Mr O Donnelly
Business Manager
North & West Belfast Trust
Glendinning House
6 Murray Street
BELFAST
BT1 6DP

20 September 2004

Dear Mr Donnelly

Service Improvement Project – Improved Discharge Processes: Muckamore Abbey Hospital

Further to your letter of 6 August requesting a funding contribution to the above initiative I regret to inform you that the Board is not currently in a position to do so.

We are attempting to address a number of significant non-recurrent funding submissions at present including some from North and West Belfast Trust.

We will however keep your request under review in the event of any resources becoming available.

Yours sincerely

Kevin Keenan
Assistant Director Social Services (Adult Services)

cc Mrs T McCaig, Finance

h/Resettlement MAH Fld
kk/dt

Mr Sam Vallelly
Assistant Director Community Care
Causeway Health & Social Services Trust
8E Coleraine Road
BALLYMONEY
BT53 6BP

18 February 2005

Dear Mr Vallelly

Please find attached the most recent monthly statistics for January which we have received from Muckamore.

As you can see there has been a very significant rise in admissions during the month with no discharge. This is a very concerning development and has the capacity to impact on our plans for 2005 in a very negative way.

I would be grateful if you would provide me with an update on this development from the Trusts perspective. Thereafter it may be necessary to meet to consider our next move.

Yours sincerely

Kevin Keenan
Acting Director Social Services

Encs.

Same letter to E Taggart – Homefirst Trust

Mrs Miriam Somerville
Director of Hospital Services and
Community Learning Disability Services
Muckamore Abbey Hospital
1 Abbey Road
ANTRIM
BT41 4SH

23 September 2005

Dear Mrs Somerville

Our recent meeting with Trust and EHSSB colleagues on 1 September to negotiate the parameters for initiating the first phase of redevelopment of Muckamore Abbey reflected a very constructive exchange of views. I undertook to clarify our requirements for finalising the 'Options in Commissioning Phase 1 at Muckamore Abbey Hospital' paper which can be approved by the Trust, agreed with Boards and form the basis for discussion with DHSS&PS in early November.

I have attempted to make them as definite as possible whilst acknowledging a number of the caveats which were articulated at our meeting. The comments are largely based on the Trust discussion paper which provided a focus for the discussion and also, hopefully, a basis for final revision of the 'Options' document.

1 Our starting position is one of full support for the Departmental position, as outlined in Andrew Hamilton's letters of 15 June 2005, requiring phase 1 to open with a capacity which is as near as possible to the 35 bed complement in Cranfield and 19 in Sixmile, and the operational arrangements and standards envisaged in the original business case. Discussions will be necessary between the two Boards and the Trust on the scope for operation of the PICU in Cranfield and the planning assumption in Andrew Hamilton's letter that the beds in Six mile will reduce from 23 to 16 if Southern and Western Boards do not purchase forensic beds as originally proposed.

2 The clinical rationale for Option A, as outlined in the discussion paper, was articulated by Trust staff. We are not however prepared to consider it because it does not, in our view, take sufficient account of resource or operational constraints. We would be strongly supportive of a refinement of Option B as a basis for moving forward. It will be essential for the two Boards and the Trusts to review the costs and levels of savings in the financial strategy for the hospital in light of the DHSS&PS determination that Phase 3 will not go ahead and Phase 2 will reduce by 12 beds. This reduction of provision should also significantly decrease the recurrent costs of the new hospital and release additional monies for use in resettlement of long-stay and discharge delayed patients.

3 Clarification of the resource assumptions underpinning the paper is also urgently required if all of the parties are to be in a position to sign up to any revised proposal. It is not clear how the original position which required additional funding of £1.8m has now moved to a saving of between £0.1m to £0.2m. It was agreed that Finance colleagues would meet as a matter of urgency to provide the required level of clarification upon which meaningful negotiation can proceed. This exercise may result in supporting papers which clarify the actual process of recurrent funding release and the temporary bridging requirement for the 'old' hospital.

4 A revision/refinement of Option B represents, in our view, a viable basis for agreement. The following suggested amendments will significantly contribute to this:

- A minor, presentational issue would involve making a distinction between Conicar and adult wards. This does not ignore the need to address the needs of adolescents.
- It is imperative that overall bed reductions are classified as those due to vacant beds and those resulting from discharge.
- The reduction in patient numbers in Cushendall and the impact on nurse staffing should be factored into this Option.
- Whilst recognising the limited capacity to correlate the impact of a small reduction of beds in Erne on staffing we would want the potential to do this examined.

- The 50% release assumptions regarding Fintona South, Movilla B and Mallow need to be examined.
- It was also agreed at the meeting on 01 September that under Option B the Finglass ward should operate with a maximum of 24 beds

5 Within this Option the Northern Board would expect to see a measurable impact on a reduction in bed numbers as a result of the opening of the 8 bed Crumlin supported housing development.

If these issues are addressed in a comprehensive and decisive fashion with the involvement of all parties it is felt that we should be in a position by late October to have provided a basis for the actions outlined in my opening paragraph.

The next significant date is clearly the Trust/Board meeting on 10 October. It is imperative that a high level of consensus is achieved in advance of that date so that approval thereafter will allow us to move on to resolve any outstanding regional considerations.

The meeting has been arranged to underline agreement on these matters. Should the paper be agreed by all parties prior to that date the meeting may not be necessary.

I hope that this clearly outlines our expectations. If you have any queries please feel free to contact me.

Yours sincerely

Kevin Keenan
Acting Director Social Services

Cc Mrs T McCaig, NHSSB
Mr G McGuigan, NHSSB
Mr I Deboys, NHSSB
Mrs P Smyth, NHSSB
Mrs M Kane, NHSSB
Mr L Blaney, EHSSB
Mr A Walsh, EHSSB
Mr A Murray, EHSSB
Dr G Waldron, NHSSB
Cc's e-mailed by Colette

I/Muckamore Abbey/Resettlement Fld
Kk/dt

14th June 2007

Mr Sam Vallelly
Assistant Director of Learning Disability
Northern Health & Social Care Trust
8e Coleraine Road
Ballymoney
BT53 6BP

Dear Mr Vallelly

ACCOMMODATION DEVELOPMENTS – LEARNING DISABILITY

In the course of recent POC discussions regarding 2007/8 investments and associated PFA targets some concerns were raised about the accommodation options to meet our discharge target from Muckamore.

I refer specifically to the development currently being negotiated with Mr T Dunlop. A number of issues appear to be unresolved regarding the status and funding assumptions underpinning the scheme and the implications for residents. These may create difficulties for the Board in approving and expediting the Business Case. I have asked my secretary to identify an opportunity for us to meet to bottom out any outstanding matters.

Yours sincerely

Kevin Keenan
Acting Director Social Services

cc. T McCaig
O Donnelly

I:LD/MAH/RESETTLEMENT

UPDATE ON RECENT DEVELOPMENTS RELATING TO MUCKAMORE ABBEY HOSPITAL AND IMPLICATIONS OF THE DEPARTMENTAL RESPONSE TO THEM

1.0 Background

1.1 On Wednesday 17th January 2007, BBC Newsline ran a story on Muckamore Abbey which referred to people being 'trapped' in the hospital, being kept unnecessarily in 'locked wards' and human rights being infringed. On the following night, a subsequent item focussed on children being unnecessarily detained in Muckamore. The story generated associated publicity in the local and regional press and on radio involving Departmental, Trust and voluntary sector responses to the issues raised.

1.2 This culminated in a public Ministerial commitment on BBC Newsline, on Thursday 18th January 2007, to develop a response within two weeks. Board representatives were apprised of the proposed outcome on Thursday 25th and on the following Monday the official response was shared with the media. The relevant press release is attached as Appendix 1. This paper will attempt to detail the sequence of events and their antecedents and to analyse the implications of the eventual outcome.

2.0 Northern Board Residents in Muckamore

2.1 On 31st December 2006, there were 79 NHSSB patients in the hospital – 75 adults and 4 children.

They were categorised as follows:–

24 Active Treatment (2 Children)
38 Delayed Discharges (2 Children)
17 Resettlement

The latter two categories are defined as being able to live outside of the hospital setting, some with very high levels of support. A high proportion of this composite group would have been regarded as in the 'trapped' population after taking

ability, readiness and preparedness of individuals and community to be discharged.

2.2 Unfortunately, the media coverage may have suggested this as having been discovered on the back of media interest in the topic. As the Board members know from previous strategies and planning, the scale of the long stay populations in our hospitals for learning disability and mental illness is of longstanding. The issue has been addressed over recent years via piecemeal investment in the absence of confidence in the deliverability of policy commitments to dramatically reform and downsize what all are agreed are outmoded models of care. The initiatives in acute hospitals which have aggressively reduced waiting lists and demanded relocation of elderly patients have not, to date, allocated resources to address essentially the same issue for mentally ill or people with learning disabilities.

2.3 There is a statutory requirement placed on DHSSPS to monitor long stay hospital populations on a regional basis. The data contained in Table 1 was set out in its last annual report.

Table 1

Number of years in hospital	**People with a learning disability**	**People with a mental illness**
5-10 years	47	103
10-20 years	69	58
20-30 years	57	29
30 + years	113	60

2.4 The problem has been reducing gradually for many years, yet there has been no truly decisive investment or policy initiative to impact significantly on it. The Board has been utilising the small allocations referred to above to meet very modest, departmentally defined targets in recent years. Board members will have previously been apprised that for 2005/6 and 2006/7, investment in learning disability services was **nil.**

3.0 Human Rights and Locked Wards

3.1 An inevitable aspect of the current change process at Muckamore, as the new hospital emerges, has been the pragmatic use of the remaining wards for patients with different needs. This can result in a temporary, relatively inappropriate patient mix which commissioners expect to be managed within the collective clinical and therapeutic expertise of the hospital staff. In the case of the patients referred to in the BBC reports we had been advised that the hospital was managing the situation.

3.2 The security measures which prevented freedom of movement and access/exit from some wards are an integral aspect of the functioning of hospitals of this type. Due to the vulnerability of people with learning disabilities such arrangements can, and must, be viewed in part as protective and supportive. The media attention did not adequately explain that, in many units across the region, particularly in facilities catering for people with learning disabilities, dementia and children with disabilities, there are equivalent arrangements which fulfil these functions.

4.0 Children

4.1 The number of children from the Northern Board in the hospital has been small in recent years. The current figure of four is high when viewed over a 2/3 year period and stubbornly static. We have two young people who are delayed discharges. Whilst the delays for children are small when compared to the adult statistics above there is a particular poignance when, for example, Trusts are unable to discharge a 7 year old for months and a teenager's wait is approaching 2 years.

4.2 Recent funding has been labelled for use solely for discharging adolescents from adult wards. We have no Northern Board adolescents in adult wards. The Board has been awaiting the reprovisioning of the current Conicar Children's Ward to a new location off the Muckamore site for over three years but as junior funding partners we are dependent on EHSSB/North and West Belfast Business Case planning processes to conclude.

5.0 The Way Ahead

The media attention, whilst potentially helpful in highlighting a number of issues, unhelpfully presented an amalgam of points in a way that did not fully portray the longstanding broader strategic intent in relation to the hospital. Notwithstanding the seriously constrained timescale for identifying solutions, a 'package' was announced on Monday 29th January and comments are offered against each of its components in Table 2.

5.1 As our comments indicate, while there is very little new, nevertheless, the plan will advance long held aspirations if it is truly progressed in a vigorous, well resourced fashion. The one 'new' proposal is the opening of a ward but this is anti-strategic and at variance with international opinion on learning disability hospital redevelopment. The direction of 'travel' of funding is in our view unfortunate and may deprive the community of much needed resources, if we cannot redeploy these resources quickly as hospital pressures reduce.

