
2. HSC organisations must produce and disseminate, where appropriate, an Annual Report on Complaints;
3. HSC organisations must ensure that they have in place the necessary technology/information system to record and monitor all complaints and outcomes;
4. HSC organisations should have a mechanism to routinely request feedback from service users and staff on the operation of the complaints process;
5. HSC organisations must review the arrangements for complaints handling and responsiveness; and
6. HSC organisations must be assured, that ISPs with which they contract have appropriate governance arrangements in place for the effective handling, management and monitoring of all complaints.

STANDARD 8: LEARNING

HSC organisations will promote a culture of learning from complaints so that, where necessary, services can be improved when complaints are raised.

Rationale:

Complaints are viewed as a significant source of learning within HSC organisations and are an integral aspect of its patient/client safety and quality services ethos. Complaints will help organisations to continue to improve the quality of their services and safeguard high standards of care and treatment. HSC organisations must have effective structures in place for identifying and minimising risk, identifying trends, improving quality and safety and ensuring lessons are learnt and shared.

Criteria:

1. HSC organisations will monitor the nature and volume of complaints so that trends can be identified and acted upon;
2. HSC organisations will ensure there are provisions made within governance arrangements for the identification of learning from complaints and the sharing of learning locally and regionally;
3. Learning will take place at different levels within the HSC (individual, team and organisational);
4. HSC organisations will ensure that they have adequate mechanisms in place for reporting on progress with the implementation of action plans arising from complaints;
5. HSC organisations will incorporate learning arising from any review of findings of an investigation;
6. HSC organisations will contribute to, and learn from, regional, national and international quality improvement and patient safety initiatives; and
7. HSC organisations will include learning from complaints within its Annual Report on Complaints.

ANNEX 2: LEGAL FRAMEWORK

HPSS Complaints Procedure Regulations:

- The Health and Personal Social Services (General Medical Services Contracts) Regulations (NI) 2004;
- Health and Personal Social Services General Dental Services (Amendment) Regulations (NI) 2008;
- The General Ophthalmic Services (Amendment) Regulations
- (Northern Ireland) 2014The Pharmaceutical Services Regulations (NI) 1997.

The Children (NI) Order 1995:

- The Representations Procedure (Children) Regulations (NI) 1996.

HSC Complaints Procedure Directions:

- The Health and Social Care Complaints Procedure Directions (NI) 2009;
- Directions to the Health and Social Care Board on Procedures for Dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers (NI) 2009;
- Amendment Directions to the Health and Social Care Board on Procedures for Dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers (2009);
- Complaints about Family Health Services Practitioners and Pilot Scheme Providers (2009) (Honest Broker Timescales) (Amended 2013)
- Directions to the Regional Business Services Organisation on Procedures for Dealing with Health and Social Care Complaints (2010);
- Directions to the Regional Agency for Public Health and Social Well-being on Procedures for Dealing with Health and Social Care Complaints (2010).

The Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003

- The Residential Care Homes Regulations (NI) 2005;
- The Nursing Homes Regulations (NI) 2005;
- The Independent Health Care Regulations (NI) 2005;
- The Nursing Agencies Regulations (NI) 2005;
- The Adult Placement Agencies Regulations (NI)2007;
- The Day Care Settings Regulations (NI) 2007;
- The Residential Family Centres Regulations (NI) 2007;
- The Domiciliary Care Agencies Regulations (NI) 2007;

ANNEX 3: PROFESSIONAL REGULATORY BODIES

General Chiropractic Council (GCC) Chiropractors Phone: 020 7713 5155 www.gcc-uk.org	**Nursing and Midwifery Council (NMC)** Nurses, midwives and specialist community public health nurses Phone: 020 76377181 www.nmc-uk.org
General Dental Council (GDC) Dentists, dental therapists, dental hygienists, dental nurses, dental technicians, clinical dental technicians and orthodontic therapists Phone: 020 71676000 www.gdc-uk.org	**Royal Pharmaceutical Society of Great Britain (RPSGB)** Pharmacists, pharmacy technicians (on the voluntary register) and pharmacy premises Phone: 08452572570 https://www.rpharms.com
General Medical Council (GMC) Doctors Phone: 01619236602 www.gmc-uk.org	**Pharmaceutical Society of Northern Ireland** Pharmacists and pharmacy premises in Northern Ireland Phone: 02890 326927 www.psni.org.uk
General Optical Council (GOC) Opticians Phone: 020 7580 3898 www.optical.org **General Osteopathic Council (GOsC)** Osteopaths Phone: 020 7357 6655 www.osteopathy.org.uk	**Professional Standards Authority for Health and Social Care (the Authority)** aims to protect the public, promote best practice and encourage excellence among the nine regulators of healthcare professionals listed. Phone: 020 73898030 http://www.professionalstandards.org.uk
Health and Care Professions Council (HCPC) Arts therapists, biomedical scientists, chiropodists, podiatrists, clinical scientists, dieticians, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, prosthetists and orthotists, radiographers, speech and language therapists Phone: 03005006184 www.hpc-uk.org	**Northern Ireland Social Care Council (NISCC)** Social care workers, qualified social workers, and social work students on approved degree courses in Northern Ireland Phone: 028 95362600 www.niscc.info

ANNEX 4: HSC PRISON HEALTHCARE

1. From 1 April 2008 responsibility for HSC prison healthcare was transferred to the DOH. From that date the DOH delegated responsibility for commissioning those health and social services to the Eastern Health and Social Services Board (EHSSB). From 1 April 2009 this responsibility transferred to the HSC Board. The South Eastern HSC Trust has responsibility for providing or securing the provision of health and social care services for prisoners.

2. Complaints raised about care or treatment or about issues relating to the provision of prison healthcare will be dealt with under the HSC Complaints Procedure.

ANNEX 5: THE NI PUBLIC SERVICES OMBUDSMAN

1. The Ombudsman[23] can carry out independent investigations into complaints about poor treatment or service or the administrative actions of HSC organisations. If someone has suffered because they have received poor service or treatment or were not treated properly or fairly, and the organisation or practitioner has not put things right where they could have, the Ombudsman may be able to help. The Ombudsman powers have also been extended to include the power to investigate complaints about social care decisions.

All listed authorities within the Ombudsman's jurisdiction have a statutory obligation to signpost complainants to the Ombudsman's office where the listed authority's complaints handling procedure is exhausted.

Section 25 of the Public Services Ombudsman Act (Northern Ireland) 2016 states:

25. (1) This section applies where a listed authority's complaints handling procedure is exhausted.

(2) The authority must, within 2 weeks of the day on which the complaint handling procedure is exhausted give the person aggrieved a written notice stating –

(a) that the complaints handling procedure is exhausted, and

(b) that the person aggrieved may, if dissatisfied, refer the complaint to the Ombudsman.

(3) A notice under subsection (2) must –

(a) inform the person aggrieved of the time limit for referring the complaint to the Ombudsman; and

(b) provide details of how to contact the Ombudsman.

[23] With effect from 1 April 2016 the statutory office of "NI Commissioner for Complaints" was abolished and the new statutory office of "Northern Ireland Public Services Ombudsman" was created as a result of the Public Services Ombudsman Act (Northern Ireland) 2016 coming into operation.

2. The Ombudsman's contact details are:

Northern Ireland Public Services Ombudsman
Progressive House
33 Wellington Place
Belfast
BT1 6HN

Freepost: Freepost NIPSO
Telephone: (028) 9023 3821
Freephone: (0800) 34 24 24
Email: nipso@nipso.org.uk

3. Additional information on the jurisdiction and powers under the Public Services Ombudsman Act (NI) 2016 can be accessed at:

www.nipso.org.uk

ANNEX 6: THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY (RQIA)

1. The RQIA is an independent non-departmental public body. The RQIA is charged with overall responsibility for regulating, inspecting and monitoring the standard and quality of health and social care services provided by independent and statutory bodies in Northern Ireland.

2. The RQIA has a duty to assess and report on how the HSC and the regulated sector handle complaints in light of the standards and regulations laid down by the DOH. The RQIA will assess the effectiveness of local procedures and will use information from complaints to identify wider issues for the purposes of raising standards.

3. The RQIA has a duty to encourage improvement in the delivery of services and to keep the DOH informed on matters concerning the provision, availability and quality of services.

4. The RQIA may be contacted at:

9th Floor, Riverside Tower
Lanyon Place
Belfast
BT1 3BT
Tel: 028 90 517500

http://www.rqia.org.uk/

ANNEX 7: ADVOCACY

1. Some people who might wish to complain do not do so because they do not know how, doubt they will be taken seriously, or simply find the prospect too intimidating. Advocacy services are an important way of enabling people to make informed choices. Advocacy helps people have access to information they need, to understand the options available to them, and to make their views and wishes known. Advocacy also provides a preventative service that reduces the likelihood of complaints escalating. Advocacy is not new. People act as advocates every day for their children, for their elderly or disabled relatives and for their friends.

2. Within the HSC sector, advocacy has been available mainly for vulnerable groups, such as people with mental health problems, learning disabilities and older people (including those with dementia). However, people who are normally confident and articulate can feel less able to cope because of illness, anxiety and lack of knowledge and be intimidated by professional attitudes.

3. HSC organisations should encourage the use of advocacy services and ensure complainants are supported from the outset and made aware of the role of advocacy in complaints, including those services provided by the PCC. Advocacy in complaints must be seen to be independent to retain confidence in the complaints process.

ANNEX 8: CONCILIATION

1. Conciliation is a process of examining and reviewing a complaint with the help of an independent person. The conciliator will assist all concerned to a better understanding of how the complaint has arisen and will aim to prevent the complaint being taken further. He/she will work to ensure that good communication takes place between both parties involved to enable them to resolve the complaint. It may not be appropriate in the majority of cases but it may be helpful in situations:

- where staff or practitioners feel the relationship with the complainant is difficult;
- when trust has broken down between the complainant and the Practice/ Practitioner/HSC organisation/HSC Board and both parties feel it would assist in the resolution of the complaint;
- where it is important, e.g. because of ongoing care issues, to maintain the relationship between the complainant and the Practice/Practitioner/HSC organisation/HSC Board; or
- when there are misunderstandings with relatives during the treatment of the patient.

2. All discussions and information provided during the process of conciliation are confidential. This allows staff to be open about the events leading to the complaint so that both parties can hear and understand each other's point of view and ask questions.

3. Where a complainant is considered unreasonable or abusive under the *Unacceptable Action Policy* (Annex 13 refers) then conciliation would NOT be an appropriate option.

4. Conciliation is a voluntary process available to both the complainant and those named in the complaint. Either may request conciliation but both must agree to the process being used. In deciding whether conciliation should be offered, consideration must be given to the nature and complexity of the complaint and what attempts have already been made to achieve local resolution. The decision to progress to conciliation must be made with the agreement of both parties. The aim is to resolve

difficulties, for example, if there is a breakdown in the relationship between a doctor or practitioner and their patient.

5. Conciliation may be requested by the complainant, the Practice/Practitioner/HSC organisation/HSC Board. In FPS complaints it may be suggested by the HSC Board.

FPS arrangements

6. The Practitioner/Practice/Pharmacy Manager (respondent) should approach the HSC Board Complaints Manager for advice.

7. Where a request for a conciliator is received the HSC Board Complaints Manager will liaise with the relevant FPS lead to consider the best way forward. Where it is considered that conciliation would aid resolution then the HSC Board Complaints Manager will advise the FPS Practice/Practitioner. In some cases the HSC Board may consider an alternative to conciliation, such as, an honest broker.

Agreement by parties involved

8. The FPS Practice/Practitioner/HSC organisation must contact the complainant and discuss the rationale for involving a conciliator and provide an opportunity to allow the complainant to agree to such an approach and consent to share information. It is important that all parties involved are aware of the confidentiality clause attached to conciliation services. Once agreement is received, the HSC organisation or the HSC Board Complaints Manager (on behalf of FPS) will make the necessary arrangements.

9. Where it has been agreed that the intervention of a conciliator is appropriate, the HSC organisation or HSC Board (on behalf of FPS) should clearly define the remit of the appointment for the purposes of:

- explaining the issue(s) to be resolved;
- ensuring all parties understand what conciliation involves;
- agreeing the timescales;
- agreeing when conciliation has ended; and

- explaining what happens when conciliation ends.

10. The conciliator must advise the Practice/Practitioner/ HSC organisation when conciliation has ceased and whether a resolution was reached. No further details should be provided. The Practice/Practitioner must then notify the HSC Board of the outcome.

11. Using conciliation does not affect the right of a complainant to pursue their complaint further through the HSC organisation or HSC Board (for FPS) if they are not satisfied. Neither does it preclude the complainant from referring their complaint to the Ombudsman should they remain dissatisfied.

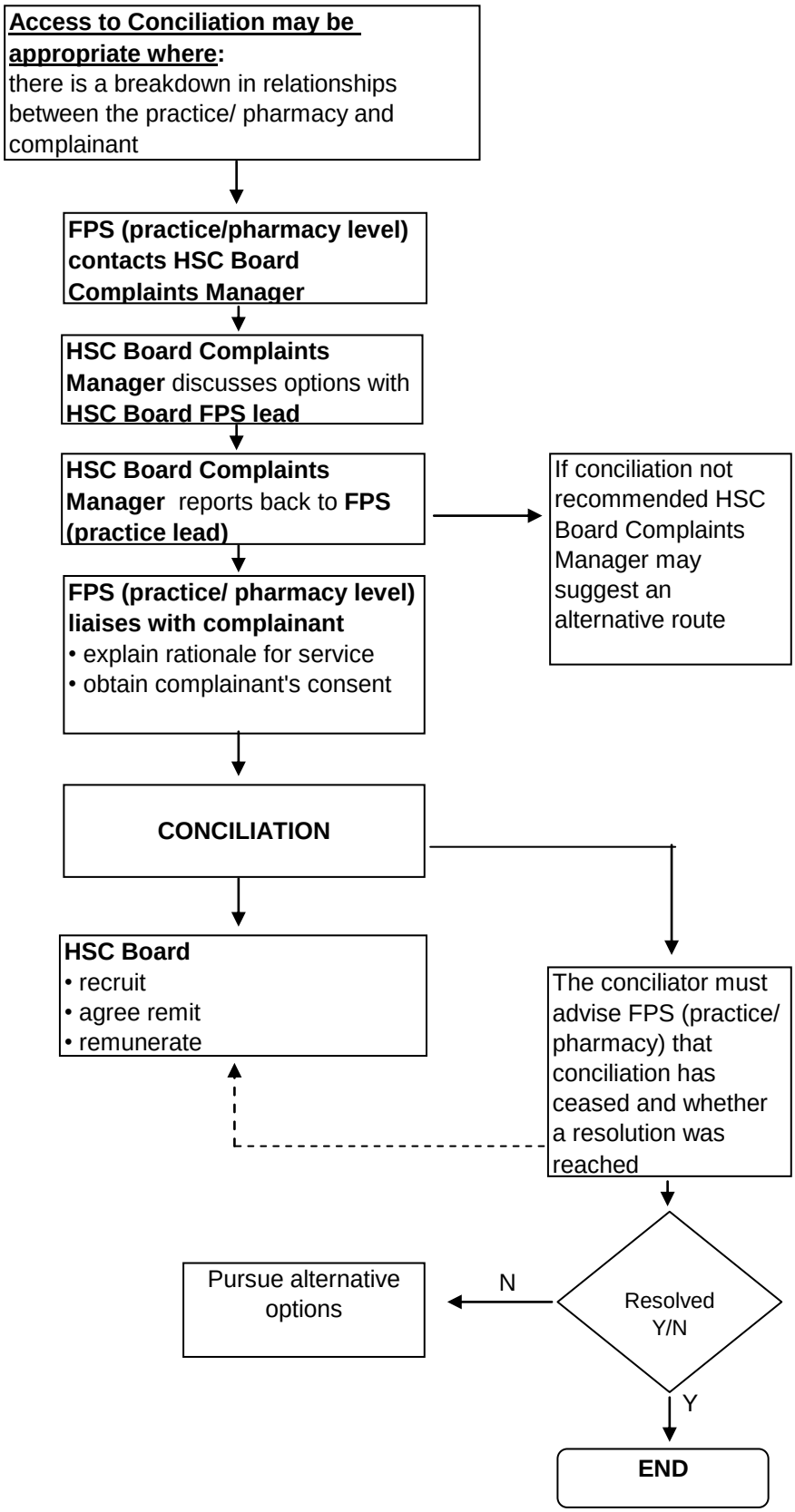
Appointment of conciliators

12. The HSC organisation or HSC Board (on behalf of FPS) is responsible for communicating with, ascertaining the availability of and formally appointing an appropriate conciliation service. In addition it is responsible for all other arrangements, including remuneration.

Monitoring

13. The HSC Board will monitor the effectiveness and usage of conciliation arrangements within HSC Trusts and FPS.

Conciliation – FPS Access



ANNEX 9: INDEPENDENT EXPERTS

1. The use of an Independent Expert in the resolution of a complaint may be requested by the complainant, the Practice/Practitioner/ HSC organisation. In FPS complaints it can also be suggested by the HSC Board. In deciding whether independent advice should be offered, consideration must be given, in collaboration with the complainant, to the nature and complexity of the complaint and any attempts at resolution. Input will not be required in every complaint but it may be considered beneficial where the complaint:

- cannot be resolved locally;
- indicates a risk to public or patient safety;
- could give rise to a serious breakdown in relationships, threaten public confidence in services or damage reputation; and
- to give an independent perspective on clinical issues.

FPS arrangements

2. The Practice/Practitioner should approach the HSC Board Complaints Manager for advice.

3. Where a request for an Independent Expert is received the HSC Board Complaints Manager **may** wish to liaise with the relevant FPS lead to consider the best way forward. Where it is considered that independent expert advice would aid resolution then the HSC Board Complaints Manager will advise the FPS practice. In some cases the HSC Board may consider an alternative to an Independent Expert.

Agreement and consent

4. The FPS Practice/Practitioner/HSC organisation/HSC Board must contact the complainant and discuss the rationale for involving an Independent Expert and provide an opportunity to allow the complainant to agree to such an approach and consent to share information. Once agreement is received, the HSC organisation or the HSC Board Complaints Manager (on behalf of FPS) will make the necessary arrangements.

5. The HSC organisation or HSC Board may decide to involve an Independent Expert in a complaint without the complainant's consent, outside the complaints procedure, for the purposes of obtaining assurances regarding health and social care practice.

6. Where it has been agreed that an Independent Expert will be involved the Practice/Practitioner/HSC organisation/HSC Board should clearly define the remit of the appointment for the purposes of:

- explaining and agreeing the issue(s) to be reviewed;
- ensuring all parties understand the focus of the issue(s);
- agreeing the timescales;
- agreeing to the provision of a final report; and
- explaining what happens when this process is complete.

7. The Independent Expert's findings/report will be forwarded to the Practice/Practitioner/HSC organisation/HSCB (if acting as contact point). A full report of the findings should be made available by the practice/pharmacy/HSC organisation to:

- the complainant; and
- the HSC Board (for FPS only).

8. The letter of response to the complainant is the responsibility of the Practice/Practitioner/ HSC organisation

Appointment of Independent Experts

9. The HSC organisation or HSC Board (on behalf of FPS) is responsible for communicating with, ascertaining the availability of and formally appointing an appropriate Independent Expert. In addition, it is responsible for all other arrangements, including remuneration and indemnity.

10. Independent Experts must be impartial, objective and independent of any parties to the complaint. Independent Experts should be recruited from another Local

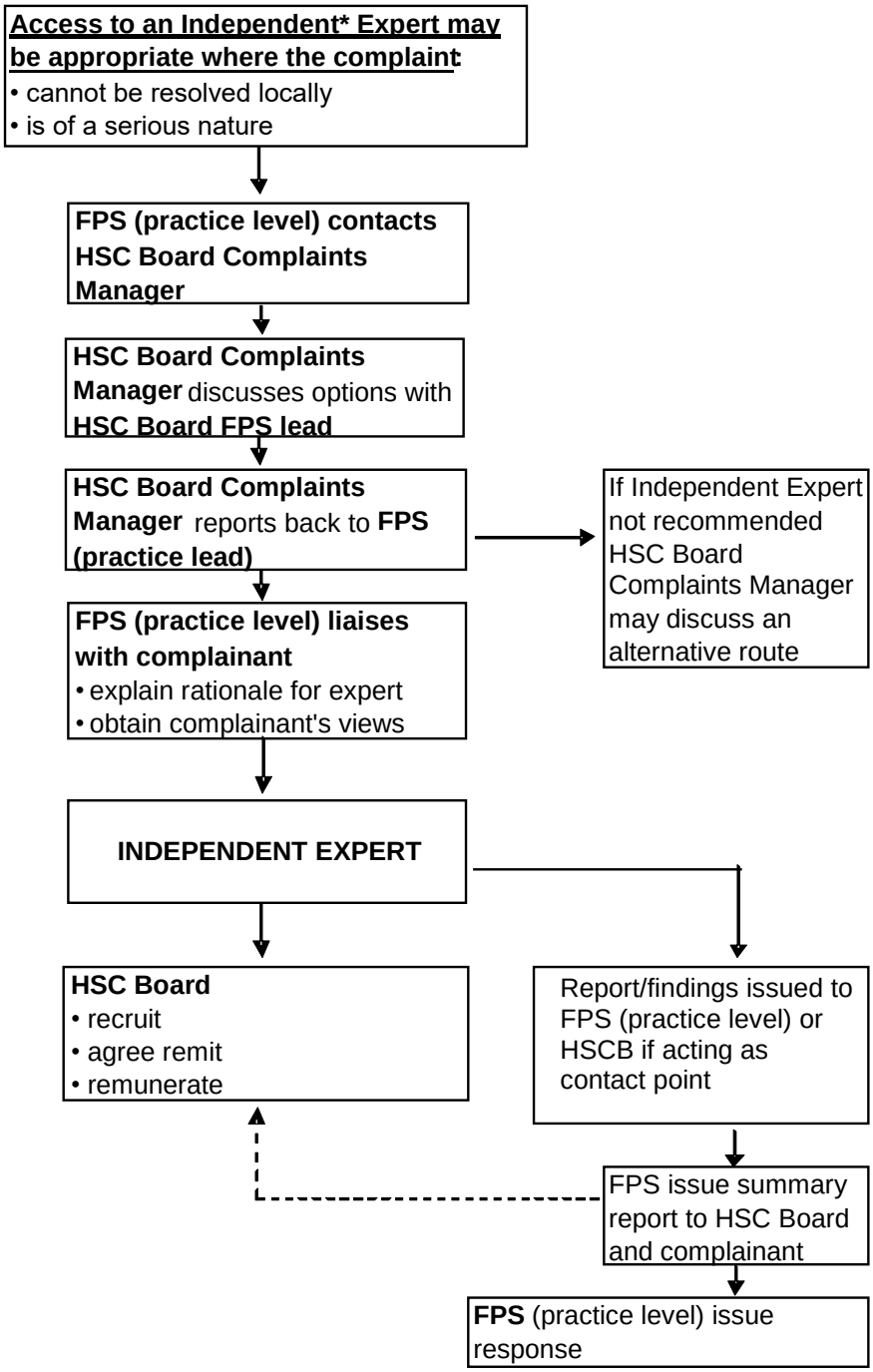
Commissioning group (LCG) area to ensure this impartiality (and in certain circumstance may be recruited from outside Northern Ireland).