Table 2

Strand	Comments
1 Reopen and refurbish a ward for 9 people from the locked ward, appoint 26 nurses and invest up to £1m recurrently in the hospital and £181k as a short term measure.	This action is at variance with all previous efforts to reduce hospital ward numbers in order to release funds to be invested in the community. It is possibly unique as a response to problems of this type in any modern Western society.
2 Resettle children from adult wards under the Children and Young People's Funding Package.	This package had previously been announced. No NHSSB children in adult wards. No account taken of delayed discharges.
2a Reprovide for current Conicar children in a new off-site purpose built facility. Capital cost £3.5m, recurrent cost £1.5m.	Planning commenced 2001/2. Business case being finalised. NHSSB awaiting EHSSB and North and West Belfast determinations on this matter.

3. Resettle 8 EHSSB patients from Cushendall Ward.	No impact on NHSSB. Premised on completion of a project which has experienced significant planning delays.
4. Resettle up to 40 patients per annum. Potential investment of £2m recurrently.	Need to resurrect planning process for accommodation options created by lack of investment 2004/5/6. Uncertainty about scale and source of funding. May need to be found from other programmes such as mental health.
5. Establish Project Team.	Already promoted by Bamford Review and somewhat belated.

6.0 Conclusions

This analysis has been formulated to provide Board members with a more rounded background to recent events relating to Muckamore Abbey Hospital specifically and learning disability services more generally. It is put forward as a wider context to recent reportage of these difficult and sensitive issues. The attention to the subject is welcome but the eventual outcome risks taking a number of strategic steps backward before providing hope of some progress. The foundations had been laid for a more aggressive approach to hospital downsizing, with the expectation of relatively generous funding in 2007/8. These have been significantly weakened. It is to be hoped that the ground can be regained and major change initiated and concluded in this programme.

Appendix 1

DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY PRESS RELEASE – GOGGINS OUTLINES ACTION FOR LEARNING DISABILITY HOSPITALS

DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

30 January 2007

GOGGINS OUTLINES ACTION FOR LEARNING DISABILITY HOSPITALS

Health Minister Paul Goggins has announced an action plan to discharge all patients from learning disability hospitals, including Muckamore.

Key elements of the plan include:

· An end to the permanent placement of children in learning disability hospitals. This will begin immediately with no children permanently resident by March 2009;
· A new community-based, £3.5 million 8-bedded unit for children and adolescents will be fast-tracked. In the meantime, more appropriate accommodation will be provided for children as quickly as possible;
· Increase the numbers of patients who are resettled from 25 to 40 each year;
· No learning disabled patient to stay in hospital for longer than 12 months depending on the level of treatment and assessment they need;
· By 2014 no learning disabled patient will have a hospital as a permanent address;
· New protocols to be drawn up so there is clear guidance on patients only being kept in locked wards if they pose a risk to themselves or others;
· Care plans to be developed for every learning disabled patient in Hospital.

The Minister said: “Less than two weeks ago I asked officials to draw up, as a matter of urgency, an action plan to address the problems in Muckamore Abbey Hospital. In particular, I wanted a

plan which would set out how we would move those patients who have been staying in Muckamore, and other learning disability hospitals, for too long back into the community.

“I am confident that the plan I have announced today will move people, as quickly as possible, out of learning disability hospitals and back into the community where they belong. The plan seeks to ensure that patients are provided with the most appropriate accommodation, tailor-made for their individual needs, and, that families have access to support and respite care to help them look after their relative.

“It is important that we move forward as quickly as possible, however, we must remember that many of these patients have very complex needs and challenging behaviours that require very specialist and intensive care. We must also ensure that patients who have been living in learning disability hospitals for many years are moved in a sensitive way and that this is not too rushed.”

Health Trusts will now be required to draw up individual care plans for patients upon admission which will consider arrangements for their discharge.

The Minister said: “Learning Disability hospitals, such as Muckamore, still have a key role to play in assessing and treating people with a learning disability or mental health problem. Last year, the first phase of new assessment and treatment facilities was opened at Muckamore at a cost of nearly £9 million. Progress on the second phase of this project is well underway, bringing a total capital investment of around £14 million in Muckamore alone. In 2006, I also opened the new Lakeview learning disability hospital in Londonderry at a cost of nearly £5 million.

“However, we need to move away from a situation where patients end up in a learning disability hospital with no plan for when they should return to the community. That is why I am requiring health trusts to draw up clear plans for all patients who need treatment in hospital. I am asking trusts, from day one, to have a set date as to when patients will be returned to the community.

“I also want to acknowledge the dedicated care that staff have been providing to patients in learning disability hospitals, such as Muckamore, for many years. A great deal of progress has already

been made in resettling patients back into the community. For example, over the last 20 years the numbers of patients in Muckamore has reduced from 800 to under 300 – more than 500 people are now living back in the community."

NOTES TO EDITORS:

Action Plan for Discharge of Patients from Learning Disability Hospitals

· The Department will strengthen the learning disability services available to support people and their families to remain in the community, prevent inappropriate admissions and facilitate early discharge. This will include dealing with challenging behaviour, short break respite for families and carers and day opportunities for improved social integration and occupation.

· An end to the permanent placement of children in learning disability hospitals. This will begin immediately with no children permanently resident by March 2009. This will include the provision of an 8-bedded assessment and treatment centre in Belfast for children with a learning disability. There are plans for four children to be resettled in the community in the next few months using funds from the Children and Young People's funding package. In addition, the intention is to place a further six children in the community before the end of the year.

· The Department will accelerate the rate of resettlement and discharge of patients from Learning Disability Hospitals, from 25 to 40 each year, so that the programme will be complete by 2014 at the latest and no-one will have a hospital as their permanent address. Discharge planning will begin immediately upon admission for patients as part of their care plan so that they have a date for discharge back into the community.

· Steps will be taken to separate those patients who need to be kept in a secure ward from other patients. If necessary a vacant ward within Muckamore will be re-opened by June 2007 for two years to allow this to be achieved. Care plans must be in place to ensure that no-one is held in a secure ward inappropriately.

· A Regional Resettlement Team will be established to oversee the discharge of patients across learning disabled hospitals. The Team will bring together all of the Departments and agencies needed to ensure adequate planning is being carried out. This Team should also include representatives from groups such as the Friends of Muckamore and Housing Associations.

Number of patients in Learning Disability Hospitals admitted for assessment and treatment in April 2007		
Hospital: **MUCKAMORE ABBEY**		
Board: **NHSSB**		
A	Number of patients admitted for assessment and treatment in April 2007	3
B	Number of patients at A whose treatment is complete and are ready for discharge	0
C	Number of patients at B whose discharge has commenced but is not complete	0
D	Number of patients at B whose discharge is complete	0
E	Number of patients at B whose treatment is complete but have not yet been discharged (including the figure at C) [This is the cumulative total]	0
F	Number of patients still being assessed/treated	3

Number of patients in Learning Disability Hospitals admitted for assessment and treatment in May 2007		
Hospital: **MUCKAMORE ABBEY**		
Board: **NHSSB**		
A	Number of patients carried forward from E above (April table)	0
B	Number of patients carried forward from F above (April table)	3
C	Number of patients admitted for assessment and treatment in May 2007	3
D	Cumulative total (A + B + C)	6
E	Number of patients at D whose treatment is complete and are ready for discharge	0
F	Number of patients at E whose discharge has commenced but is not complete	0
G	Number of patients at E whose discharge is complete	0
H	Number of patients at E whose treatment is complete but have not yet been discharged (including the figure at F)	0
J	Number of patients still being assessed/treated	6

Number of patients in Learning Disability Hospitals admitted for assessment and treatment in June 2007		
Hospital: **MUCKAMORE ABBEY**		
Board**:** **NHSSB**		
A	Number of patients carried forward from H above (May table)	0
B	Number of patients carried forward from J above (May table)	6
C	Number of patients admitted for assessment and treatment in June 2007	1
D	Cumulative total (A + B + C)	7
E	Number of patients at D whose treatment is complete and are ready for discharge	0
F	Number of patients at E whose discharge has commenced but is not complete	0
G	Number of patients at E whose discharge is complete	0
H	Number of patients at E whose treatment is complete but have not yet been discharged (including the figure at F)	0
J	Number of patients still be assessed/treated	7

Number of patients in Learning Disability Hospitals admitted for assessment and treatment in July 2007		
Hospital: : **MUCKAMORE ABBEY**		
Board**:** **NHSSB**		
A	Number of patients carried forward from H above (June table)	0
B	Number of patients carried forward from J above (June table)	7
C	Number of patients admitted for assessment and treatment in July 2007	4
D	Cumulative total (A + B + C)	11
E	Number of patients at D whose treatment is complete and are ready for discharge	2
F	Number of patients at E whose discharge has commenced but is not complete	1
G	Number of patients at E whose discharge is complete	1
H	Number of patients at E whose treatment is complete but have not yet been discharged (including the figure at F)	1
J	Number of patients still being assessed/treated	9

MAHI - STM - 097 - 10005

Template 2

Number of patients in Learning Disability Hospitals admitted for assessment and treatment in August 2007		
Hospital: **MUCKAMORE ABBEY**		
Board: **NHSSB**		
A	Number of patients carried forward from H above (July table)	1
B	Number of patients carried forward from J above (July table)	9
C	Number of patients admitted for assessment and treatment in August 2007	2
D	Cumulative total (A + B + C)	12
E	Number of patients at D whose treatment is complete and are ready for discharge	1
F	Number of patients at E whose discharge has commenced but is not complete	0
G	Number of patients at E whose discharge is complete	1
H	Number of patients at E whose treatment is complete but have not yet been discharged (including the figure at F)	0
J	Number of patients still being assessed/treated	11

MAHI - STM - 097 - 10006

Template 1

Number of People in Learning Disability Hospitals on 31 March 2007	
Hospital: **MUCKAMORE ABBEY**	
Board: **NHSSB**	
Number resettled during April 2007	0
Number resettled during May 2007	0
Number resettled during June 2007	0
Number resettled during July 2007	0
Number resettled during August 2007	
Number remaining to be resettled at 31 August 2007	57
Number currently being assessed or treated	24

MAHI - STM - 097 - 10007

FROM THE DIRECTOR OF DISABILITY POLICY
DR BERNIE STUART

Mr Stuart MacDonnell
Chief Executive
Northern Health and Social Services Board
182 Galgorm Road
BALLYMENA BT42 1QB

Castle Buildings
Upper Newtownards Road
BELFAST BT4 3SQ

[redacted]

Our Ref:

Date: 10 August 2007

Dear Mr MacDonnell

ESTABLISHMENT OF REGIONAL RESETTLEMENT TEAM

A Regional Resettlement Team, announced as part of an Action Plan in January 2007, is being established to oversee and drive the discharge of patients across the three learning disability hospitals Muckamore Abbey, Longstone and Lakeview. The team will also drive and monitor the development of appropriate accommodation and support in the community.

I will be chairing the Regional Resettlement Team and am keen to get it operational as soon as possible. It is hoped that it will meet for the first time by the end of September 2007.

The resettlement programme has been given a high priority by the Minister for Health Social Services and Public Safety. I would therefore appreciate it if you would offer the name of a representative from your organisation to participate in the Team and who will provide expertise from a Commissioning perspective.

I would be grateful for a response by 31 August 2007.

I have also enclosed a copy of the Team's Terms of Reference for your information.

Yours sincerely

Bernie Stuart

DR BERNIE STUART
DIRECTOR OF DISABILITY POLICY

Terms of Reference

Regional Resettlement Team

Background

A Regional Resettlement Team, announced as part of an Action Plan in January 2007, is being established to oversee the discharge of patients across the three learning disabled hospitals Muckamore Abbey, Longstone and Lakeview. The team will drive and monitor the development of appropriate accommodation and support in the community. Active Discharge Teams, which have been set up at each of the three hospitals, will be responsible for the discharge of patients from Learning Disability Hspitals and development of appropriate associated accommodation. Progress will be monitored on a monthly basis and the Regional Team will report to the Department on a quarterly basis.