Monitoring

11. The HSC Board will monitor the effectiveness and usage of Independent Expert arrangements within HSC Trusts and FPS including the implementation of any recommendations in FPS.

12. A flowchart outlining the process for FPS is shown overleaf.

Independent Experts - FPS Access



* Definition of "Independent" = an Independent Expert must be recruited from another LCG area (and in certain circumstances outside Northern Ireland) and must have no connection with any of the parties to the complaint to avoid calling into question their objectivity and independence.

ANNEX 10: LAY PERSONS

1. Lay persons may be beneficial in providing an independent perspective of non-clinical/ technical issues within the local resolution process. Lay persons are NOT intended to act as advocates, conciliators or investigators. Neither do they act on behalf of the provider or the complainant. The lay persons involvement is to help bring about a resolution to the complaint and to provide assurances that the action taken was reasonable and proportionate to the issues raised. For example, the lay person could accompany the investigator during the investigation process where the complainant is considered unreasonable (Annex 13 refers).

2. Input from a lay person may be valuable to test key issues that are part of the complaint, such as:

- communication issues;
- quality of written documents;
- attitudes and relationships; and
- access arrangements (appointment systems).

3. It is essential that both the provider and the complainant have agreed to the involvement of a lay person.

4. Lay persons should have appropriate training in relation to the HSC complaints procedure and have the necessary independence and communication skills.

FPS arrangements

5. The Practice/Practitioner should approach the HSC Board Complaints Manager for advice.

6. Where a request for a lay person is received the HSC Board Complaints Manager **may** liaise with the relevant FPS lead to consider the best way forward. Where it is considered that a lay person's involvement would aid resolution then the HSC Board Complaints Manager will advise the FPS practice. In some cases the HSC Board **may** consider an alternative to a lay person.

Agreement and consent

7. The FPS Practice/ Practitioner/ HSC Organisation/HSC Board must contact the complainant and discuss the rationale for involving a lay person and provide an opportunity to allow the complainant to agree to such an approach and consent to share information. Once received, the HSC organisation/HSC Board Complaints Manager (on behalf of FPS) will make the necessary arrangements.

8. Where it has been agreed that a lay person will be involved the Practice/Practitioner/HSC Organisation/HSC Board should clearly define the remit of the appointment for the purposes of:

- explaining the issue(s) to be resolved;
- ensuring all parties understand the focus of the issue(s);
- ensuring all parties understand what lay person involvement means;
- agreeing the timescales;
- agreeing to the provision of a final report, and
- explaining what happens when this process is complete.

9. The layperson's findings/ report will be forwarded to the Practice/Practitioner/HSC Organisation/HSC Board. The full report will be made available by the Practice/ Practitioner/HSC Organisation/HSC Board (for FPS only) and to the complainant.

10. The letter of response to the complainant is the responsibility of the Practice/Practitioner/HSC Organisation/HSC Board.

Appointment of lay persons

11. The HSC organisation or HSC Board (on behalf of FPS) is responsible for communicating with, ascertaining the availability of and formally appointing an appropriate lay person. In addition it is responsible for all other arrangements, including training, performance management and remuneration.

Monitoring

12. The HSC Board will monitor the effectiveness and usage of lay person arrangements within HSC Trusts and FPS.

ANNEX 11: HONEST BROKER ROLE

1. "Honest broker" is the term used to describe the role of the HSC Board Complaints Manager in supporting and advising FPS on the handling of complaints. The complainant or the Practice/Practitioner can ask the HSC Board to act in this role at any point in the complaints process. It is expected that the HSC Board will not carry out the investigation but it is also expected that the HSC Board will add value to the process by providing support and advice to FPS.

2. It is not an alternative to local resolution. Neither is it an opportunity for the HSC Board to take over an investigation. Rather it is about facilitating communications and building relationships between the Practice/Practitioner and the complainant or reaching positions of understanding. The honest broker will act as an intermediary and is available to both, the complainant or Practice/Practitioner staff throughout the complaints process. For example, the honest broker may:

- provide advice to both the complainant and the Practice/Practitioner;
- act as a link between both parties and/ or negotiate with them; and
- facilitate and attend meetings between/with both parties together or separately.

3. Paragraphs 2.16 to 2.21 outline the options available to complainants when pursuing FPS complaints. This includes an option to lodge their complaint directly with the HSC Board. Where the complainant contacts the HSC Board the Complaints Manager will explain the options available to resolve the complaint:

- that the complaint can be copied to the relevant practice/pharmacy for investigation, resolution and response; or
- that the HSC Board can act as honest broker between the complainant and the Practice/Practitioner.

4. FPS co-operation in complaints of this type is essential for the role of honest broker to effectively assist in the successful local resolution of complaints. FPS will be asked for their agreement should the complainant prefer the HSC Board's involvement.

5. Where the HSC Board Complaints Manager has been asked to act as honest broker he/she will:

- act as intermediary between the complainant and the practice/ pharmacy;
- make arrangements for independent expert advice, conciliation, lay person assistance, where appropriate;
- provide advice to the complainant and the Practice/Practitioner on target timescales[24]; and
- where there is a delay, ensure the complainant is advised as set out in paragraph 3.39.

6. Whichever process is used it is important to note that the Practice/Practitioner are responsible for the investigation and the response. The HSC Board Complaints Manager, however, must ensure that:

- a written response is provided by the Practice/Practitioner to the complainant and any other person subject to the complaint (whether this is direct from the Practice/Practitioner or from the HSC Board after receiving a report from the Practice/Practitioner ;
- the response is of sufficient quality and addresses the complainant's concerns;
- the written response is provided within target timescales and where this is not possible that the complainant is informed; and
- the response notifies the complainant of their right to refer their complaint to the Ombudsman should they remain dissatisfied with the outcome of the complaints procedure.

7. The complainant may contact the HSC Board Complaints Manager for further advice and support.

[24] For 'honest broker' this is 20 working days from receipt of the complaint: for FPS, this is 10 working days from receipt of the complaint.

ANNEX 12: ADULT SAFEGUARDING

Definition of vulnerable adult

1. The regional policy 'Adult Safeguarding – Prevention and Protection in Partnership' defines the terms 'adult at risk of harm' and 'adult in need of protection[25]'.

2. The definition of an 'adult at risk of harm' takes account of a complex range of interconnected personal characteristics and/or life circumstances, which may increase exposure to harm either because a person may be unable to protect him/herself or their situation may provide opportunities for others to neglect, exploit or abuse them. It is not possible to definitively state when an adult is at risk of harm, as this will vary on a case by case basis. The following definition is intended to provide guidance as to when an adult may be at risk of harm, in order that further professional assessment can be sought.

3. An 'adult at risk of harm' is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

a) **personal characteristics**

AND/OR

b) **life circumstances**

Personal characteristics may include, but are not limited to, age, disability, special educational needs, illness, mental or physical frailty or impairment of, or disturbance in, the functioning of the mind or brain.

Life circumstances may include, but are not limited to, isolation, socio-economic factors and environmental living conditions.

[25] 'Adult Safeguarding – Prevention and Protection in Partnership' (July 2015) (https://www.health-ni.gov.uk/publications/adult-safeguarding-prevention-and-protection-partnership-key-documents), p10

4. An '**adult in need of protection**' is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

a) **personal characteristics**

AND/OR

b) **life circumstances**

AND

c) who is **unable to protect** their own well-being, property, assets, rights or other interests;

AND

d) where the action or inaction of another person or persons is causing, or is likely to cause, him/her to be harmed.

5. In order to meet the definition of an 'adult in need of protection' either (a) or (b) must be present, in addition to both elements (c), and (d).

6. The decision as to whether the definition of an 'adult in need of protection' is met will demand the careful exercise of professional judgement applied on a case by case basis. This will take into account all the available evidence, concerns, the impact of harm, degree of risk and other matters relating to the individual and his or her circumstances. The seriousness and the degree of risk of harm are key to determining the most appropriate response and establishing whether the threshold for protective intervention has been met.

Reportable offences and allegations of abuse

7. Very careful consideration must be given to complaints alleging offences that could be reportable to the police, and there should be explicit policies about the arrangements for such reporting. Where it is apparent that a complaint relates to abuse, exploitation or neglect of an adult at risk then the regional *'Adult Safeguarding Operational Procedures' (September 2016)* and the associated *'Protocol for Joint Investigation of Adult Safeguarding Cases' (August 2016)* should be activated (see paragraph 1.26).

ANNEX 13: UNREASONABLE OR ABUSIVE COMPLAINANTS

1. HSC staff must be trained to respond with patience and empathy to the needs of people who make a complaint, but there will be times when there is nothing further that can reasonably be done to assist them. Where this is the case and further communications would place inappropriate demands on HSC staff and resources, consideration may need to be given to classifying the person making a complaint as an unreasonable, demanding or persistent complainant.

2. In determining arrangements for handling such complainants, staff need to:

- ensure that the complaints procedure has been correctly implemented as far as possible and that no material element of a complaint is overlooked or inadequately addressed;
- appreciate that even habitual complainants may have grievances which contain some substance;
- ensure a fair approach; and
- be able to identify the stage at which a complainant has become habitual.

3. The following *Unacceptable Actions Policy*[26] should only be used as a last resort after all reasonable measures have been taken to resolve the complaint.

Unacceptable Actions Policy

4. People may act out of character in times of trouble or distress. There may have been upsetting or distressing circumstances leading up to a complaint. HSC organisations do not view behaviour as unacceptable just because a complainant is forceful or determined. In fact, it is accepted that being persistent can be a positive advantage when pursuing a complaint. However, we do consider actions that result in unreasonable demands on the HSC organisation or unreasonable behaviour towards HSC staff to be unacceptable. It is these actions that HSC organisations aim to manage under this policy.

[26] Unacceptable Actions Policy based on best practice guidelines issued by the Scottish Public Services Ombudsman-Updated 18 January 2017

Aggressive or abusive behaviour

5. HSC organisations understand that many complainants are angry about the issues they have raised in their complaint. If that anger escalates into aggression towards HSC staff, it will consider that unacceptable. Any violence or abuse towards staff will not be accepted.

6. Violence is not restricted to acts of aggression that may result in physical harm. It also includes behaviour or language (whether verbal or written) that may cause staff to feel afraid, threatened or abused. Examples of behaviours grouped under this heading include threats, physical violence, personal verbal abuse, derogatory remarks and rudeness. HSC organisations will judge each situation individually and appreciate individuals who come may be upset. Language which is designed to insult or degrade, is racist, sexist or homophobic or which makes serious allegations that individuals have committed criminal, corrupt or perverse conduct without any evidence is unacceptable. HSC organisations may decide that comments aimed at third parties are unacceptable because of the effect that listening or reading them may have on staff. HSC organisations also consider that inflammatory statements and unsubstantiated allegations can be abusive behaviour.

7. HSC organisations expect its staff to be treated courteously and with respect. Violence or abuse towards staff is unacceptable and staff should refer to the Zero Tolerance campaign launched in 2007 to clarify the HSC position in relation to attacks on the workforce. HSC staff understand the difference between aggression and anger. The anger felt by many complainants involves the subject matter of their complaint. However, it is not acceptable when anger escalates into aggression directed towards HSC staff.

Unreasonable demands

8. HSC organisations consider these demands become unacceptable when they start to (or when complying with the demand would) impact substantially on the work of the organisation.

9. Examples of actions grouped under this heading include:

- repeatedly demanding responses within an unreasonable timescale;
- insisting on seeing or speaking to a particular member of staff when that is not possible; and
- repeatedly changing the substance of a complaint or raising unrelated concerns.

10. An example of such impact would be that the demand takes up an excessive amount of staff time and in so doing disadvantages other complainants.