The Team will be chaired by Dr Bernie Stuart, Director of Disability Policy, and will comprise members from a range of stakeholders and organisations who are involved in the provision of accommodation and support. It will normally meet quarterly.

The Team's remit will be to:

- Oversee, drive and monitor the work of the Active Discharge Teams;

- Identify and highlight issues which need to be addressed and facilitate resolution, and

- Liaise, as required, with the Equal Lives Implementation Team and the Panel of Experts on Mental Health and Learning Disability.

- The Team may use focus groups of users/carers for reference purposes, as required.

MAHI - STM - 097 - 10010

Community Integration Project

MEETING	**3rd September 2012**
DATE, TIME & VENUE	**1st October 2012 @ 11.15am Cranfield, Muckamore Abbey Hospital**
Present	Names of individuals including MAH staff, patients and relatives [redacted]
Apologies	Names of individuals including MAH staff, patients and relatives [redacted]
Date of next meeting	**1st October 2012**
In attendance	

MAHI - STM - 097 - 10011

Issue	Key Information	Recommended Actions
Newsletter	The Newsletter information including articles from Advocacy, Patient perspective, Family perspective and Care Manager, will provide the basis for the next newsletter. Questions and Answers from TILLI and/or Patients Council has not been forwarded to [redacted] to date.	[redacted] to speak to TILLI and include same in next Newsletter
Carers Letter	Letters to carer's was discussed in relation to responses from NOK etc. No further updates at present.	Stakeholders to continue to be vigilant and escalate concerns from NOK etc if raised**.**
Vela Microbaords	Susan Taylor from Vela Microboards gave the group a presentation at the meeting All present agreed that this was a good document.	All Stakeholders are encouraged to make contact with Vela Microboards**.**
Service Information	Discussion regarding the potential for providers to give information in pictorial, written or video format to create community facility resource pack for patients . To date little information has been forwarded to [redacted] Trusts to forward Provider details to [redacted] to facilitate the collation of a resource folder of residential, supported and nursing providers.	[redacted] to forward reminder to Care Mangers to forward information on Provider details to [redacted]
Project Update	Relatives Questionnaire is currently being completed by Care Managers Patients Individual Questionnaires are now nearly complete. Easy read documentation and Newsletter has been forwarded to all wards. All patients to be asked the key questions to inform assessment process, this should be extended to	Project Team to implement • Questionnaire's to be returned to [redacted] and [redacted] for completion to ascertain Patient view and Relative view.

Issue	Key Information	Recommended Actions
	Relatives and carers where appropriate. [redacted] stated that to date he has not seen Betterment in the Community and asked about support services within the community when issues arise. [redacted] and [redacted] explained the services available. [redacted] has offered [redacted] the opportunity to see services within the Northern Trust. [redacted] stressed the importance that patients who are being resettled from MAH need to be resettled at their pace. He stressed that in the community their is less restrictions on an individual with more lifestyle and activity opportunities	[redacted] to arrange for [redacted] to Visit services within the Northern Trust

[redacted]

Mary Donaghy Notes SE Trust
Resettlement Workshop
Antrim Enterprise Centre
12th May 2014

Regional

D/D-Learning Disability=30	Mental Health=72
Resettled=6	Resettled=26

- Complex-Cap share given

- New builds-beyond 2015;
  -timing
  -elements in place
  -can discuss with DHSSPS

- Where differences-concern

- Patient lack of engagement;
  -common?
  -feedback needed x5 Trusts

- Patient/carer opposition
  -quality of life issue
  -patient advocacy } Helped

- Hospital treatment beyond 2015;
  -delays
  -support
  -community infrastructure ideas

- Longer term hospital treatment needs;
  -resource implications
  -size/shape
  -process to identify

- Greater need patients re. Forensic;

-cost implications
-community interest
-infrastructure (community)
-pathways (F)

- Children's transitions issues
- Forensic learning disability-infrastructure bid; June Monitoring round.
- Type of service, skill mix, meet need, hospital and community, assessment and treatment
- Trends-future profile needs. Southern Trust-2 sessions (forensic) from Comm. Infrastructure.
- Brain injury
- Review of deaths
- ECR-future needs met locally
- Older peoples issues
- Tenancy Agreements;

NIHEX-Brian

- Comm. Consultation issues (Housing Association)
- Project management approach
- Critical schemes in planning beyond 2015
- Design and tech issues=capital issues
- Change in monitoring arrangements. Schemes that are slipping

Forward

- Research and evidence base
- Align resources/engagement
- RQIA-housing vs. support issues

DSD Pressures

- Reduce SNMA funding-closure 2015
- Review of SP Programme

Southern Trust C. Response

- Screening-health needs/specialist
- Screening hospital admission, including detained
- Support/crisis management
- Advice/support
- Liaison to Acute Emergency Department 9am-1am Monday-Sunday

Staffing1 BD 6 and BD 5
2 week rolling shift pattern, 37.5 hours and on call
Nurse bank cover
Budget of £120k

Home Treatment-evolving

- Earlier discharge from psychiatric hospital with M/D team
- Provide support and treatment in persons home following discharge

Referral Criteria

- Resident of the Southern Trust
- Acute crisis/breakdown mental health and challenging behaviour
- Confirmed diagnosis of learning disability and accept emergency referral.
- Any referral from health professionals/families

- Staffing1 BD 6 and BD 5
- 2 week rolling shift pattern, 37.5 hours and on call
- Nurse bank cover
- Budget of £120k

Evaluation-1 year post formation

- Monthly activity report

- ¼ meets with Consultant Psychiatrist and Community Learning Disability Teams
- Bi-monthly meetings L/M
- Feedback from service users and other stakeholders:-how?

1.5 admissions per year

Learning Disability

- No hospital in Trust
- 24/7-crisis response
- Psychiatric Cover from Belfast-possible shift
- Trust Del. Plan-24/7 cover- Monday to Friday; 9-5pm

In year Resettlement-Plans for all
-Absolute dates
-Other partners-delivery

Learning Disability 11-6=Def
3← 4=Possible design/planning issue
1=No-palliative care

Long Stay;

- Ambivalence
- Better understand and deal with
- High level funding/emotionally not ready
- Traditional type placement

Challenges;

- New providers-value for money
- New Models-staffed with response
- Outside of S/people
- Forensic Service for Learning Disability
- 18-25
- Comm. Infrastructure
- Key P Indicator <10% reduction in admissions
- Additional staff and skill mix

- Independent sector, small organisations-governance issues and thresholds and quality
- Staff support-diffs-mindset

Brain Injury;

- Maine in Belfast Trust-disconnect x 4 South Eastern Trust. Knockbracken Site-sit outside of Resettlement

Mental Health-Target to Resettlement 8 patients

Strategic Issues;

- Defining low secure and rehab population
- Low Secure-need to bottom out
- 3 facilities region-possibly 5

Acute Inpatient;

- *New population*
- Block beds
- Discharge issues
- Investment
- Population changing, older people, longer-reduce cap

Community Infrastructure-more housing and varied
ECR's-reduce part Eating Disorder
-high risk association
-length of stay 6-1-2 years
-capacity of turnover of beds
-solution for Eating Disorder

Young People;
-number of referrals from CAMHS-new trend
-high cost
-more complex
Ardglass Road tenancy issues

Solutions

-low secure-make decision. Learning disability within this

-Workshop-ward 28

-how are we using Acute beds

-spec provision or inpatient provision

} Regional to look at this

Shannon-Provision of Forensic for Mental Health and Learning Disability

3:1-Mental Health Hospital-Deficient in funding

-to bridge the gap

Solutions-Learning Disability

-Model needed rather funding

-Crisis response driven-310-400k

-Skill mix

-7 day targeted response

-not yet 24/7

-Re profiling already in place

-Hub and spoke Forensic

Demographics

-Development of Housing-not necessary S.P work to do regarding this

-Governance issues-support other organisations too with this

Brain Injury

- Showcase benefits
- Extended hours of working-crisis resolution
- Resettlement function post 2015
- Skills mix-CRHT/Behavioural management-shift of expertise
- Models for community based consistent ax region

} Learning Disability

- New long stay patients
- Complex needs-providers
- Fast track planning

} Mental Health

Northern Trust

- Media attention
- Remains resettled- 1:1 support
- Psychiatric support-review of profiling psychiatry into community
- Resettled/care ? function
- ECR's
- Spec F Psychiatric network-general psychiatry

Learning Disability

- Resettled 2:1 (DOLS)
- Community mental health team
- Liaison psychiatrist in addictions-whole Service response

Mental Health

Southern Trust

- Bespoke packages
- Learn from mental health treatment in community
- Forensic
- Demand
- ECR only
- Young people-transitions-funding issues

Learning disability

Stephen Bergin-Low secure

-first draft early June with "costs"

Aidan

Agreed Actions:

- Needs Assessment post Resettlement
- Housing issues-consistency
- Specialist services-RQIA Learning disability
- Long term treatment needs it. Low secure and rehab patients
- Above on Programme Board meeting (June)

Mental Health and Learning Disability
Community Integration Programme Board
Conference Room 3, HSCB, 12-22 Linenhall Street, Belfast

16 June 2014 @ 10.00am

Present: Names of individuals including MAH staff, patients and relatives [redacted]

Apologies: Names of individuals including MAH staff, patients and relatives,

1. **Minutes of Last Meeting – 28th April 2014**
   The minutes were approved.

2. **Matters arising**
   There were no matters arising.

3. **Workshop 12th May 2014 – follow up**
   The Board (Aidan Murray) provided a summary of the discussions/ issues raised in the workshop on 12th May.

   He reported that the priority for the programme board going forward from delivery of the Ministerial target by 31 March 2015 would be;
   1. Community Care Infrastructure/ Expansion
   2. Type and scope of specialist services required
   3. Low Secure/Longer term treatment mental health provision

   He stressed the need to keep the Department fully informed of progress towards achievement of the target and any areas where delivery of the target may be delayed beyond 31 March 2015. Equally important is the need to apprise the Department of the post resettlement needs of the mental health and learning disability populations. Aidan has sought a meeting with DHSSPS Director of Mental Health and Learning Disability on these issues.

   He commented that the Boards approach to the Department should be that resettlement of the long stay and delayed discharge

populations should not be an end in itself but rather a step towards ensuring that the appropriate mental health and learning disability services were available on the ground.

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4. Cross Trust Resettlement Issues

The issue of patients from one Trust area being resettled in another Trust area was raised with various examples being given.

The following issues were discussed;

- Patient safety - The need for prior notice and communication between Trusts to plan for such patients with appropriate lead in times for such transfers to allow for a seamless transfer.

- The risk identified is that patients move from one Trust to another without an accompanying movement in funding, leaving the receiving Trust with a resource shortfall.

- The need for information on flows to establish if there are material funding consequences for Trusts or if it's a position of "swings and roundabouts".

- The need to agree in principle who should provide services during the trial discharge. The consensus in the meeting was that the transferring Trust should provide all the services the patient needs following resettlement commencing in another Trust area until the patient is formally discharged.

- The need to agree in principle who should provide services after the patient is resettled. The consensus in the meeting was the patient has effectively moved to a home in a new Trust area and should be able to avail of the services of that area.

It was agreed that the Board would share its data on cross Trust Resettlements with Trusts for their comments in advance of next meeting. The Board would then review to see if this required further commissioning decisions.

Action: HSCB to review cross Trust resettlement data and share with Trusts for their quality assurance.

5. 2014/15 Targets/Plans Progress

The Board (Linus Mc Laughlin) advised that 49 Learning Disability and 42 Mental Health patients are required to be resettled by 31 March 2015 if the Ministerial target is to be met. He reported that one Mental Health patient had been resettled during April and that he had now received the Trusts plans for the remainder of the year. He advised that all Trusts were planning to resettle the majority of their patients in the final quarter of the year and highlighted the risk if these timescales slipped.

He noted that Trust were identifying PTL patients who may not be fit for discharge at 31 March 2015, e.g. patients detained for treatment, and that they were also indicating slippage on timescales re some learning disability accommodation developments but that they were monitoring these situations closely.