Unreasonable levels of contact

11. Sometimes the volume and duration of contact made to the HSC organisation by an individual causes problems. This can occur over a short period, for example a number of calls in one day or one hour. It may occur over the life-span of the complaint when a complainant repeatedly makes long telephone calls to the organisation or inundates the organisation with copies of information that has been sent already or that is irrelevant to the complaint.

12. The HSC organisation considers that the level of contact has become unacceptable when the amount of time spent talking to a complainant on the telephone, or dealing with emails or written correspondence impacts on its ability to deal with that complaint, or with other people's complaints.

Unreasonable use of the complaints process

13. Individuals with complaints have the right to pursue their concerns through a range of means. They also have a right to complain more than once about an organisation with which they have a continuing relationship, if subsequent incidents occur.

14. However, this contact becomes unreasonable when the effect of the repeated complaints is to harass, or to prevent the organisation from pursuing a legitimate aim or implementing a legitimate decision. The HSC organisation considers access to a

complaints system to be important and it will only be in exceptional circumstances that it would consider such repeated use is unacceptable, however it reserves the right to do so in those exceptional circumstances.

Unreasonable refusal to co-operate

15. When the HSC organisation is looking at a complaint, it will need to ask the individual who has complained to work with them. This can include agreeing with the HSC organisation the complaint it will look at; providing it with further information, evidence or comments on request; or the individual summarising the concerns or completing a form for the HSC organisation.

16. Sometimes, an individual repeatedly refuses to cooperate and this makes it difficult for the HSC organisation to proceed. The HSC organisation will always seek to assist someone if they have a specific, genuine difficulty complying with a request. However, the HSC organisation consider it is unreasonable to bring a complaint to it and then not respond to reasonable requests.

Examples of how the HSC manage aggressive or abusive behaviour

17. The threat or use of physical violence, verbal abuse or harassment towards HSC staff is likely to result in a termination of all direct contact with the complainant. All incidents of verbal and physical abuse will be reported to the police.

18. HSC organisations will not accept any correspondence (letter, fax or electronic) that is abusive to staff or contains allegations that lack substantive evidence. The HSC organisation will tell the complainant that it considers their language offensive, unnecessary and unhelpful and ask them to stop using such language. It will state that it will not respond to their correspondence if the action or behaviour continues.

19. HSC staff will end telephone calls if they consider the caller aggressive, abusive or offensive. The staff member taking the call has the right to make this decision, tell the caller that their behaviour is unacceptable and end the call if the behaviour persists. In extreme situations, the HSC organisation will tell the

complainant in writing that their name is on a “no personal contact” list. This means that it will limit contact with them to either written communication or through a third party.

Examples of how the HSC deal with other categories of unreasonable behaviour

20. The HSC organisation has to take action when unreasonable behaviour impairs the functioning of its office. It aims to do this in a way that allows a complainant to progress through its process. It will try to ensure that any action it takes is the minimum required to solve the problem, taking into account relevant personal circumstances including the seriousness of the complaint and the needs of the individual.

21. Where a complainant repeatedly phones, visits the organisation, raises issues repeatedly, or sends large numbers of documents where their relevance is not clear, the HSC organisation may decide to:

- limit contact to telephone calls from the complainant at set times on set days;
- restrict contact to a nominated member of staff who will deal with the future calls or correspondence from the complainant;
- see the complainant by appointment only;
- restrict contact from the complainant to writing only;
- return any documents to the complainant or, in extreme cases, advise the complainant that further irrelevant documents will be destroyed; and
- take any other action that the HSC organisation considers appropriate.

22. Where the HSC organisation considers correspondence on a wide range of issues to be excessive, it may tell the complainant that only a certain number of issues will be considered in a given period and ask them to limit or focus their requests accordingly.

23. In exceptional cases, the HSC organisation will reserve the right to refuse to consider a complaint or future complaints from an individual. It will take into account the impact on the individual and also whether there would be a broader public interest in considering the complaint further.

24. The HSC organisation will always tell the complainant what action it is taking and why.

The process the HSC follows to make decisions about unreasonable behaviour

25. HSC staff who directly experience aggressive or abusive behaviour from a complainant have the authority to deal immediately with that behaviour in a manner they consider appropriate to the situation in line with this policy. With the exception of such immediate decisions taken at the time of an incident, decisions to restrict contact with the organisation are only taken after careful consideration of the situation by a more senior member of staff. Wherever possible, the HSC organisation will give the complainant the opportunity to change their behaviour or action before a decision is taken.

How the HSC lets people know it has made this decision

26. When a HSC member of staff makes an immediate decision in response to aggressive or abusive behaviour, the complainant is advised at the time of the incident. When a decision has been made by senior management, a complainant will always be told in writing[28] why a decision has been made to restrict future contact, the restricted contact arrangements and, if relevant, the length of time that these restrictions will be in place. This ensures that the complainant has a record of the decision.

The process for appealing a decision to restrict contact

27. It is important that a decision can be reconsidered. A complainant can appeal a decision to restrict contact. If they do this, the HSC organisation will only consider arguments that relate to the restriction and not to either the complaint made to the organisation or its decision to close a complaint. An appeal could include, for example, a complainant saying that: their actions were wrongly identified as unacceptable, the restrictions were disproportionate; or that they will adversely impact on the individual because of personal circumstances.

28. A senior member of staff who was not involved in the original decision will consider the appeal. They have discretion to quash or vary the restriction as they think best. They will make their decision based on the evidence available to them. They must advise the complainant in writing[27] that either the restricted contact arrangements still apply or a different course of action has been agreed.

How the HSC record and review a decision to restrict contact

29. The HSC organisation records all incidents of unacceptable actions by complainants. Where it is decided to restrict complainant contact, an entry noting this is made in the relevant file and on appropriate computer records. A decision to restrict complainant contact as described above, may be reconsidered if the complainant demonstrates a more acceptable approach. A member of the Senior Management Team reviews the status of all complainants with restricted contact arrangements on a regular basis.

[27] Unacceptable Actions Policy based on best practice guidelines issued by the Scottish Public Services Ombudsman-Updated 18 January 2017

ANNEX 14: CHILDREN ORDER REPRESENTATIONS AND COMPLAINTS PROCEDURE

1. Under the Children (NI) Order 1995[28] (the Order) HSC Trusts are statutorily required to establish a procedure for considering:
   - any representations (including any complaint) made to it about the discharge of its functions under Part IV of, and paragraph 4 of Schedule 5 to, the Order, and
   - matters in relation to children accommodated by voluntary organisations and privately run children's homes, and
   - those personal social services to children provided under the Adoption Order (NI) 1987[29].

2. HSC Trusts functions are outlined in Article 45 of, and paragraph 6 of Schedule 5 to, the Order and in the Representations Procedure (Children) Regulations (NI) 1996[30].

3. Departmental guidance on the establishment and implementation of such a procedure is included at Chapter 12 of the Children Order Guidance and Regulations, Volume 4 (a flowchart to aid decision making is attached).

4. The HSC Board and HSC Trusts should familiarise themselves with these requirements.

[28] Children (NI) Order 1995: http://www.legislation.gov.uk/nisi/1995/755/contents
[29] Adoption Order (NI) 1987: http://www.legislation.gov.uk/nisi/1987/2203/contents
[30] Representations Procedure (Children) Regulations (NI) 1996: http://www.legislation.gov.uk/nisr/1996/451/contents/made

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CHILDREN ORDER REPRESENTATIONS AND COMPLAINTS PROCEDURE

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1. Complaint: Does it fit the definition of a Children Order complaint as below?

"…Any representation (including any complaint) made to the Trust … about the discharge of any of its functions under Part IV of the Order in relation to the child."
(Children (NI) Order 1995, Article 45(3))

OR

"A written or oral expression of dissatisfaction or disquiet in relation to an individual child about the Trust's exercise of its functions under Part IV of, and para 6 of Schedule 5 to, the Children Order."
(Guidance & Regulations – Vol. 4, Para 12.5 – DHSS)

If **YES** to **EITHER** of above

If **NO** to **EITHER** of above → Progress via HSC Complaints Procedure

↓

2. Does it meet the criteria of what may be complained about under Children Order?

"… about Trust support for families and their children under Part IV of the Order."
(Vol. 4, Para 12.8)

a. Day care;
b. Services to support children within family home;
c. Accommodation of a child;
d. After care;
e. Decisions relating to the placement of a child;
f. The management or handling of a child's case (in respect of Part IV services);
g. Process involved in decision making (in respect of Part IV services);
h. Denial of a (Part IV) service;
i. Exemptions to usual fostering limit;
j. Matters affecting a group of children (receiving a Part IV service);
k. Issues concerning a child subject to Adoption Services.

If **YES** to **ANY** of above

If **NO** to **ALL** of above → Progress via HSC Complaints Procedure

↓

3. <u>Complainant</u>: Does he/she fit the definition of a Children Order complainant?

a. **Any child** who is being looked after by the Trust;

b. **Any child** who is not being looked after by the Trust, but is in need;

c. A parent **of his**;

d. Any person who is not a parent of his but who has **parental responsibility for him**;

e. Any Trust foster parent;

f. Such other person as the Trust considers has a sufficient interest in **the child's welfare** to warrant his representations being considered by the Trust, i.e.

- the person who had the day to day care of the child within the past two years;
- the child's Guardian ad Litem;
- the person is a relative of the child (as defined by Children Order, Article 2(2));
- The person is a significant adult in the child's life, and where possible, this is confirmed by the child;
- a friend;
- a teacher;
- a general practitioner.
  (Children (NI) Order 1995 Article 45(3))

If **<u>YES</u>** to **ANY** of above → **Progress via Children Order Procedure**

If **<u>NO</u>** to **ALL** of above → Progress via HSC Complaints Procedure

<u>NB</u>: In order for a complaint to be eligible to be considered under the Children Order Procedure, the answer to 1 <u>and</u> 2 <u>and</u> 3 MUST all be YES.

Consent: *The (Trust) should always check with the child (subject to his understanding) that a complaint submitted reflects his views and that he wishes the person submitting the complaint to act on his behalf.* (Where it is decided that the person submitting the complaint is not acting on the child's behalf, that person may still be eligible to have the complaint considered).

Definitions of Key Terms

Throughout the standards and guidelines the following terms have the meanings set out below:

Complaint	"an expression of dissatisfaction that requires a response"
Complainant	an existing or former patient, client, resident, family, representative or carer (or whoever has raised the complaint)
Chief Executive	the Chief Executive of the HSC organisation
Complaints Manager	the person nominated by an HSC organisation to handle complaints
DoH[31]	Department of Health in Northern Ireland
Family Practitioner Service (FPS)	family doctors, dentists, pharmacists and opticians
Honest Broker	this is the term used to describe the HSC Board's role in FPS complaints
HSC Board	Health and Social Care Board
HSC Organisation	an organisation which commissions or provides health and social care services and for the purpose of this guidance includes the HSC Board, HSC Trusts, the Northern Ireland Ambulance Service (NIAS), the Business Services Organisation (BSO), the Public Health Agency (PHA), Family Practitioner Services (FPS), Out-of-Hours Services, and pilot scheme providers
Local Resolution	the resolution of a complaint by the organisation, working closely with the service user

[31] Formally the Department for Health, Social Services and Public Safety (DHSSPS)

	Northern Ireland Blood Transfusion Service
NIBTS	Northern Ireland Public Services Ombudsman (NIPSO, known as 'the Ombudsman')
NIPSO	refers to immediate necessary treatment provided by FPS 6.00 pm to 8.00 am Monday – Friday, weekends and local holidays
Out of-Hours services	Patient and Client Council
PCC	a small-scale experiment or set of observations undertaken to decide how and whether to launch a full-scale project (refers to personal
Pilot Scheme	dental services provided by an HSC Trust in this case)
	is a complaints procedure established by the pilot scheme
Pilot Scheme Complaints Procedure	is an FPS complaints procedure established within the terms of the relevant regulations
Practice based complaints procedure	person carrying on or managing the establishment or agency
Registered Provider	Regulation, Quality and Improvement Authority which is the organisation responsible for regulating, inspecting and monitoring the standard and
RQIA	quality of health and social care services provision by independent and statutory bodies in Northern Ireland
Registered Establishments and Agencies	for example, residential care homes, nursing homes, children's homes, nursing agencies, independent clinics/hospitals, etc. registered with
	and regulated by the RQIA

Regulated Sector	refers to registered establishments and agencies
Senior Person	means the person designated to take responsibility for delivering the organisation's complaints process e.g. a Director in the HSC Trust
Service User	means a patient, client, resident, carer, visitor or any other person accessing HSC services
Special Agency	For example the NI Blood Transfusion Service (NIBTS)

HEALTH AND SOCIAL CARE BOARD

POLICY FOR THE MANAGEMENT OF COMPLAINTS

1. Introduction

1.1 This policy sets out how the HSC Board should deal with complaints raised by service users or former service users and outlines for staff a consistent procedure on how complaints relating to the HSC Board, its actions and decisions are to be handled and how the monitoring of complaints processes and outcomes relating to the HSC Board, HSC Trusts, Family Practitioner Services. These procedures reflect the new arrangements for dealing with complaints which became effective from 1 April 2009 and should be read in conjunction with "Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning" (thereafter the HSC Complaints Procedure).

1.2 The proper handling of complaints, suggestions or queries is a fundamental responsibility of the HSC Board. Complaints should therefore be dealt with promptly, sympathetically and constructively. It is important that every complainant should feel that his or her complaint has been dealt with appropriately.

1.3 The HSC Board must be cognisant of the legal and ethical duty to protect the confidentiality of the service user's information as set out in the Data Protection Act 1998 and the Human Rights Act 1998. The common law duty of confidence must also be observed. Ethical guidance is provided by the respective professional bodies. It is not necessary to obtain the service user's express consent to the use of their personal information to investigate a complaint. However the service user's wishes should always be respected, unless there is an overriding public interest in continuing with the matter (paras 2.8 and 2.9).

1.3 The HSC Complaints Procedure is designed to address patient and client complaints, not staff grievances, which will continue to be handled separately. Disputes on contractual matters between the HSC Board and Family Practitioners should not be handled through the HSC Complaints Procedure. HSC Board staff may complain about the way they have been dealt with under the HSC Complaints Procedure and, provided they have exhausted the local grievance procedure, may complain to the NI Commissioner for Complaints (Ombudsman). Family Health Services Practitioners may complain to the Commissioner about the way they have been dealt with under the HSC Complaints Procedure.

2. Standards for Complaints Handling

2.1 The standards and guidelines for complaints handling reflect the changing culture across health and social care with an increasing emphasis on the promotion of safety and quality and the need to be open, to learn and take action in order to reduce the risk of recurrence. The standards for HSC organisations in terms of complaints handling are: -

- Accountability
- Accessibility
- Receiving complaints
- Supporting complainants and staff
- Investigation of complaints
- Responding to complaints
- Monitoring
- Learning

These standards complement existing Controls Assurance Standards, the Quality Standards for Health and Social Care, the Nursing Homes and Residential Care Homes Standards and the Standards for Patient and Client Experience.

3. Standards and Guidelines for Resolution and Learning

3.1 These provide HSC organisations with detailed, yet flexible, complaints handling arrangements designed to: -

- Provide effective local resolution
- Improve accessibility
- Clarify the options for pursuing a complaint
- Promote the use and availability of support services, including advocacy
- Provide a well defined process of investigation
- Promote the use of a range of investigative techniques
- Promote the use of a range of options for successful resolution, such as the use of independent experts, laypersons and conciliation
- Resolve complaints more quickly
- Provide flexibility in relation to target response times
- Provide an appropriate and proportionate response
- Provide clear lines of responsibility and accountability
- Improve record keeping, reporting and monitoring
- Increase opportunities for shared learning.

4. Definitions

4.1 Complaint:

The HSC Complaints Procedure (para 2.1) defines a complaint as:

> **"an expression of dissatisfaction that requires a response".**

A criticism of a service or the quality of care, whether written or oral, becomes a complaint when it requires a response. A single communication may include more than one complaint.

4.2 **Complainant:**

Complainants will be existing or former users of the HSC Board's services and facilities. People may complain on behalf of existing or former patients/clients provided they have their consent. If the patient/client is unable to act then consent is needed from their next of kin.

Where a complaint concerns family health services, complainants will be existing or former patients of a practitioner who has arrangements with the HSC Board to provide family health services.

Complaints to the HSC Board may also be from existing or former users of services provided by a family health services practitioner where the complainant has requested that the HSC Board act as an “honest broker” to assist in the local resolution of a complaint.

5. Complaints concerning commissioning decisions by the HSC Board

5.1 The HSC Board will need to have arrangements in place to deal with complaints about commissioning decisions it has made. It will also respond to complaints about its own actions and decisions.

5.2 Complaints about a commissioning decision of the HSC Board may be made by, or on behalf of, any individual personally affected by a commissioning decision taken by the HSC Board. The HSC Complaints Procedure may not deal with complaints about the merits of a decision where the HSC Board has acted properly and within its legal responsibilities.

5.3 The public or the Patient and Client Council may wish to raise general issues about commissioning decisions with the HSC Board and they should receive a full explanation of the HSC Board's policy. These are not, however, issues for the HSC Complaints Procedure.

6. Local resolution of complaints concerning commissioning decisions by the HSC Board

6.1 The HSC Board must have a local resolution process and designated complaints officers to deal with commissioning complaints and other complaints about the HSC Board's own actions and decisions. The HSC Board's complaints officers are based at: -

Eastern/Northern offices: 12-22 Linenhall Street, Belfast, BT2 8BS

Mrs Liz Fitzpatrick

Mr Michael Cruikshanks

Mrs Michele Clawson

Ms Christine Gray

[redacted]

Western office: 15 Gransha Park, Clooney Road, L'derry, BT47 6FN

Mrs Rosemary Henderson [redacted]

6.2 The primary objective of local resolution is to provide the fullest possible opportunity for investigation and resolution of the complaint, as quickly as is sensible in the circumstances. The emphasis is on complaints being dealt with quickly and, wherever possible, by those on the spot. The intention of local resolution is that it should be open, fair, flexible, and conciliatory. The complainant should be given the opportunity to understand all

possible options for pursuing the complaint and the consequences of following any of these.

6.3 The process should encourage communication on all sides. The aim should be to resolve a complaint during this stage to the satisfaction of the complainant while being fair to staff. Rigid, bureaucratic, and legalistic approaches should be avoided at all stages of the procedure.

6.4 All complaints, whether oral or written, should receive a positive and full response, free of jargon. The aim should be to satisfy the complainant that their concerns have been heeded, and offer an apology and explanation as appropriate, referring to any remedial action that is to follow.

6.5 In the context of local resolution for the HSC Board, for example, a member of staff from a relevant Directorate may respond directly to a complainant about a commissioning decision. The HSC Board's Complaints Office ***(or in the first instance the complaints officer in the relevant local office***) should, however, be made aware of the nature of the complaint and response.

6.6 The HSC Complaints Procedure (para 3.41) states that the Chief Executive may delegate responsibility for responding to a complaint, where in the interests of a prompt reply, a designated senior person may undertake the task.

6.7 Where complaints have been raised electronically the HSC Board must obtain a postal address for the purposes of the response to maintain appropriate levels of confidentiality. Responses should not be made electronically (para 3.39).

7. HSC Board involvement in local resolution of complaints concerning Family Practitioner Services

7.1 If requested by a complainant and/or a family practitioner, the HSC Board's Complaints Office (or local office), with the agreement of both parties and consultation with the (relevant) Integrated Care

designate may arrange for a layperson, conciliator, independent expert to be appointed to assist in resolution of the complaint.

8. Receipt of complaints

8.1 Complaints received orally should be dealt with by staff promptly, sympathetically and constructively. Such complaints should be dealt with according to the principles of local resolution and should be resolved immediately or within two days of receipt.

8.2 Oral complaints which cannot be resolved to the complainant's satisfaction should be referred to the HSC Board's Complaints Office ***(or relevant local office).***

8.3 Complaints received through the Private Office of the DHSSPS will be forwarded to the HSC Board's Complaints Office which will arrange for an acknowledgement and the preparation of a response. When the reply is ready it will be signed by the Chief Executive (or designated senior person).

8.4 Complaints addressed directly to the HSC Board Chairman or Chief Executive, such as those from Members of Parliament, Members of the Legislative Assembly, District Councillors etc, will be dealt with as in 8.3 above.

8.5 Complaints received from members of the public and others not specified above, will be forwarded to the HSC Board's Complaints Office who will arrange for an acknowledgement and the preparation of a response from the Chief Executive (or designated senior person).

8.6 In all cases complaints will receive an acknowledgement within 2 working days, and a full investigation and resolution sought within 20 working days.

8.7 Written responses to complaints will be under the signature of the Chief Executive or a designated senior person.

8.8 Complainants will be advised of what action they can take should they remain dissatisfied following consideration of the response.

8.9 Where a complaint is received by the HSC Board in error, the Complaints Office should ensure that it is passed immediately to the correct body with the consent of the complainant.

9. NI Commissioner for Complaints (Ombudsman)

9.1 All papers relating to the local resolution stage will be made available to the Commissioner where such a case has been referred by the complainant to the Commissioner for investigation.

10. Complaints Monitoring

10.1 Under the HSC Complaints Procedure the complaints handling role and responsibilities of the HSC Board are to monitor complaints processess, outcomes and service improvement; performance management and dissemination of learning.

10.2 The operation and effectiveness of the HSC Complaints Procedure will be monitored continuously. A Regional Complaints Group (HSC Board/Public Health Agency) has been established and will meet on a bi-monthly basis to consider analysis of information pertaining to HSC Board complaints, Family Practitioner complaints and HSC Trust complaints.

10.3 This includes monitoring of the subject of complaints raised, the particular specialties they relate to and/or their locality, as well as ensuring that there are appropriate systems in place to manage complaints, that complaints are responded to comprehensively and in a timely manner and that in enhancing the local resolution stage, complaints can be resolved more quickly and as close to the source as possible.

10.4 Monitoring information will be: -

(i) **Health and Social Care Board**

Regular statistical information must be made available in respect of complaints received from existing or former service users regarding commissioning decisions of the HSC Board, or from those being denied a service as a consequence of commissioning decisions of the HSC Board, and its actions and responses.

(ii) **Family Practitioner Services**

The HSC Complaints Procedure requires Family Practitioners to forward to the respective local HSC Board office an anonymised copy of each complaint and its subsequent response within 3 working days of issue of the response. Family Practitioners are also required to forward to the local HSC Board office any other significant correspondence or report relating to the complaint and; copies of any correspondence received from the Commissioner.

(iii) **Health and Social Care Trusts**

HSC Trusts will supply monthly returns that provide a summary of all complaints received, their site location, classification of complaint (eg treatment and care, communication, staff attitude), response time and a summary of the outcome of the investigation and any actions taken or to be taken. These returns will also include details of complaints relating to out of hours services, independent sector providers (where the Trust has commissioned the care/service) and prison healthcare (South Eastern HSC Trust).

HSC Trusts will supply any information relating to the investigation of any complaint(s) that the HSC Board

considers necesary. In addition the HSC Board may request from Trusts access to complaints files for monitoring and learning purposes and performance management.