6. Supporting People Programme 2013/15 Update-Mary McDonnell

The NIHE (Mary Mc Donnell) gave an update on the in year and the 2014/15 Supporting People Programme which showed the progress on the relevant MH & LD schemes.
Mary identified a number of schemes across N. Ireland that had now fallen behind their critical time lines for completion by 31 March 2015. In particular she noted that Dympna House Scheme will not now be completed until December 2015.

Mary advised that the cut off point for this years capital spend is going to be September.

7. A.O.B

There was no AOB.

8. Next meeting

Monday 18th August 2014 @ 10.00 am, CR3 Linenhall Street

COMMUNITY INTEGRATION PROJECT

STAKEHOLDER GROUP MEETINGS 2015

- *Monday 2nd March 2015 11am Boardroom MAH*
- *Monday 1st June 2015 11am Boardroom MAH*
- *Monday 6th July 11am Boardroom MAH*
- *Monday 3rd August 11am Boardroom MAH*
- *Monday 7th September 11am Boardroom MAH*
- *Monday 5th October 11am Boardroom MAH*
- *Monday 2nd November 11am Boardroom MAH*
- *Monday 7th December 11am Boardroom MAH*

MAHI - STM - 097 - 10024

Resettlement - Performance Update; Mar-15

LEARNING DISABILITY
Resettlement PTL - 2015/16

Trust of Residence	To be resettled by March 2016	Total Number Resettled at 31 March 2016	Deceased	No Planned Date	Planned Date after March 2016	Planned Date after March 2017	In Treatment/ Detained/ Legal Challenge at March 2016	Total
Belfast	16	3	1	2	6	4	0	16
Northern	9	3	0	3	3	0	0	9
South Eastern	10	4	0	2	2	1	1	10
Southern	1	0	0	1	0	0	0	1
Western	-	-	-	-	-	-	-	-
Region	**36**	**10**	**1**	**8**	**11**	**5**	**1**	**36**

MENTAL HEALTH
Resettlement PTL - 2015/16

Trust of Residence	To be resettled by March 2016	Total Number Resettled at 31 March 2016	Deceased	No Planned Date	Planned Date after March 2016	Planned Date after March 2017	In Treatment/ Detained/ Legal Challenge at March 2016	Total
Belfast	7	1	0	0	3	0	3	7
Northern	5	0	0	1	3	0	1	5
South Eastern	-	-	-	-	-	-	-	-
Southern	2	0	0	0	0	0	2	2
Western	9	4	0	0	3	0	2	9
Region	**23**	**5**	**0**	**1**	**9**	**0**	**8**	**23**

Delayed Discharge - Performance Update;

LEARNING DISABILITY
Delayed Discharge PTL - 2015/16

Trust of Residence	To be resettled by March 2016	Total Number Resettled at 31 March 2016	Deceased	No Planned Date	Planned Date after March 2016	Planned Date after March 2017	In Treatment/ Detained/ Legal Challenge at March 2016	Total
Belfast	3	0	0	0	0	3	0	3
Northern	7	1	0	5	1	0	0	7
South Eastern	3	1	0	2	0	0	0	3
Southern	-	-	-	-	-	-	-	-
Western	3	2	0	0	1	0	0	3
Region	**16**	**4**	**0**	**7**	**2**	**3**	**0**	**16**

MENTAL HEALTH
Delayed Discharge PTL - 2015/16

Trust of Residence	To be resettled by March 2016	Total Number Resettled at 31 March 2016	Deceased	No Planned Date	Planned Date after March 2016	Planned Date after March 2017	In Treatment/ Detained/ Legal Challenge at March 2016	Total
Belfast	6	2	0	1	2	0	1	6
Northern	7	2	0	0	0	0	5	7
South Eastern	2	0	0	0	0	0	2	2
Southern	1	0	0	1	0	0	0	1
Western	6	4	0	0	0	0	2	6
Region	**22**	**8**	**0**	**2**	**2**	**0**	**10**	**22**

COMMUNITY INTEGRATION PROJECT

STAKEHOLDER GROUP MEETING

BOARD ROOM, MUCKAMORE

MONDAY 7th SEPTEMBER 2015, 11AM.

PRESENT	ORGANISATION
[redacted]	Soc. of Parents + Friends
[redacted]	Advocate, Bryson House
[redacted]	Advocate, MENCAP
[redacted]	BHSCT
[redacted]	HSCB
[redacted]	NHSCT
[redacted]	ARC
[redacted]	TILII Patients Council
[redacted]	Bryson

APOLOGIES	ORGANISATION
[redacted]	BHSCT
[redacted]	Soc. of Parents + Friends
[redacted]	SEHSCT
[redacted]	BHSCT
[redacted]	BHSCT
[redacted]	SET

Names of individuals including MAH staff, patients and relatives [redacted]

1. Apologies

Apologies were received and noted above.

2. Matters Arising

There was no meeting in August as agreed by the group due to holidays.

3. Update from this Mornings CIT Meeting

Belfast Trust

[redacted] gave an overview/update of Belfast Trust position. There are 29 PTL remaining and 39 DD. Trust working with a number of organisations to progress remaining individuals to be resettled.

Northern Trust

Northern Trust has 12 to resettle this year. There are 5 have commenced, 2 plans in place and 5 under way. Trust is progressing with all the individuals.

South Eastern Trust

South Eastern Trust in the same position to Northern Trust. 10 PTL to be resettled this year. Plans in place for majority of individuals.

Southern Trust

One individual remaining from Southern Trust. He is currently working with the Trust to look at number of options in number of localities.

4. Access to Advocacy Services

There was a discussion with regard to access for all individuals to Advocacy Services. Iolo confirmed that all those individuals who are linked to resettlement have access to Advocacy via Bryson Mencap and Disability Action. For those individuals who fall outside the resettlement group it is the responsibility of the particular Ward Manager to refer the request to the relevant Trust.

Action: [redacted] to remind/clarify with Ward Managers that this process is clear and adhered to.

[redacted]
Names of individuals including MAH staff, patients and relatives

5. Update on Plans for Abbey Road

[redacted] informed the group that some work was underway exploring the options for Abbey Road.

[redacted] raised his concerns that [redacted] had assured Friend and Family of Muckamore would be involved in any future work on the site. [redacted] will raise his concerns at the CIT Project Board.

[redacted] confirmed that the board had not been involved in any further discussions following the last meeting. No business case had reached the Board.

6. Any Other Business

[redacted] – Bryson House

Raised concerns with regard to individuals resettled and PSNI involvement.

Action: [redacted] to discuss detail with [redacted] outside of this meeting.

[redacted]

Raised concerns that individuals and families are not clear about their finances on discharge.

Action: [redacted] to raise with the Trusts at next CIT meeting.

[redacted] – Bryson House

Concerned that communication at times are lacking between Trust and Advocate.

Action: [redacted] to raise with Trusts at next CIT meeting.

[redacted] – Client Representation

1. Positive feedback from patients about how sleep overs and settling in process is working.
2. Some concerns that resettlement from Cranfield has slowed down.
3. Patients feel that access to Independent Advocacy continues to be very important.

Action: [redacted] to feedback to Trusts.

[redacted]
Names of individuals including MAH staff, patients and relatives

7. Date of Next Meeting

Monday 5th October 2015 11am MAH

MAHI - STM - 097 - 10028

LD Community Integration Project Meeting
Friday 22nd January 2016 @ 10.00am CR2

In Attendance:

Name	Organisation
[redacted]	BHSCT
[redacted]	Parents and Friends of Muckamore
[redacted]	Parents and Friends of Muckamore
[redacted]	Positive Futures
[redacted]	Service User
[redacted]	TILII (ARC)
[redacted]	SEHSCT
[redacted]	NIHE
[redacted]	WHSCT
[redacted]	HSCB
[redacted]	HSCB

Apologies:

Name	Organisation
[redacted]	HSCB
[redacted]	PHA
[redacted]	NIHE
[redacted]	SHSCT
[redacted]	HSCB

1. Minutes of previous meeting 09 October 15

[redacted] Names of individuals including MAH staff, patients and relatives

These were agreed.

2. Minutes of Meeting 4th June 2015

The re-circulated minutes were agreed subject to:

1) the date of the previous meeting's minutes being changed to 27th January 2015;

2) Provision of suitable wording by [redacted] to cover the query raised by [redacted] about the category of patients classified as 'no planned date for discharge'.

3. Matters Arising

NIHE Workshop

[redacted], NIHE, confirmed that the workshop had not happened yet. Needs assessment is on-going and it is expected that the workshops will take place in late February/early March.

[redacted] raised a query about whether these workshops were the same as another workshop that had been mentioned by [redacted], NIHE, which will take place in March. [redacted] clarified that workshop is different and is a stakeholder event. [redacted] notified group members that [redacted] would be speaking at an ARC conference in June.

[redacted] clarified that the ongoing needs assessment is to quantify the need for housing over the next three years but that neither the HSCB nor the NIHE had yet been notified of any available funding for this over that time period.

Future Planning

Since October 2015, the HSCB has met with the Patient Client Council (PCC) and University of Ulster (UU) about re-running training that had been previously given around adults with learning disability who are living with older adult carers. It has been agreed that this training will be re-run subject to the HSCB having funding in 2016/17.

[redacted] queried whether there was currently a service to address instances where caring arrangements in these circumstances break down. [redacted] confirmed that this future planning exercise should identify and address this issue at an earlier stage before a crisis, such as [redacted] referred to would occur. In emergency situations, care will always been provided but pre planning is much more desirable.

Names of individuals including MAH staff, patients and relatives [redacted]

[redacted] notified attendees that Positive Futures had set up a Big Lottery funded project in South Eastern Trust (SEHSCT) area and that the project was running an information day in Lisburn for carers which would include this future planning issue on the day. [redacted] noted that it is useful for any such events that are being arranged to be held in venues that are easily reached by people from across a Trust's geographical area.

[redacted] advised that Trusts are dealing on an on-going basis with any crises that arise in caring arrangements. She noted that suitable accommodation in such instances is an issue and that all strands of planning should connect up to ensure that services respond in a timely fashion to unexpected requests.

[redacted] mentioned that she had attended the project group in SEHSCT area to which [redacted] had referred and found it to be a very useful experience.

Quality of Life Questionnaires

[redacted] has recently sent out requests via the ARC forum to identify if there are any individuals who have not received advocacy through the resettlement process. Agnes noted that it was a mixed response but that she will be in a better position to respond at the next meeting.

4. Resettlement Progress Report December 2015

Although [redacted] had given his apology for not being able to attend the meeting, the resettlement performance update report that was circulated showed the following:

Overall:
Resettlement PTL; 11 patients resettled from 36 target for 2015/16
Delayed Discharge: 4 patients discharged from 15 target for 2015/16.

Trust representatives provided further information as follows:

WHSCT: [redacted] confirmed that all PTL patients had been resettled and that there were plans for all delayed discharge patients.

SEHSCT: [redacted] confirmed that 4 PTL patients had been resettled and that 2 are ready to be resettled. Of the 4 remaining, 2 are progressing with plans and are expected to be resettled before 31st March 2016, leaving 2 who will be resettled after 31st March 2016 (1 of whom has a plan and the other who has a provisional plan). For delayed discharges, 1 person has been resettled and 2 have plans but no dates for resettlement. [redacted] asked if the status of these 2 could be confirmed as figures will be notified soon to the Department.

BHSCT: The Assistant Director was not present, but the figures show that 4 people have been resettled in-year to date, with1 planned before 31st March 2016. One person's plan is in progress but with no planned date yet. For delayed discharges, none have been resettled to date in 2015/16. Of the remaining 9 PTL and 3 delayed discharges, these will be resettled after 31st March 2016 and this is as a result of delayed schemes (e.g. Dympna House).

[redacted] referred again to her query about the Northern Trust area (NHSCT) and the number of people who do not yet have a plan. [redacted] will provide a form of words to address this issue (as noted in section 1 above).