11. Role of the Patient and Client Council

Advice should be made available at all stages of the HSC Complaints Procedure about the role of the Patient and Client Council in giving individuals advice and support on making complaints. Details of other advocacy or support organisations can also be identified.

Date of Review: June 2011

Health and Social Care Board

HEALTH AND SOCIAL CARE BOARD

POLICY FOR THE MANAGEMENT OF COMPLAINTS

October 2017

1. Introduction

1.1 This policy sets out how staff working within the Health and Social Care Board (HSC Board) should deal with complaints raised by service users or former service users. It outlines a consistent procedure on how complaints relating to the HSC Board, its actions and decisions are to be handled and how the monitoring of complaints processes and outcomes relating to the HSC Board, HSC Trusts and Family Practitioner Services. These procedures reflect the new arrangements for dealing with complaints which became effective from 1 April 2009 and should be read in conjunction with "Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning" (thereafter the HSC Complaints Procedure).

1.2 The proper handling of complaints, suggestions or queries is a fundamental responsibility of the HSC Board. Complaints should therefore be dealt with promptly, sympathetically and constructively. It is important that every complainant should feel that his or her complaint has been dealt with appropriately.

What the Policy Covers

1.3 This policy deals with complaints about care or treatment, or about issues relating to the provision of health and social care. Complaints may, therefore, be raised about services provided by,

- The Health and Social Care Board (HSC Board)
  - Commissioning and purchasing decisions (for individuals)
- Family Practitioner Services (FPS)

What the Policy does not cover

1.4 This policy does **not** deal with complaints about:

- Private care and treatment or services including private dental care or privately supplied spectacles or
- Services not provided or funded by the HSC, for example, provision of private medical reports.

1.5 Complaints may be raised within an organisation which that organisation needs to address, but do not fall within the scope of the HSC Complaints Procedure. When this occurs, the HSC Organisation should ensure that there are other processes in place to deal with these concerns. For example:

- staff grievances
- an investigation under the disciplinary procedure
- an investigation by one of the professional regulatory bodies
- services commissioned by the HSC Board;
- a request for information under Freedom of Information;
- access to records under the Data Protection Act 1998
- an independent inquiry
- a criminal investigation
- the Child Order Representations and Complaints Procedure
- protection of vulnerable adults
- child protection procedures
- coroner's cases
- legal action.

1.6 HSC Board staff may complain about the way they have been dealt with under the HSC Complaints Procedure and, provided they have exhausted the local grievance procedure, may complain to the NI Public Services Ombudsman, (the Ombudsman). Family Health Services Practitioners may complain to the Ombudsman about the way they have been dealt with under the HSC Complaints Procedure.

Confidentiality

1.7 The HSC Board must be cognisant of the legal and ethical duty to protect the confidentiality of the service user's information as set out in the Data Protection Act 1998 and the Human Rights Act 1998. The common law duty of confidence must also be observed. Ethical guidance is provided by the respective

professional bodies. It is not necessary to obtain the service user's express consent to the use of their personal information to investigate a complaint. However the service user's wishes should always be respected, unless there is an overriding public interest in continuing with the matter (paras 2.8 and 2.9).

2. Standards for Complaints Handling

2.1 The standards and guidelines for complaints handling reflect the changing culture across health and social care with an increasing emphasis on the promotion of safety and quality and the need to be open, to learn and take action in order to reduce the risk of recurrence. The standards for HSC organisations in terms of complaints handling are: -

- Accountability
- Accessibility
- Receiving complaints
- Supporting complainants and staff
- Investigation of complaints
- Responding to complaints
- Monitoring
- Learning

These standards complement existing Controls Assurance Standards, the Quality Standards for Health and Social Care, the Nursing Homes and Residential Care Homes Standards and the Standards for Patient and Client Experience.

3. Standards and Guidelines for Resolution and Learning

3.1 These provide HSC organisations with detailed, yet flexible, complaints handling arrangements designed to: -

- Provide effective local resolution
- Improve accessibility
- Clarify the options for pursuing a complaint

- Promote the use and availability of support services, including advocacy
- Provide a well-defined process of investigation
- Promote the use of a range of investigative techniques
- Promote the use of a range of options for successful resolution, such as the use of independent experts, laypersons and conciliation
- Resolve complaints more quickly
- Provide flexibility in relation to target response times
- Provide an appropriate and proportionate response
- Provide clear lines of responsibility and accountability
- Improve record keeping, reporting and monitoring
- Increase opportunities for shared learning.
- Provide confidentiality to protect staff and those who complain
- Promote fairness with clear procedures and guidance
- Increase openness through clear communications
- Value diversity, equality and human rights

3.2 Complaints should be dealt with patience and empathy but there will be times when nothing further can reasonably be done to assist the complainant. The changes to the HSC complaints procedure introduce an “Unacceptable Actions” policy for handling unreasonable, vexatious or abusive complainants.

Where this is the case and further communications would place inappropriate demands on the HSC Board, staff and resources, consideration may need to be given to classifying the person making a complaint as an unreasonable, demanding or persistent complainant.

In determining arrangements for handling such complaints, staff need to ensure that the complaints procedure has been correctly implemented, appreciating that even habitual complainants may have grievances which contain some substance and identify the stage at which a complainant has become habitual.

The Unacceptable Actions Policy should only be used a last resort after all reasonable measures have been taken to resolve the complaint.

The HSC Board will record all incidents of unacceptable actions by complainants.

4. Definitions

4.1 Complaint:

The HSC Complaints Procedure (Para 2.1) defines a complaint as:

> **"an expression of dissatisfaction that requires a response".**

A criticism of a service or the quality of care, whether written or oral, becomes a complaint when it requires a response. A single communication may include more than one complaint.

It should be noted that complainants may not always use the word ‘complaint’. They may offer a comment or suggestion that can be extremely helpful it is important to recognise those comments that are really complaints and need to be handled as such.

4.2 Complainant:

Complainants will be existing or former users of the HSC Board's services and facilities.

Where a complaint concerns family health services, complainants will be either existing or former patients of a practitioner who has arrangements with the HSC Board to provide family health services.

Complaints to the HSC Board may also be from existing or former users of services provided by a family health services practitioner where the complainant has requested that the HSC Board act as an “honest broker” to assist in the local resolution of a complaint

4.3 **Consent**

People may complain on behalf of existing or former patients/clients provided they have their consent. Complaints by a third party should be made with written consent of the individual concerned. There will be situations where it is not possible to obtain consent such as;

- where the individual is a child and not of sufficient age or understanding to make a complaint on their own behalf;
- where the individual is incapable (for example, rendered unconscious due to an accident; judgement impaired by learning disability, mental illness, brain injury, or serious communication problems);
- where the subject of the complaint is deceased

4.4 Where a person is unable to act of him/herself, their consent shall not be required. However the Complaints Manager will determine whether the complainant has sufficient interest to act as a representative. The question of whether a complainant is suitable to make a representation depends, in particular on the need to respect the confidentiality of the patient. If it is determined that a person is not suitable to act as a representative, the Chief Executive (or senior person) must provide information in writing to the person outlining the reasons the decision has been taken.

5. Complaints concerning commissioning decisions by the HSC Board

5.1 The HSC Board has arrangements in place to deal with complaints about commissioning decisions it has made. It will also respond to complaints about its own actions and decisions.

5.2 Complaints about a commissioning decision of the HSC Board may be made by, or on behalf of, any individual personally affected by a commissioning decision taken by the HSC Board. The HSC Complaints Procedure may not deal with complaints about the merits of a decision where the HSC Board has acted properly and within its legal responsibilities.

5.3 The public or the Patient and Client Council may wish to raise general issues about commissioning decisions with the HSC Board and they should receive a full explanation of the HSC Board's policy. These are not, however, issues for the HSC Complaints Procedure.

6. Local resolution of complaints concerning commissioning decisions by the HSC Board

6.1 The HSC Board must have a local resolution process and designated complaints officers to deal with commissioning complaints and other complaints about the HSC Board's own actions and decisions.

The HSC Board's complaints officers are based at 12-22 Linenhall Street, Belfast, BT2 8BS

Complaints Direct Line: 02895 363893 (Monday-Friday, 9am-5pm)
Text Relay: 18001 0289536 3893

6.2 The primary objective of local resolution is to provide the fullest possible opportunity for investigation and resolution of the complaint, as quickly as is sensible in the circumstances. The emphasis is on complaints being dealt with quickly and, wherever possible, by those on the spot. The intention of local resolution is that it should be open, fair, flexible, and conciliatory. The complainant should be given the opportunity to understand all possible options for pursuing the complaint and the consequences of following any of these.

6.3 The process should encourage communication on all sides. The aim should be to resolve a complaint during this stage to the satisfaction of the complainant while being fair to staff. Rigid, bureaucratic, and legalistic approaches should be avoided at all stages of the procedure.

6.4 Complaints can be submitted, in writing via email or letter or in person. All complainants should receive a positive and full

response, free of jargon. The aim should be to satisfy the complainant that their concerns have been heeded, and offer an apology and explanation as appropriate, referring to any remedial action that is to follow.

6.5 In the context of local resolution for the HSC Board, for example, a member of staff from a relevant Directorate may respond directly to a complainant about a commissioning decision. The HSC Board's Complaints Office should, however, be made aware of the nature of the complaint and response.

6.6 The HSC Complaints Procedure (para 3.41) states that the Chief Executive may delegate responsibility for responding to a complaint, where in the interests of a prompt reply, a designated senior person may undertake the task.

7. HSC Board involvement in local resolution of complaints concerning Family Practitioner Services

7.1. Where requested the HSC Board will act as 'honest broker' in the resolution of a complaint. The objective for the HSC Board should be wherever possible to restore the trust between the patient and the practitioner/practice staff. In addition, if requested by a complainant and/or a Family Practitioner Service (FPS), the HSC Board's Complaints Office with the agreement of both parties may arrange for a layperson or conciliator to be appointed to assist in resolution of the complaint. The advice of an independent expert will only be sought to provide clarification on clinical matters or were there is a risk to patient/client safety.

7.1.1 Once agreement has been received for the HSC Board to act as Honest Broker, the HSC Board Complaints staff (on behalf of FPS) will make necessary arrangements. The HSC Board (on behalf of FPS) is responsible for communicating with, ascertaining the availability of and formally appointing an appropriate lay person, conciliator or independent expert.

7.2 Lay persons

The HSC Board has appointed 17 Independent Lay Persons who will operate as a pool for all HSC organisations. Lay persons may

be beneficial in providing an independent perspective of non-clinical or technical issues within the local resolution process.

They are not intended to act as advocates, conciliators or investigators and neither do they act on behalf of the Family Practitioner Service or the complainant. The layperson's involvement is to bring about a resolution to the complaint and to provide assurances that the action taken was reasonable and proportionate to the issues raised.

Input from a Lay Person is valuable when testing issues such as communication, quality of written documents, attitudes and behaviours and access arrangements.

7.3 Conciliation

Conciliation is a process of examining and reviewing a complaint with the help of an independent person. The conciliator will assist all concerned to a better understanding of how the complaint has arisen. They will work to ensure that good communication takes place between both parties involved to enable them to resolve the complaint. It may not be appropriate in the majority of cases but it may be helpful in situations;

- where staff or practitioners feel the relationship with the complainant is difficult;
- when trust has broken down between the complainant and the practice/pharmacy/HSC organisation and both parties feel it would assist in the resolution of the complaint
- when there are misunderstandings with relatives during the treatment of the patient.

Conciliation is a voluntary process available to both the complainant and those named in the complaint. Either may request conciliation but both must agree to the process being used. The HSC Board has developed a select list of providers for HSC and the Complaints Department holds these details.

7.4 Independent Experts

The use of an independent expert in the resolution of a complaint may be requested by the complainant or FPS at any time, or suggested by the HSC Board. The HSC Board will however seek

an assurance from Integrated Care Professionals that the use of an Independent Expert is appropriate. In deciding whether independent advice should be offered, consideration must be given, in collaboration with the complainant, to the nature and complexity of the complaint and any attempts at earlier enhanced local resolution.

An independent expert may be considered beneficial where the complaint;

- cannot resolved locally;
- indicates a risk to public or patient safety;
- could give rise to a serious breakdown in relationships;
- threaten public confidence in services or damage reputation;
- to give an independent perspective on clinical issues

The HSC organisation may decide to involve an Independent Expert in a complaint without the complainant's consent, outside the procedure, for the purposes of obtaining assurances regarding health and social care practice.

8. Receipt of complaints

8.1 Complaints received orally should be dealt with by staff promptly, sympathetically and constructively. A statement should be taken and a record kept on file. Such complaints should be dealt with according to the principles of local resolution and should be resolved immediately or within two days of receipt.

8.2 Oral complaints which cannot be resolved to the complainant's satisfaction should be referred to the HSC Board's Complaints Office. Similarly a statement should be taken from the complainant and a record kept.

8.3 Complaints received through the Private Office of the DOH will be forwarded to the HSC Board's Complaints Office which will arrange for an acknowledgement and the preparation of a response. When the reply is ready it will be signed by the Chief Executive (or designated senior person).

8.4 Complaints addressed directly to the HSC Board Chairman or Chief Executive, such as those from Members of Parliament, Members of the Legislative Assembly, District Councillors etc, will be dealt with as in 8.3 above.

8.5 Complaints received from members of the public and others not specified above, will be forwarded to the HSC Board's Complaints Office who will arrange for an acknowledgement and the preparation of a response from the Chief Executive (or designated senior person).

8.6 Complaints concerning a HSC Board staff member, will be investigated by the relevant Directorate who will take the appropriate action. The HSC Board's Complaints Office should, however, be made aware of the nature of the complaint and response.

FPS Complaints received by the Board

8.7 Complainants will receive an acknowledgement within 2 working days, their complaint will be investigated thoroughly, treated confidentially and responded to fully in writing within 20 working days.

8.8 If there is a delay in meeting the timescales set, the complainant will be advised of the situation and when a response is expected. Complainants will be also advised of what action they can take should they remain dissatisfied following consideration of the response.

Board Complaints received by the HSCB

8.9 Complainants will receive an acknowledgement within 2 working days, their complaint will be investigated thoroughly, treated confidentially and responded to fully in writing within 20 working days.

8.10 Written responses to complaints will be under the signature of the Chief Executive or a designated senior person.

8.11 Complainants will be advised of what action they can take should they remain dissatisfied following consideration of the response.

8.12 Where a complaint is received by the HSC Board in error, the Complaints Office should ensure that it is passed immediately to the correct body with the consent of the complainant.

8.13 If timescales will not be adhered to, the complainant will be provided with an explanation for the delay and when a response should will be expected.

9. Northern Ireland Public Services Ombudsman

9.1 All papers relating to the local resolution stage will be made available to the Ombudsman where such a case has been referred by the complainant to the Ombudsman for investigation.

10. Complaints Monitoring

10.1 Under the HSC Complaints Procedure the complaints handling role and responsibilities of the HSC Board are to monitor complaints processes, outcomes and service improvement; performance management and dissemination of learning. The use of this information will also inform commissioning processes and purchasing decisions.

10.2 The operation and effectiveness of the HSC Complaints Procedure will be monitored continuously. A Regional Complaints Sub-Group (HSC Board/Public Health Agency/Patient & Client Council) has been established and will meet on a bi-monthly basis to consider analysis of information pertaining to HSC Board complaints, Family Practitioner complaints and HSC Trust complaints. The Regional Complaints Sub-Group, will identify what learning should be cascaded

regionally to ensure policies and practices are amended as a result of complaints. This information will inform a regional learning communication.

10.3 This includes monitoring of the subject of complaints raised, the particular specialties they relate to and/or their locality, as well as ensuring that there are appropriate systems in place to manage complaints, that complaints are responded to comprehensively and in a timely manner and that in enhancing the local resolution stage, complaints can be resolved more quickly and as close to the source as possible.

10.4 Monitoring information will be: -

(i) **Health and Social Care Board**

Regular statistical information must be made available in respect of complaints received from existing or former service users regarding commissioning decisions of the HSC Board, or from those being denied a service as a consequence of commissioning decisions of the HSC Board, and its actions and responses.

(ii) **Family Practitioner Services**

The HSC Complaints Procedure requires Family Practitioners to forward to the respective local HSC Board office an anonymised copy of each complaint and its subsequent response within 3 working days of issue of the response. Family Practitioners are also required to forward to the local HSC Board office any other significant correspondence or report relating to the complaint and; copies of any correspondence received from the Ombudsman.

(iii) **Health and Social Care Trusts**

HSC Trusts will supply monthly returns that provide a summary of all complaints received, their site location, classification of complaint (eg treatment and care, communication, staff attitude), response time and a summary of the outcome of the investigation and any actions taken or to be taken. These returns will also include details of complaints relating to out of hours services, independent sector providers (where the Trust has commissioned the care/service) and prison healthcare (South Eastern HSC Trust).

HSC Trusts will supply information relating to the investigation of any complaint(s) that the HSC Board considers necessary for monitoring and learning purposes, to include performance management.

In addition, Trusts will also advise the Board of the number of complaints received in a month, and the numbers reopened. In particular Trusts will highlight those which have progressed to the Ombudsman, or those from which learning has occurred.

11. Role of the Patient and Client Council

Advice should be made available at all stages of the HSC Complaints Procedure about the role of the Patient and Client Council in giving individuals advice and support on making complaints. Details of other advocacy or support organisations can also be identified.

12. Equality

12.1 The HSC Board takes account of duties under Section 75 Equality Legislation, other Equality Legislation and Human Rights Legislation in a way that promotes equality of opportunity, good relations and human rights. Where a particular need is identified

we will consider the best way to respond to this is a way that values diversity.

12.2 The HSC Board will not treat a complainant less favourably because of their gender, age, disability, marital status, race, sexual orientation, religious or political opinion or if they have dependents.

12.3 This document can be made available on request and where reasonably practicable in an alternative format, Easy Read, Braille, audio formats (CD, mp3 or DAISY), large print or minority languages to meet the needs of those for whom English is not their first language.

Health and Social Care Board

HEALTH AND SOCIAL CARE BOARD

POLICY FOR THE MANAGEMENT OF COMPLAINTS

December 2019

1. Introduction

1.1 This policy sets out how staff working within the Health and Social Care Board (HSC Board) should deal with complaints raised by service users or former service users. It outlines a consistent procedure on complaints relating to the HSC Board, its actions and decisions are to be handled; and also how the monitoring of complaints processes and outcomes relating to the HSC Board, HSC Trusts and Family Practitioner Services is conducted. These procedures reflect the new arrangements for dealing with complaints which became effective from 1 April 2009 and should be read in conjunction with "Guidance in relation to the Health and Social Care Complaints Procedure" (April 2019).

1.2 The proper handling of complaints, suggestions or queries is a fundamental responsibility of the HSC Board. Complaints should therefore be dealt with promptly, sympathetically and constructively. It is important that every complainant should feel that his or her complaint has been dealt with appropriately.

What the Policy Covers

1.3 This policy deals with complaints about care or treatment, or about issues relating to the provision of health and social care. Complaints may, therefore, be raised about services provided by:

- The Health and Social Care Board (HSC Board)
  - Commissioning and purchasing decisions (for individuals);
- Family Practitioner Services (FPS).

What the Policy does not cover

1.4 This policy does **not** deal with complaints about:

- Private care and treatment or services including private dental care or privately supplied spectacles; or
- Services not provided or funded by the HSC, for example, provision of private medical reports.

1.5 Complaints may be raised within an organisation, which that organisation needs to address, but do not fall within the scope of the HSC Complaints Procedure. When this occurs, the HSC Organisation should ensure that there are other processes in place to deal with these concerns. For example:

- staff grievances
- an investigation under the disciplinary procedure
- an investigation by one of the professional regulatory bodies
- services commissioned by the HSC Board;
- a request for information under Freedom of Information;
- access to records under the Data Protection Act 1998
- an independent inquiry
- a criminal investigation
- the Child Order Representations and Complaints Procedure
- protection of vulnerable adults
- child protection procedures
- coroner's cases
- legal action.

1.6 HSC Board staff may complain about the way they have been dealt with under the HSC Complaints Procedure and, provided they have exhausted the local grievance procedure, may complain to the NI Public Services Ombudsman, (the Ombudsman). Family Health Services Practitioners may complain to the Ombudsman about the way they have been dealt with under the HSC Complaints Procedure.

Confidentiality

1.7 The HSC Board must be cognisant of the legal and ethical duty to protect the confidentiality of the service user's information. The legal requirements are set out in the General Data Protection Regulations, (GDPR). Additional requirements are detailed in the Human Rights Act 1998 and the common law duty of confidence must also be observed. Ethical guidance is provided by the respective professional bodies. A service user's consent is

required if their personal information is to be disclosed. It is not necessary to obtain the service user's express consent to the use of their personal information to investigate a complaint. However the service user's wishes should always be respected, unless there is an overriding public interest in continuing with the matter (paras 2.8 and 2.9).

2. Standards for Complaints Handling

2.1 The standards and guidelines for complaints handling reflect the changing culture across health and social care with an increasing emphasis on the promotion of safety and quality and the need to be open, to learn and take action in order to reduce the risk of recurrence. The standards for HSC organisations in terms of complaints handling are: -

- Accountability
- Accessibility
- Receiving complaints
- Supporting complainants and staff
- Investigation of complaints
- Responding to complaints
- Monitoring
- Learning

These standards complement existing Controls Assurance Standards, the Quality Standards for Health and Social Care, the Nursing Homes and Residential Care Homes Standards and the Standards for Patient and Client Experience.

3. Standards and Guidelines for Resolution and Learning

3.1 These provide HSC organisations with detailed, yet flexible, complaints handling arrangements designed to: -

- Provide effective local resolution
- Improve accessibility
- Clarify the options for pursuing a complaint

- Promote the use and availability of support services, including advocacy
- Provide a well-defined process of investigation
- Promote the use of a range of investigative techniques
- Promote the use of a range of options for successful resolution, such as the use of independent experts, laypersons and conciliation
- Resolve complaints more quickly
- Provide flexibility in relation to target response times
- Provide an appropriate and proportionate response
- Provide clear lines of responsibility and accountability
- Improve record keeping, reporting and monitoring
- Increase opportunities for shared learning
- Provide confidentiality to protect staff and those who complain
- Promote fairness with clear procedures and guidance
- Increase openness through clear communications
- Value diversity, equality and human rights.

3.2 Complaints should be dealt with patience and empathy but there will be times when nothing further can reasonably be done to assist the complainant, and parties should agree to come to a position of understanding. The Complaints Guidance includes an "Unacceptable Actions Policy" for handling unreasonable, vexatious or abusive complainants.

Where this is the case and further communications would place inappropriate demands on the HSC Board, staff and resources, consideration may need to be given to classifying the person making a complaint as an unreasonable, demanding or persistent complainant.

In determining arrangements for handling such complaints, staff need to ensure that the Complaints Procedure has been correctly implemented, appreciating that even habitual complainants may have grievances which contain some substance and identify the stage at which a complainant has become habitual.

The Unacceptable Actions Policy should only be used a last resort after all reasonable measures have been taken to resolve the complaint. The HSC Board will record all incidents of unacceptable actions by complainants.

4. Definitions

4.1 Complaint:

The HSC Complaints Procedure (Para 2.1) defines a complaint as:

> **"an expression of dissatisfaction that requires a response".**

A criticism of a service or the quality of care, whether written or oral, becomes a complaint when it requires a response. A single communication may include more than one complaint.