[redacted] also queried why a NHSCT representative was not in attendance at this meeting and noted that NHSCT non-attendance seemed to be the issue at other meetings (e.g. Stakeholder Group meetings). [redacted] undertook to raise this with NHSCT.

Names of individuals including MAH staff, patients and relatives [redacted]

5. Progress on Housing Developments

[redacted] gave an update on remaining schemes.

1. Knockcairn Phase 2
The second property has now been secured and the Housing Association will be purchasing it in the current financial year (before 31st March 2016). People have been identified for this house.
2. Dympna House
The Commissioning Body has passed this scheme. Approval for demolition is awaited from the NIHE's Development Programme section. It is hoped that this will be progressed by 31st March 2016 with a March 2016 start.

6. Funding 2016/17

[redacted] informed attendees that new delayed discharge patients remain an issue (funding for the original PTL and delayed discharge population has been allocated to Trusts). A bid has been submitted to the Department for additional funding for such delayed discharges.

[redacted] queried if the Living Wage issue had been put forward as a funding issue. [redacted] confirmed that this is being taken forward across all programmes of care in discussions between the Department, the HSCB and Trusts about the overall financial position for 2016/17. [redacted] confirmed that NIHE is communicating with providers about the Living Wage issue. [redacted] and [redacted] queried whether the NIHE would also be contacting Trusts as statutory providers of supported living schemes. [redacted] will confirm the position on this.

Names of individuals including MAH staff, patients and relatives [redacted]

7. Any Other Business

[redacted] queried the position about people from Northern Ireland who had been referred to the U.K. mainland and will have to be resettled to Northern Ireland. [redacted] stressed that these people were still in U.K. as a result of clinical need and that these needs are reviewed on an on-going basis. He also advised that a number of these will have been included by Trusts in identification of young people transitioning to adult services for which additional funding had been identified. Relevant funding for people out of NI who meet PTL or DD criteria is available.

[redacted] noted that patients are generally happy with the resettlement process but that one person had commented that the process was long. [redacted] said that this was a good point and that the resettlement process is intended to happen as quickly as possible but that with some schemes there may be unavoidable delays. [redacted] also raised the issue about breakdown of resettlement placements.

[redacted] enquired about Oldstone ward. [redacted] replied that this was not part of the resettlement issue and hence could not be discussed by this group, but noted that the Parents and Friends of Muckamore Abbey Hospital group could raise the issue with Belfast Trust (BHSCT) and Northern Trust (NHSCT).

[redacted] raised an issue about patient choice in deciding on resettlement.[redacted] replied that if a person was unhappy about lack of choice then this issue should be raised with the relevant Trust responsible for the resettlement process as the process was designed to take people's views into account.

8. Date of Next Meeting:

Monday 23rd June 2016 @ 10.00a.m, CR1, HSCB, Linenhall Street.

[redacted]
Names of individuals including MAH staff, patients and relatives

Mental Health and Learning Disability
Community Integration Programme Board
Conference Room 1, HSCB, 12-22 Linenhall Street, Belfast
28 November 2016 @2.00pm

1. **Present:** Names of individuals including MAH staff, patients and relatives [redacted]

2. **Apologies;** Names of individuals including MAH staff, patients and relatives [redacted]

3. **Minutes of Last Meeting –** 22 August 2016
   The minutes were approved.

4. **Matters arising**

   There were no matters arising.

5. **2016/17 Targets/Plans Progress / Performance Update**

[redacted] (HSCB) reported on Resettlement and Delayed Discharge progress to end of October 2016.

Resettlement

[redacted] reported that 3 Learning Disability patients have been resettled against the target of 25.

He advised that the current Trusts plans show that for Learning Disability;

- 7 PTL patients have planned dates to commence resettlement before 31st March 2017,
- 6 have on going assessments but no planned date,
- 7 have a planned date after 31 March 2017 and

- 2 patients are in treatment.

With regard to Mental Health; 8 patients have been resettled against the target of 18.

- 3 PTL patients have planned dates to commence resettlement before 31st March 2017 and
- 7 patients are in treatment or detained

Delayed Discharges

With regard to delayed discharges

- Learning Disability - Delayed Discharge: 3 patients discharged against the target of 12.
- Mental Health - Delayed Discharge: 3 patients discharged against the target of 14.
- 1 Learning Disability and 2 Mental Health delayed discharge patients have planned dates before 31 March 2017.
- 2 Learning Disability and 3 Mental Health delayed discharge patients have currently no planned date.
- 4 Learning Disability delayed discharge patients had currently a commencement date that falls after 31 March 2017 and
- 2 Learning Disability and 6 Mental Health delayed discharge patients are currently expected to be in treatment or detained by 31 March 2017.

Action; [redacted] to provide analysis of those patients categorised as "In Treatment/Detained/Legal Challenge"

6. **Supporting People Programme**

Unfortunately, due to significant changes in personnel within the Supporting People team, there was no one available to provide an update today.

Names of individuals including MAH staff, patients and relatives

7. **Future arrangements for Community Integration**

[redacted] (Chair) provided a brief history of the purpose of the programme board and its role in giving focus to the resettlement process. Because of the review of Bamford a new group will be required to take on Bamford going forward however there is nothing definitive decided at the minute.

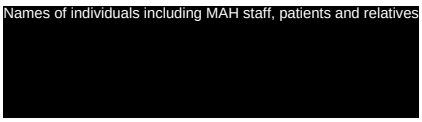
[redacted] (WHSCT) highlighted the fact that this group is the only regional group where the NI Housing Executive Supported Living Arm is represented and stressed the importance of this relationship going forward.

8. Any Other Business

There was no other business.

9. Next meeting

24 April 2017 @ 2.00pm, CR1 Linenhall Street.



Community Integration Programme (CIP): Terms of Reference.

Context:
A co-ordinated approach is essential to manage the planned and safe re-settlement of patients in Muckamore Abbey Hospital (MAH) and other Learning Disability In Patient Units [Dorsy and Lakeview] deemed medically fit for discharge, (i.e. not currently under active assessment or treatment) into accommodation/ community placements which effectively meet assessed risks and needs. The health and social care system in Northern Ireland see the resettlement of these individuals as a priority.

It is imperative that these service users and their families are involved in decisions regarding care and discharge planning, working in partnership with relevant professionals and agencies to facilitate appropriate re-settlement arrangements. It is essential that these new homes are safe and caring environments, and that the plans for resettlement are progressed at pace.

Aim:
To ensure the safe and timely discharge of medically fit patients in MAH, Dorsy and Lakeview, into re-settlement placements which effectively meet their assessed needs and addresses effective risk identification and management, as agreed by working in partnership with service users, their families, multi-disciplinary team members, salient professionals and organisations.

Objectives:
- Enable the HSCB to monitor performance and progress in relation to the delivery of the Regional LD Resettlement Programme.
- Ensure Trust representatives to provide a monthly up-date by completing the ‘tracking tool’ in relation to all medically fit patients requiring re-settlement, to provide assurance that discharge arrangements are being progressed.
- To identify and review those individuals for whom discharge plans and dates have slipped, or for whom there is no effective discharge plan in place.
- Highlight any issues, impacting on discharge. These issues will be captured on the issues log for discussion with the Project Board.

- Identify and review funding and resourcing plans associated with the Learning Disability Resettlement Plan, and develop actions to address or escalate shortfalls.

Membership:

The membership will comprise the AD/Co-Director for Learning Disability Services in the 5 Trusts in Northern Ireland, who collectively have senior operational responsibility for the delivery of the regional resettlement programme for people with learning disability. The AD's/Co-D will co-opt as necessary other membership of their Trust professional and corporate teams as required to fulfil the aims and objectives as laid out above. The AD/Co-Director will hold overall accountability for the contribution of all co-opted members.

Bria Mongan	CIP Co-Chair Associate – Leadership Centre
Ian Sutherland	CIP Co-Chair Associate – Leadership Centre
Caroline McGonigle,	Social Care Lead, HSCB
Frances McGreevy	Head Accountant ,HSCB
TBC	PSMI
Gareth Farmer	Assistant Director, Learning Disability, NHSCT
Lyn Preece Fiona McClean	Assistant Director, Learning Disability, SESCT Operations Manager for Adult Disability, SESCT
Tracy Kennedy [redacted] [redacted]	Co-Director, Learning Disability, BHSCT MAH/BHSCT MAH/BHSCT

Christine McLaughlin	Assistant Director, Learning Disability, WHSCT
John McEntee	Assistant Director, Learning Disability, SHSCT
TBC	BHSCT Planning/Business Case Lead
Marion Fisher/TBC	Supporting People Team, NIHE.

Roles and Responsibilities:

- Trusts will submit updates on the regional 'tracker tool' 5 working days before the CIP meeting to allow HSCB staff to collate the regional overview.
- HSCB will organise meetings, agendas, update tracker tool and action log.
- Meetings will be held monthly. It is required that the AD/Co-D for each Trust attends, or nominates a named deputy. Other attendees as co-opted by the AD/Co-D will also attend.
- MAH representatives will support discharge planning arrangements by sharing pertinent information regarding changes to patient's assessed level of need or care requirements, as appropriate.
- Attendees will be able to provide verbal updates as required to support the information submitted by the Trust teams.

Operating Arrangements

1. Internal or external persons may be invited to attend the meetings at the request of the Chair on behalf of the Group to provide advice and assistance where necessary.
2. Members will be expected to provide feedback to and from their own organisations on issues of relevance and work in partnership with salient individuals, professionals and agencies to expedite appropriate resettlement schemes.
3. In terms of the related governance reporting structure, issues, themes and progress re resettlement are discussed at the Mental Health and Learning Disability Leadership Group [Project Board for Regional Resettlement Project] as well as the Regional Learning Disability Operational Delivery Group and the Muckamore Development Assurance Group. Salient issues regarding resettlement are also raised via the Learning Disability Assistant Directors Forum.

Date for Review of Terms of Reference: The terms of reference will be reviewed for approval at the meeting in March 2022, for operation from the 1st of April 2022.

Terms of Reference

Regional Learning Disability Operational Delivery Group

Version 2 as at 4/9/19

REGIONAL LEARNING DISABILITY OPERATIONAL DELIVERY GROUP: TERMS OF REFERENCE

1. Introduction

1.1 This paper sets out the Terms of Reference (ToR) for the Regional Learning Disability Operational Delivery Group (RLDODG).

1.2 The introduction to the draft Health and Social Care HSC (HSC) Action Plan initiated in response to the Independent SAI Review of Muckamore Abbey Hospital indicated that 'the first but critical step will be to develop and deliver enhanced services in the community to source, support and sustain people in the places where they live'. This will be one of the key roles of the RLDODG.

2. Aim

2.1 The RLDODG has been established to provide the DOH, through the Health and Social care Board (HSCB), with assurance regarding the HSC's actions, following 'A Way to Go' (Review into safeguarding at MAH; to provide oversight regarding the Permanent Secretary's commitment on resettlement made in December 2018 and to ensure that the development of enhanced and regionally consistent community services for people with a learning disability and their carers are designed to support and sustain people in their communities and avoid the need for inappropriate inpatient admission.

3. Objectives

3.1 The objectives of the RLDODG group are to deliver the HSC Action Plan:

i. To ensure the commitment given by the Permanent Secretary to resettle the primary target list of patients is met;

ii. To address the regional issue of delayed discharges for those patients who are encountering obstacles in their return to the community;

iii. To share the lessons learned from MAH (including the SAI report) and influence the transformation of Learning Disability services across NI which are consistent;

iv. To support the Trusts to develop regional admissions criteria, a regional bed management protocol and a regionally agreed acute care pathway thus ensuring necessary hospital admissions are planned and discharges expedited in a timely manner;

v. To review the training needs and capacity of the multidisciplinary workforce designed to deliver improved intensive home treatment and crisis response interventions in the community;

vi. To improve the skills for the social care workforce and their capacity to provide safe and effective person centred care in all community settings when people experience episodic mental ill health or exhibit distressed behaviours;

vii. To review current forensic LD services and identify service development needs required to improve support in the community;

viii. To engage with the NI Housing Executive and provider organisations with a view to the identification of barriers to meeting housing needs and enable the development of innovative approaches to accommodation in the short, medium and longer term;

ix. To improve the capability of current providers of supported living, housing, residential, nursing care, domiciliary care to meet the needs of people with complex needs and by doing so support family carers to prevent placement breakdown.