It should be noted that complainants may not always use the word 'complaint'. They may offer a comment or suggestion that can be extremely helpful. It is important to recognise those comments that are really complaints and need to be handled as such.

4.2 Complainant:

Complainants will be existing or former users of the HSC Board's services and facilities.

Where a complaint concerns family health services, complainants will be either existing/former patients or family members raising concerns on a patients behalf regarding a practitioner, who has arrangements with the HSC Board to provide family health services.

Complaints to the HSC Board may also be from existing/former users, or family members, of services provided by a family health services practitioner where the complainant has requested that the

HSC Board act as an “honest broker” or intermediary to assist in the local resolution of a complaint.

4.3 Consent

Explicit consent must be obtained from complainants, prior to their correspondence being shared with the Practice complained against. Any subsequent or follow up issues to those originally raised will be discussed on a case by case basis in order to determine how they should be appropriately handled. However, should a complaint raise issues of a clinical, professional or regulatory concern and/or issues regarding fraud, these will be shared with the Practice/HSC Organisation accordingly.

People may complain on behalf of existing or former patients/clients provided they have their consent. Complaints by a third party should be made with written consent of the individual concerned. There will be situations where it is not possible to obtain consent such as:

- where the individual is a child and not of sufficient age or understanding to make a complaint on their own behalf;
- where the individual is incapable (for example, rendered unconscious due to an accident; judgement impaired by learning disability, mental illness, brain injury, or serious communication problems);
- where the subject of the complaint is deceased.

4.4 Where a person is unable to act of him/herself, their consent shall not be required. However the Complaints Manager will determine whether the complainant has sufficient interest to act as a representative. The question of whether a complainant is suitable to make a representation depends, in particular on the need to respect the confidentiality of the patient. If it is determined that a person is not suitable to act as a representative, the Chief Executive (or senior person) must provide information in writing to the person outlining the reasons

the decision has been taken.

5. Complaints concerning commissioning decisions by the HSC Board

5.1 The HSC Board has arrangements in place to deal with complaints about commissioning decisions it has made. It will also respond to complaints about its own actions and decisions.

5.2 Complaints about a commissioning decision of the HSC Board may be made by, or on behalf of, any individual personally affected by a commissioning decision taken by the HSC Board. The HSC Complaints Procedure may not deal with complaints about the merits of a decision where the HSC Board has acted properly and within its legal responsibilities.

5.3 The public or the Patient and Client Council may wish to raise general issues about commissioning decisions with the HSC Board and they should receive a full explanation of the HSC Board's policy. These are not, however, issues for the HSC Complaints Procedure.

6. Local resolution of complaints concerning commissioning decisions by the HSC Board

6.1 The HSC Board must have a local resolution process and designated complaints officers to deal with commissioning complaints and other complaints about the HSC Board's own actions and decisions.

The HSC Board's complaints officers are based at 12-22 Linenhall Street, Belfast, BT2 8BS

Complaints Direct Line: 02895 363893 (Monday-Friday, 9am-4pm)
Text Relay: 18001 0289536 3893
Email: complaints.hscb@hscni.net

6.2 The primary objective of local resolution is to provide the fullest

possible opportunity for investigation and resolution of the complaint, as quickly as is sensible in the circumstances. The emphasis is on complaints being dealt with quickly and, wherever possible, by those on the spot. The intention of local resolution is that it should be open, fair, flexible, and conciliatory. The complainant should be given the opportunity to understand all possible options for pursuing the complaint and the consequences of following any of these.

6.3 The process should encourage communication on all sides. The aim should be to resolve a complaint during this stage to the satisfaction of the complainant while being fair to staff. Rigid, bureaucratic, and legalistic approaches should be avoided at all stages of the procedure.

6.4 Complaints can be submitted, in writing via email, letter, in person or verbally. All complainants should receive a positive and full response, free of jargon. The aim should be to satisfy the complainant that their concerns have been heeded, and offer an apology and explanation as appropriate, referring to any remedial action that is to follow.

6.5 In the context of local resolution for the HSC Board, for example, a member of staff from a relevant Directorate may respond directly to a complainant about a commissioning decision. The HSC Board's Complaints Office should, however, be made aware of the nature of the complaint and response.

6.6 The HSC Complaints Procedure (para 3.41) states that the Chief Executive may delegate responsibility for responding to a complaint, where in the interests of a prompt reply, a designated senior person may undertake the task. In cases where the response is signed on the Chief Executive's behalf, the Chief Executive will be provided with a copy.

7. HSC Board involvement in local resolution of complaints concerning Family Practitioner Services

7.1. Where requested the HSC Board will act as 'honest broker' or intermediary in the resolution of a complaint or by assisting all parties in reaching a position of understanding. The objective for the HSC Board should be wherever possible to restore the trust between the patient and the practitioner/practice staff. requested by a complainant and/or a Family Practitioner Service (FPS), the HSC Board's Complaints Office with the agreement of both parties may arrange for a lay person or conciliator to be appointed to assist in resolution of the complaint. The advice of an independent expert will only be sought to provide clarification on clinical matters or were there is a risk to patient/client safety.

7.1.1 Once agreement has been received for the HSC Board to act as Honest Broker, the HSC Board Complaints staff (on behalf of FPS) will make necessary arrangements. The HSC Board (on behalf of FPS) is responsible for communicating with, ascertaining the availability of and formally appointing an appropriate lay person, conciliator or independent expert.

7.2 **Lay Persons**

The HSC Board has a number of Independent Lay Persons who will operate as a pool for all HSC organisations. Lay Persons may be beneficial in providing an independent perspective of non-clinical or technical issues within the local resolution process.

They are not intended to act as advocates, conciliators or investigators and neither do they act on behalf of the Family Practitioner Service nor the complainant. The Lay Person's involvement is to bring about a resolution to the complaint and to provide assurances that the action taken was reasonable and proportionate to the issues raised.

Input from a Lay Person is valuable when testing issues such as communication, quality of written documents, attitudes and behaviours and access arrangements.

7.3 **Conciliation**

Conciliation is a process of examining and reviewing a complaint with the help of an independent person. The conciliator will assist all concerned to a better understanding of how the complaint has arisen. They will work to ensure that good communication takes place between both parties involved to enable them to resolve the complaint. It may not be appropriate in the majority of cases but it may be helpful in situations:

- where staff or practitioners feel the relationship with the complainant is difficult;
- when trust has broken down between the complainant and the practice/pharmacy/HSC organisation and both parties feel it would assist in the resolution of the complaint;
- when there are misunderstandings with relatives during the treatment of the patient.

Conciliation is a voluntary process available to both the complainant and those named in the complaint. Either may request conciliation, but both must agree to the process being used. The HSC Board has developed a select list of providers for HSC and the HSC Board's Complaints Office holds these details.

7.4 **Independent Experts**

The use of an independent expert in the resolution of a complaint may be requested by the complainant or FPS at any time, or suggested by the HSC Board. The HSC Board complaints office may, must, seek an assurance from Integrated Care Professionals that the use of an Independent Expert is appropriate. In deciding whether independent advice should be offered, consideration must be given, ~~in collaboration with the complainant~~, to the nature and complexity of the complaint and any attempts at earlier enhanced local resolution.

An independent expert may be considered beneficial where the complaint:

- cannot resolved locally;
- indicates a risk to public or patient safety;
- could give rise to a serious breakdown in relationships;
- threaten public confidence in services or damage reputation;
- to give an independent perspective on clinical issues.

The HSC organisation may decide to involve an independent expert in a complaint without the complainant's consent, outside the procedure, for the purposes of obtaining assurances regarding health and social care practice.

8. Receipt of Complaints

8.1 Complaints received orally should be dealt with by staff promptly, sympathetically and constructively. A statement should be taken and a record kept on file. Such complaints should be dealt with according to the principles of local resolution and should be resolved immediately or within two days of receipt.

8.2 Oral complaints which cannot be resolved to the complainant's satisfaction should be referred to the HSC Board's Complaints Office. Similarly a statement should be taken from the complainant and a record kept.

8.3 Complaints received through the Private Office of the Department of Health (NI) will be forwarded to the HSC Board's Complaints Office which will arrange for an acknowledgement and the preparation of a response. When the reply is ready it will be signed by the Chief Executive (or designated senior person).

8.4 Complaints addressed directly to the HSC Board Chairman or Chief Executive, such as those from Members of Parliament, Members of the Legislative Assembly, District Councillors etc, will be dealt with as in 8.3 above.

8.5 Complaints received from members of the public and others not specified above, will be forwarded to the HSC Board's Complaints Office who will arrange for an acknowledgement and the preparation of a response from the Chief Executive (or designated senior person).

8.6 Complaints concerning a HSC Board staff member will be investigated by the relevant Directorate who will take the appropriate action. The HSC Board's Complaints Office should, however, be made aware of the nature of the complaint and response.

FPS Complaints received by the Board

8.7 Complainants will receive an acknowledgement within 2 working days, their complaint will be investigated thoroughly, treated confidentially and responded to fully in writing within 20 working days.

8.8 If there is a delay in meeting the timescales set, the complainant will be advised of the situation and when a response is expected. Complainants will be also advised of what action they can take should they remain dissatisfied following consideration of the response.

Board Complaints received by the HSCB

8.9 Complainants will receive an acknowledgement within 2 working days, their complaint will be investigated thoroughly, treated confidentially and responded to fully in writing within 20 working days.

8.10 Written responses to complaints will be under the signature of the Chief Executive or a designated senior person.

8.11 Complainants will be advised of what action they can take should

they remain dissatisfied following consideration of the response, which will include recourse to the Northern Ireland Public Services Ombudsman (the Ombudsman). Complainants must bring their complaint to the Ombudsman within 6 months following completion of the HSC Board's internal complaints process.

Northern Ireland Public Services Ombudsman
33 Wellington Place
Belfast
BT1 6HN
Freephone: 0800 343424
Email: nipso@nipso.org.uk

8.12 Where a complaint is received by the HSC Board in error, the Complaints Office should ensure that it is passed immediately to the correct body with the consent of the complainant.

8.13 If timescales will not be adhered to, the complainant will be provided with an explanation for the delay and when a response should will be expected.

9. Northern Ireland Public Services Ombudsman

9.1 All papers relating to the local resolution stage will be made available to the Ombudsman where such a case has been referred by the complainant to the Ombudsman for investigation.

10. Complaints Monitoring

10.1 Under the HSC Complaints Procedure the complaints handling role and responsibilities of the HSC Board are to monitor complaints processes, outcomes and service improvement; and dissemination of learning. The use of this information will also inform commissioning processes and purchasing decisions.

10.2 The operation and effectiveness of the HSC Complaints Procedure will be monitored continuously. A Regional Complaints Sub-Group

(HSC Board/Public Health Agency/Patient & Client Council) has been established and will meet on a quarterly basis to consider analysis of information pertaining to HSC Board complaints, Family Practitioner complaints and HSC Trust complaints. The Regional Complaints Sub-Group, will make recommendations to QSE via the HSCB Complaints Manager, in respect of potential regional learning.

10.3 This includes monitoring of the subject of complaints raised, the particular specialties they relate to and/or their locality, as well as ensuring that there are appropriate systems in place to manage complaints, that complaints are responded to comprehensively and in a timely manner and that in enhancing the local resolution stage, complaints can be resolved more quickly and as close to the source as possible.

10.4 If a complaint has escalated to an SAI, the SAI reference number will be shared with the HSCB Governance Team, who will relay any learning identified. This learning will be shared with the RSCG accordingly.

10.5 Monitoring information will be: -

(i) **Health and Social Care Board**

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Legislation in a way that promotes equality of opportunity, good relations and human rights. Where a particular need is identified we will consider the best way to respond to this is a way that values diversity.

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