4. Membership & Frequency of Meetings

4.1 It is anticipated that the RLDODG will meet at least once a month, but the frequency of meeting will be kept under review, and frequency will be determined by progress being made.

4.2 The group initially will be chaired by the HSCB and PHA. Membership will include:

i. DOH LD Policy Lead; LD Nursing, LD Social Work and Medical Leads;
ii. Assistant Directors in LD within each of the 5 HSCTs;
iii. HSCB Performance Lead;
iv. PHA Assistant Director for LD:
v. HSCB Social Care Lead for LD and
vi. Director of Older People, Mental Health & Learning Disability BHSCT
vii. Nominee from NI Housing Executive

5. Operating Arrangements:

5.1 The Regional group will meet monthly.

5.2 A quorum of five members, which includes representation from five organisations, must be present before a meeting can proceed.

5.3 If members cannot attend they are requested to send a suitable nominee of sufficient seniority to represent them. E.g. Senior Manager or Co-Director.

5.4 Internal or external persons may be invited to attend a designated part of the meetings at the request of the Chair/Co-chair on behalf of the Group to provide advice and assistance where necessary.

6. Accountability arrangements:

6.1 The Regional group will be convened by the HSCB and will be responsible to the Muckamore Abbey Assurance Group (MDAG) through the MH and LD Improvement Board.

6.2 The HSCTs will provide a Report in advance of the regional meetings to the HSCB which will identify strategic issues impacting on the resettlement of patients which will inform part of the agenda for the regional meetings.

6.3 Regional group members will be expected to provide feedback to and from their own organisations on issues of strategic relevance.

6.4 Regional members will be expected to contribute to the agenda and assist with the work plan and its associated tasks.

6.5 Action points from meetings will be collated by HSCB and circulated to members.

7. Outcomes

7.1 The RLDODG will strive to ensure that the following outcomes are achieved:

i. all delayed patients have been resettled in line with the strategic direction;

ii. the recommendations of the independent investigation have been delivered on and the learning is disseminated regionally where appropriate;

iii. regional issues regarding services, systems and processes with respect to LD services are discussed and solutions agreed and delivered consistently in line with future needs.

iv. BHSCT will have delivered the specific improvements required in Muckamore Abbey Hospital.

i. HSCTs continue to deliver services that continue to be safe, effective and fully Human Rights compliant;

v. MDAG is assisted in the achievement of its objectives.

8. Review & Duration

8.1 The effectiveness of these ToRs and the membership of RLDODG will be reviewed at the first meeting and as necessary with a view to ensuring an enhanced focus on service delivery into the future.

8.2 It is intended that RLDODG will form part of the regional operational structure of LD services; ensure oversight and governance arrangements between HSCB and Trusts in NI into the future and provide ongoing advice and guidance to DOH on LD needs and service requirements in light of the new LD service model.

Regional LD Operational Delivery Group (RLDODG)
16 October 2019
The Boardroom, Muckamore Abbey Hospital, Antrim
Action Points

In attendance: Lorna Conn (chair) HSCB, John McEntee SHSCT, Margaret O'Kane SEHSCT, Alyson Dunn NHST, Sean Scullion DOH, Kelly Hilock NIHE, Michael Conway, NIHE Gary Paul NIHE, Roy Bailie NIHE, Gerard Murphy NIHE, Fiona Rowan, BHSCT Gillian Traub, BHSCT Aisling Curran BHSCT, Maire Redmond DOH, Linus McLaughlin HSCB, Deirdre McNamee PHA

By invitation: Orla Donachy (HSCB-Pals), Mary Donaghy HSCB

Via Tele link:

Apologies: Aine Morrison DOH, Christine McLaughlin WHSCT, Kieran McShane HSCB, Laura O'Neill NIHE, Elma Newberry NIHE Marie Heaney BHSCT, Alison McCaffrey DOH, Siobhan Rogan DOH, Patrice Curran WHSCT, Miceal Crilly SHSCT (replaced by John McEntee) Noel McDonald HSCB, Anne Sweeney NIHE Ian McMaster DOH

Agenda item	Discussion points	Actions agreed	By whom	By when
1. Welcome, introductions & and apologies	LC welcomed all to the meeting, noted apologies and a round of introductions took place.			
2. Action points from September Meeting	LC advised all areas are on this month's agenda and for discussion today except:- 1. The action regarding trusts confirming that people with LD had security of tenure. Assurance was already provided by SHSCT. 2. Consideration to be given to how best to involve carers and service users.	Trusts to confirm numbers of people with LD who have tenancy agreements and those with licences to occupy. LC has raised with Marie Roulston	BHSCT; NHSCT; SEHSCT; WHSCT LC	**ASAP**
3. Discussion of TOR & membership of RLDODG	Revised TOR was circulated post last meeting and LC advised of the need to have these finalised today. It was noted that BHSCT require both hospital and community staff representation.	TOR to be amended to revised regarding:- 1. Deidre McNamee is attending as co- chair on behalf of Briege Quinn from PHA 2. BHSCT to indicate who is most appropriate to attend from MAH 3. NIHE wish to	LC/All BHSCT	**25 October 2019**

Agenda item	Discussion points	Actions agreed	By whom	By when
		be included as 'in attendance' as not all of the objectives are within their responsibility Once amendments made TOR will be considered approved.		
4. Update on current position in acute Hospitals - PTL; CD & DD; Active treatment	The need to avoid duplication was agreed. Frequency and timing of these updates were discussed. It was agreed that they would be provided monthly by each of the trusts as at 1st of the month in question. Going forward the need for each trust to provide a high level update of progress for PTL since last meeting was agreed.	Existing template to be updated to include column regarding estimated costings for care package. This will be shared with the community integration team to ensure consistency. Trusts will complete monthly and the next one will reflect figures as at 1 October 2019. HSCB will produce a dashboard on PTL patients for MDAG on 30 October 2019. At subsequent meeting HSC Trusts to provide high level	LC LMCL BHSCT; NHSCT; SEHSCT; WHSCT & SHSCT LMCL BHSCT; NHSCT; SEHSCT	**Completed and circulated** **ASAP- 23 October 2019** **30 October 2019** **13 November 2019**

Agenda item	Discussion points	Actions agreed	By whom	By when
	Numbers of PTL=13 as 1 person resettled in August. 6 have planned dates for 19/20; 4 for 20/21 and 2 have no specific date. **Numbers of DD**=4 with 1 person with December discharge date and 2 with June 2020. **Numbers of CDD=38** it was noted that it is important to consider those who are in active treatment. Need for planning for need was discussed and an update provided regarding the piece of work strategic needs assessment being piloted in LD. For purposes of Action Plan where recommendations relate to only 3 trusts, the trusts will report to DOH. However, where it is relevant to all 5 trusts, all 5 will report to HSCB.	overview of progress since last meeting		
5. HSC Muckamore Abbey Action Plan	This was shared after the last meeting. LC and MR gave the context for the Action plan in terms of its origin in the level 3 SAI investigation recommendations and the Permanent Secretary's commitments in regard to MAH. Some concern expressed regarding the commitment made. However, the timescale has been communicated and the expectation is that this group will progress it. The Action Plan has been approved by MDAG but is still in draft awaiting final sign off by Richard Pengelly. Actions are	Formal request to come from DOH for return of action plan with areas of rag rating due for next MDAG meeting on 30 October. Where individual trust responses ware required, these will be submitted in accordance with timescale of 24 October.	DOH; BHSCT; NHSCT; SEHSCT; WHSCT & SHSCT; HSCB/PHA	**24 October 2019**

Agenda item	Discussion points	Actions agreed	By whom	By when
	indicated for HSC Trusts, DOH and HSCB/PHA. Action plan is owned by DOH and monthly updates are now required from all in advance of the MDAG meeting where it will be rag rating of actions will be reviewed. Discussion held regarding what each colour should indicate. It was agreed rating should be as indicated in the key at the end of plan. Extra time as requested by ADs for actions pertaining to all trusts or 3 trusts to ensure some consistency.	For collective actions, ADS will consider at their meeting on 25 October and submit consistent return to DOH. For noting DOH	DOH; BHSCT; NHSCT; SEHSCT; WHSCT & SHSCT; DOH	**To be agreed with DOH**
	AC highlighted that timescale for completion of recommendation 1 was at variance with timescales for the associated actions. This was noted but has been interpreted as the steps which are required to progress recommendation.		MR; LC & DMcN	**ASAP**
	MO'K requested that findings of Review of acute assessment and treatment be circulated. It was noted that trusts need more information about investment model for assessment and treatment as per page 5.	Status of Review findings to be ascertained and to be circulated asap to LDSM Project Steering Group; MH and LD Improvement Board & this group. Clarity to be sought regarding investments and direction of travel to be supported.	MR; LC	**ASAP**

Agenda item	Discussion points	Actions agreed	By whom	By when
6. Update - Seclusion Policy Review and adoption	No further update as this has been shared in draft and piloting and evaluation underway. Minor changes have been made and this will be presented for final approval to the policy and standards committee in BHSCT. This will take 4-6 weeks for sign off by Trust.	All Trusts to remain involved with the development and adoption of a regionally consistent seclusion policy.	BHSCT; NHSCT; SEHSCT; WHSCT & SHSCT	**Ongoing**
7. Update - Acute Pathway and criteria update on progress	The need for a regional approach was reiterated and clear criteria/thresholds to be developed. All Trusts had attended some meetings regarding this and LC was off the view that criteria had been amended and approved at AMH & LD meeting on 30 September 2019 but these do not appear to have been shared with all trusts. Once Bed Manager is appointed this will form part of their role. There was discussion regarding the essential need for enhanced community services and a clear pathway where inpatient treatment is identified as increasing there appears to be limited capacity in MAH. This is impacting on ASWs role and issues regarding risks and legality were noted as of concern. LC advised that the issue of lack of capacity was being raised formally by some of the Trusts with HSCB and PHA.	Draft criteria to be shared**.** Regional consideration needs to be given to the current capacity issue and a care pathway developed.	BHSCT/GT HSCB/PHA; BHSCT; NHSCT; SEHSCT; WHSCT & SHSCT	**ASAP** **ASAP**

Agenda item	Discussion points	Actions agreed	By whom	By when
8. Regional Bed Management	LC advised that the above issues regarding criteria, capacity and pathways should form part of the role of the regional Bed manager. LC asked for an update on process of the appointment and reiterated that the funding was in-year until March 2020 and it needs to be utilised asap. The investment also includes 0.5 Band 3 admin support. FR advised JD drafted but being reviewed by nursing colleague. This post holder will be located within BHSCT and will assist with development of a care pathway and criteria as well as facilitate essential admissions across and between all 3 LD hospitals. There was some discussion regarding whether it would be possible to attract staff for this short period and whether investment could be rolled over but LC advised that current post needs to be filled and be seen to be working well before any case could be made for further investment.	Follow up required regarding progress on this appointment by JD to be shared with the other trusts for information. Expression of Interest process to be expedited.	FR FR	**ASAP** **31 October 2019**
9. Procurement	Following one from the last meeting Donna Morgan had shared a service specification previously developed in 2014 for supported living services. This work had made good progress but had not been fully operationalised as legislative change	OD to produce an options paper to be tabled at the next meeting. NIHE colleagues to discuss this concept	OD KN	**13 November 2019**

Agenda item	Discussion points	Actions agreed	By whom	By when
	would have been required. This was discussed and was considered to be very helpful for the development of a framework with which to focus a procurement of services. HSCB is considering focusing on small pieces of social procurement phased over the next 3-5 years and is proposing to start with services for people with LD and forensic needs, followed by services for people with LD and autism and then LD and complex physical health needs. OD outlined the commitment and time required to produce a robust procurement. There was agreement that this would the way to proceed but that there would be a number of ways including joint/combined commissioning with NIHE and that organisations might not be in a position to engage with a combined process at this time. There was discussion regarding the possible use of voids and how this might be progressed fir resettlement.	with colleagues and feedback to the next meeting. It was agreed that trusts and NIHE would discuss current voids to ascertain where there is capacity to utilise these for service users.	BHSCT; NHSCT; SEHSCT; WHSCT & SHSCT, NIHE	**13 November 2019**
9. Forensic Needs and Scoping	Under a transformation project in HSCB, which is funded until March 2020, Noel McDonald is currently conducting a scoping of need including those with LD. Noel was invited but is off on leave so Mary Donaghy from HSCB kindly attended to provide detail regarding this aspect. Mary provided a paper at the meeting to inform the group	Network would welcome membership from NIHE. This group will keep in contact with the Network Manager. Noel will attend to provide an update.	MD/LO'N LC/MD/NMCD LC/MD/NMICD	**By next meeting** **Ongoing** **February 2020**

Agenda item	Discussion points	Actions agreed	By whom	By when
	regarding the work of the Forensic Managed Care Network. (attached) The role of this network is to bring regional consistency to and act as a conduit for data collection, service provision and accommodation regarding forensic population. Work being undertaking by Noel as network manager will be very helpful for LD generally and the procurement process in particular and could be linked to the strategic needs assessment.			
10.Provider Engagement re: capacity	Action from the last meeting was to seek the collated feedback regarding LDSM work with providers from Heather McFarlane, HSCB. LC advised that having reviewed this it had focussed more the specific themes of the LDSM and generic challenges such as the need for a workforce planning and upskilling. LC asked OD if engagement at this point would impact on procurement process. OD advised that engagement for procurement would be treated as distinct from an engagement regarding capacity issues now and a very specific process would be indicated. ADs are meeting at the end of this month to consider issues regarding quality of current service delivery and collating across trusts. Issues relate to quality but also staff capacity and resilience.	Trusts to advise HSCB of collation of issues re providers HSCB/PHA to convene a separate meeting with ADs regarding building provider capacity.	BHSCT; NHSCT; SEHSCT; WHSCT & SHSCT LC/DMCN	**Post 25 October 2019 and before 13 November 2019** **13 November 2019**

Agenda item	Discussion points	Actions agreed	By whom	By when
	It was agreed that it would be very helpful to have a regional perspective on this and HSCB will assist with this.			
10. AOB- Resettlement housing options	**1**. DOH requested specific information and discussion regarding the 2 current business cases pertaining to forensic patients to be resettled from Muckamore. These have been given approval to proceed to full business cases and it was noted that NIHE assistance had proved very helpful in assisting with this. Full business cases are due to be presented by BHSCT at end of November 2019 to Strategic Advisory Board. It was noted that there had been changes to the original outline proposals due to recent levels of assessed need. Discussion occurred regarding queries and funding aspects of same. MOK advised 3 trusts are meeting to draft an options appraisal to inform business cases. **2**. DOH requested specific detail regarding development of Mallusk site for PTL patients. 3 Trusts are working closely regarding Mallusk. Concern was raised by AD regarding affordability in the future if there are any vacancies. For current cohort NIHE had agreed to pay housing	Trusts to provide update on PTL patients at next meeting.	BHSCT; NHSCT; SEHSCT;	**13 November 2019**

Agenda item	Discussion points	Actions agreed	By whom	By when
	benefit at the necessary level but longer term sustainability needs to be considered as without this level of housing benefit support, the rents would not be affordable. It was agreed that this was a solution to the current circumstances but that caution was required to using this as a more generalised approach to housing for people with LD. AD advised that at the moment, only 3 people from NHSCT had no distinct date as she was pursuing private sector accommodation. NIHE offered assistance regarding where voids may exist which could be help.	Trusts to quantify the numbers and needs and bring to the next meeting in order that conversations can occur to explore what solutions could be sought with respect to existing vacancies in the housing provision.	BHSCT; NHSCT; SEHSCT; WHSCT & SHSCT	**13 November 2019**
	3. LC circulated a copy of the SIT report which the Directors of MH & L have been asked to complete on a monthly basis.	LC to insert column regarding those offered an admission to a MH ward.	LC	**ASAP**
	4. A discussion took place regarding housing benefit and several queries were raised.	A slot for Gerard Murphy on Housing Benefit and specific queries to be tabled at the next meeting.	LC / GM	**13 November 2019**
		Assistant Directors to bring queries to the next meeting.	BHSCT; NHSCT; SEHSCT; WHSCT & SHSCT	**13 November 2019**

Agenda item	Discussion points	Actions agreed	By whom	By when
11. Date of next meeting:	Muckamore as a venue was agreed. Next meeting was noted 13 November 2019 from 10-12pm. **December 2019 meeting**- LC had circulated to ask if 9th December suited rather than 17/18 December. This will allow better alignment with MH & LD Improvement Board and MDAG meetings in December 2019.	BHSCT to check if Muckamore is available and book. Date will be recirculated and if members could indicate their availability if they have not done so previously.	FR LC	**ASAP** **ASAP**

Glossary Summary

MH Mental Health

LD Learning Disability

PTL Primary Target List

CD Complex Discharge

CDD Complex Delayed Discharge

MAHI - STM - 097 - 10058

Regional LD Operational Delivery Group (RLDODG)

21st April 2021 11:30-1 via zoom

Action Notes

Present:

Apologies:

Lorna Conn (Chair)	Lyn Preece SET	Aine Morrison DoH
Laura O'Neill NIHE	Ann Stevenson BT	Linus McLaughlin HSCB
Sean Scullion DoH	Siobhan Rogan DoH	Roy Baillie NIHE
Maire Redmond DoH	Tracy Kennedy BT	Clayre Thompson BT
Deirdre McNamee PHA		Ian McMaster DoH
Mary Bell Expert by Experience		Kieran McShane HSCB
Pauline Cummings NT		
John McEntee ST		
Christine McLaughlin WT		

In attendance: Gabrielle Scott HSCB

Next meetings: All will occur at 11:30am- 1pm

19th May

24th June

21st July

18th Aug

22nd Sept

20th Oct

17th Nov

22nd Dec

Agenda Item	Discussion Points	Actions Agreed	By Whom	By When
Welcome, introductions and apologies	LC welcomed all to the meeting and noted apologies. A round of introductions took place. It was noted Aine Morrison would no longer attend the meeting as Maire and Sean could report back any issues and actions	Remove Aine from distribution list	GS	Next meeting
Matters Arising: Action points from last meeting	• **Business Cases** Update- Langthorne Mews business case was returned to BT with finance queries and it will be returned to NIHE. Rushy Hill Knockcairn- monthly project meetings set up for discussions re: this business case. This will be presented for the SAB meeting in Sept as deadline missed for July. It was noted the provider has yet to identify a site. Dympna Mews- Tracy to get a further update An outline case has been developed for Meadowburn but it is very early days. **Bed Manager Post** Tracy advised BT will not be progressing unless a funding stream is identified. • **BILD Strategic Framework Zoom**	Update on progress of Dympna Mews at next meeting	TK/BHSCT	

Agenda Item	Discussion Points	Actions Agreed	By Whom	By When
	Lorna updated the group that the meeting went ahead and work is ongoing to put a plan in place to move forward. There is a lot of learning from the Welsh model. Siobhan Rogan had also attended the meeting and she had a further conversation with Mark Lee re: a nomination from Education to be part of the group to ensure the PBS model is used across all sectors. It was noted 2 names were put forward from Education. .	Pick up with Kieran re: Children's framework as per action from last meeting	GS/LC	
	• **Mallusk** At the last meeting Ann had advised she had visited the Mallusk site and could share photos to the group. Pauline stated she had a draft brochure that she could share with the group. They are on target for opening late May/early June for resettlement from MAH and a young person transitioning from SET. Pauline is planning to visit the site and she extended the invitation to the group for anyone who wishes to visit. There have been challenges in recruitment and Inspire have been proactively trying to recruit. Deirdre asked if nursing staffing is being supplied by NT. Pauline advised the Trusts who place will follow the care. Siobhan asked if healthcare needs will be met in the community and if there is a need for additional resource.	 Mallusk Information For Families and Care Send through to Pauline if you intend to visit the Mallusk site	ALL	

Agenda Item	Discussion Points	Actions Agreed	By Whom	By When
	Pauline noted that this would be required in the longer term. Initially Trusts will provide the care but community services will need to be considered and the building of community infrastructure. Pauline noted the Trusts have learnt a lot from this process (re: DLS, governance etc) which will be applied to any future developments.			
Update on current position in acute hospitals- PTL CD &DD ; Active treatment	**BHSCT-** Currently 16 patients in MAH 1 person has been identified for Mallusk and due to move Aug 2021 2 identified for Bradley court- 1 due to move next week and the other in June 2021. 6 pts identified for The Mews 2 and date set for June 2023 pending the business case. 3 have had their full assessments completed. 1 Identified for Cherryhill- delays due to CCTV discussion- once resolved this should move quickly. (June 2021) 3 identified for the Knockcairn forensic site pending the business case (2023) the assessment have been completed. 2 identified for the onsite proposal (1 also has a parallel plan via the business case) 2 on trial leave under Article 15. These have been successful transitions- no formal discharges pending court cases.			

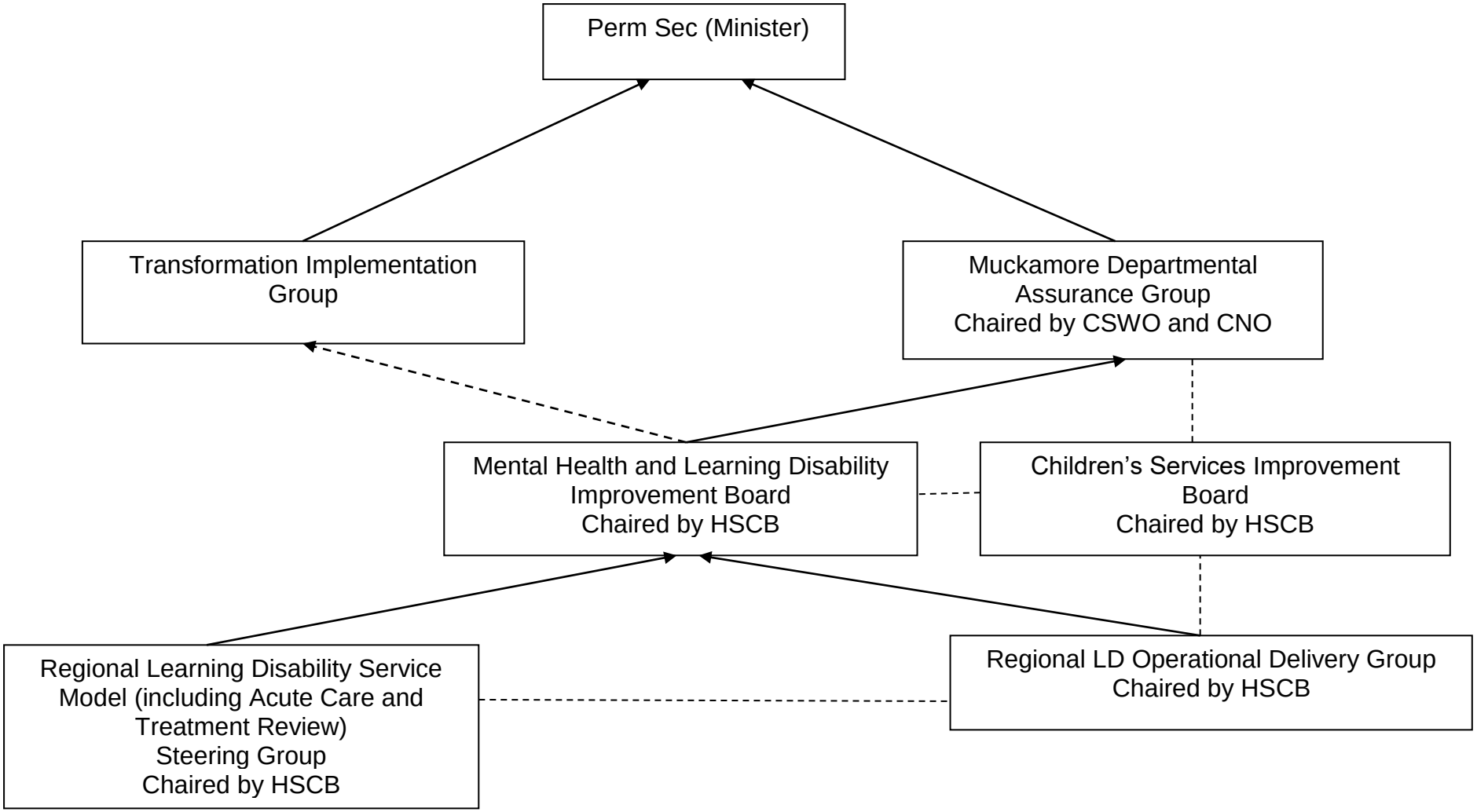
Agenda Item	Discussion Points	Actions Agreed	By Whom	By When
	John asked if the ST patient meets the criteria for the onsite proposal. Issues include the pt has a significant forensic background. Ann advised there is another internal meeting planned re: this patient and she will update further following this meeting. Tracy noted that any onsite proposal will be different to what is provided on MAH site. **SEHSCT-** 8 pts currently in MAH 1 of which is at home on trial so 7 pts on site. 2 Identified for the Knockcairn site pending b/c 1 identified for Mallusk 1 identified for Mencap scheme 2 identified for the onsite proposal but resettlement has been identified for 1 of these pts with inreach going on from July/August 2021 1 pt who has no plan in place. Engaging with providers. They don't meet the criteria for the onsite proposal but would benefit from staying onsite. **NHSCT-** 20 pts in MAH- 4 PTL, 2 DD, 12 CD and 1 in active treatment. Also 1 in Lakeview and 1 in Holywell which are both very bespoke. 1 on trial leave since Nov 2020 into WT			

Agenda Item	Discussion Points	Actions Agreed	By Whom	By When
	5 pts identified for Mallusk- 2 DD and 3 CD (May/June 2021 timeframe) Accommodation secured for 1 PTL with Positive Futures 1 DD identified for the Fairway Scheme in Coleraine- there are issues re: staffing 1pt identified for Cherryhill (late 2021) 8 pts who need placements identified. 1 pt identified for onsite proposal NT have a meeting with a provider re: plans for Brayfield which will be an extension on the Mountview residential home. This will be either supported living or residential- not nursing. **SHSCT-** 10 pts in Dorsy 1 on trial leave 5 voluntary admissions 4 detained. 1 formal delayed discharge. All patients need highly specialised accommodations **WHSCT-** No one in attendance to update on position in WT.	Provide update via email	WHSCT	
HSC MAH Action Plan & Muckamore Abbey	Sean noted that they have summarised the updates from the action plan and will be presented at MDAG next week. It was noted			

Agenda Item	Discussion Points	Actions Agreed	By Whom	By When
Departmental Assurance Group (MDAG)	the no. of red actions have increased. Maire noted that families have requested the onsite proposal be listed on the next MDAG agenda. She is very aware of the concerns re: public message around this. Maire and Sean thanked colleagues for sending through information to inform and support MDAG.			
AOB	No other business noted. Mary Bell commented it was a very positive meeting and she was happy there appeared to be links between education and health again. Next meeting: 19th May @11:30am	Invites circulated		

MAHI - STM - 097 - 10065

Muckamore Abbey Hospital HSC Response – Draft Governance Structure



Independent Review of the Learning Disability Resettlement Programme In Northern Ireland

Bria Mongan & Ian Sutherland

July 2022

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Acknowledgements

The review team completed significant engagement and received considerable documentary evidence from a wide range of stakeholders and wish to acknowledge and thank those who so kindly shared their expertise.

The review team would like to thank all those who gave so generously of their time to meet with them and contribute to the review most especially the individuals and family carers who have lived experience of resettlement. The richness of their advice and experience has informed our findings and recommendations.

Learning disability care providers from across the voluntary and independent sectors shared their knowledge as system experts with the review team.

The review team benefited from a site visit to MAH and valued the opportunity to meet with patients and ward staff

The directors in each of the HSC Trusts and their senior management teams actively engaged and supported the work of the review team providing documentary evidence and assisted in the identification of the barriers and challenges that need to be addressed to expedite resettlement.

Staff from DoH, SPPG /HSCB also provided considerable documentary evidence, advice and support.

The HSCB/SPPG provided technical and secretarial support and the review team would particularly wish to thank Patricia Elliott for her technical expertise in the production of the report and Caroline McGonigle for her support throughout the fact finding process of the review.

1. Executive Summary

1.1 In October 2021 the Health and Social Care Board (HSCB) commissioned two experienced senior leaders in health and social care to undertake an independent review of the learning disability resettlement programme in Northern Ireland, with a particular focus on the resettlement from Muckamore Abbey Hospital (MAH), which is a specialist learning disability hospital managed by the Belfast Health and Social Care Trust (BHSCT) but located outside Antrim.

1.2 The purpose of the review built on a stated intention from Department of Health and HSCB to strengthen the existing oversight arrangements for the resettlement of patients from MAH and other learning disability hospitals whose discharge plans have been delayed. The review team were required to work with stakeholders to identify both good practice and overarching vision, as well as barriers, and to develop an action plan to ensure that the needs of the patients are being considered and are met. The review was to include consideration of the effectiveness of planning and delivery for the proposed supported living and alternative accommodation schemes which were in development to support the resettlement plans for these individuals.

1.3 There is a strong legislative base and policy framework, although the policy and strategy relating to services for people with learning disabilities/ASD and their families is in urgent need of updating, and this is currently being reviewed. An overarching vision for learning disability services in the 2020's would allow stakeholders to agree a Learning Disability Service Model, which would guide commissioners and providers towards the development of better integrated, community orientated services which will deliver stronger outcomes for people with learning disability and their families. This policy will need to consolidate the outstanding ambition that no-one will live in a specialist learning disability hospital and that hospital will focus on its primary function of offering assessment and treatment only for those people for whom this cannot be made available within a community setting.

1.4 Leadership and governance with regard to the resettlement programme in Northern Ireland has been less than adequate. Progress and momentum to deliver homes outside of hospital for the remaining cohort has been slow. There were a number of confounding factors that impacted directly on progress. The global pandemic had a massive impact on the capacity and capability of leadership teams to maintain momentum on 'business as usual' priorities, as a determined focus to tackle ovid was required. Similarly during the same period the impact of MAH being identified at a national level as a hospital where patients had not been well safeguarded meant that the operational day to day logistics of maintaining safe practice in relation to sufficient and stable staffing was a significant challenge in itself. Additionally, there has been an extended period of

significant organisational change as the regional commissioning functions previously undertaken by the Regional HSCB were 'transitioned' back within the DoH under the Strategic Planning and Performance Group, with the new arrangements coming in to effect from the 1.4.22. in order to strengthen the focus on system wide performance management. Whilst these and other factors impacted directly on the progress of resettlement and offers something in way of mitigation for the poor progress of resettlement plans, it does not satisfactorily explain why some Trusts made negligible progress, but for others consistent stepped change was achieved.

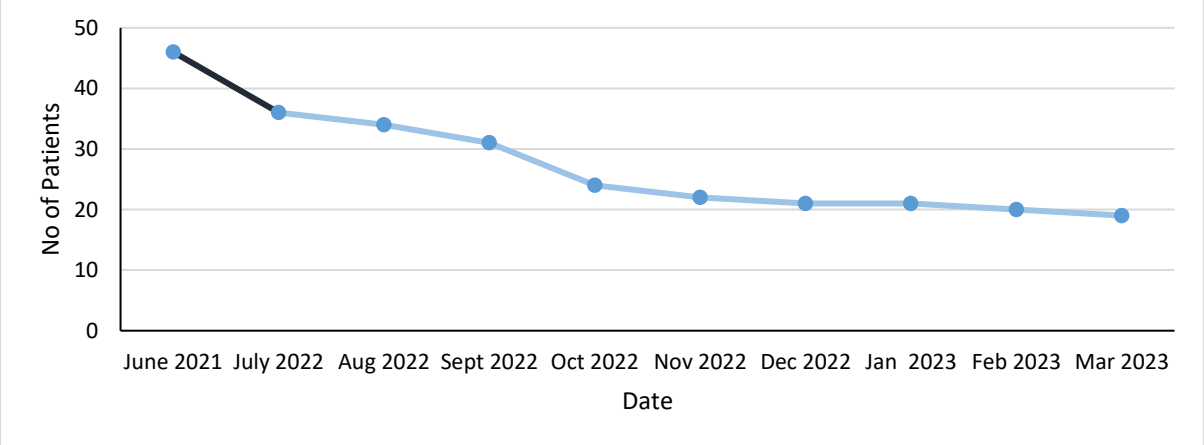
1.5 The BHSCT which managed MAH, had a significant challenge to balance the dual responsibility of rapidly improving quality and safety within the hospital, whilst maintaining progress on resettlement for those patients. This balance was not achieved, and the focus shifted away from resettlement to crisis management of MAH. The Trust Board were reassured by the executives that there were plans in place to support the resettlement of these individuals, whereas better scrutiny of the assurances provided would have shown this not to be the case, and that the plans were not robust. Arrangements in BHSCT were further hampered by significant changes in the leadership team for LD services. Other Trusts responsible for resettlement of patients from MAH had made more progress in the development of new services, although the delivery had been slower than hoped with delays relating to building over-runs and recruitment difficulties. The HSCB had made efforts to support regional co-ordination of the resettlement programme, but these were not effective in delivery of a well-co-ordinated programme plan. In particular the HSCB was not good enough in terms of performance management of the resettlement programme which amounted to little more than performance monitoring. We saw some strong leadership by individuals both in the statutory and non-statutory sectors, and whilst the rhetoric was of a robust commitment to collaboration there was little evidence of strong partnership working. In terms of leadership around the delivery of schemes in most cases management grip was weak and this contributed significantly to drift and delay. The voices of people who required resettlement and their families were not well heard within this process and they did not feel that they were empowered or engaged in the process at all levels. Opportunities to learn from their expertise by experience were missed.

1.6 Strategic commissioning and inter-agency working were supported by a clear and explicit strategic priority being identified around resettlement and workforce development in the 2019/20 commissioning plan. The Northern HSC Trust and South Eastern HSC Trust had response plans that were proactive and generally well progressed, but the BHSCT plans failed to progress beyond the preliminary stages. The lack of either effective programme or project management meant there was no over-arching, costed plan. Trusts were planning in relative isolation and communication of joint arrangements was inadequate. Generally there was

a tendency by Trusts to initiate new developments without fully exploring whether there was some existing provision within the market that could meet some of the identified need, even if this required some re-design or re-purposing of provision. The new build options, whilst being bespoke, were generally costly in terms of capital and revenue, and resulted in long lead in time to delivery. There was limited evidence of senior engagement with the independent social care sector as strategic partners as well as providers, and therefore market shaping was not evident.

1.7 The review team looked at the approach being taken to individualised care planning. There was a lack of consistency in the documentation used to support care planning for transition from hospital to community, and nor was there an agreed regional pathway for resettlement, which should map out roles and responsibilities within the process. Families and providers both commented that they felt only involved in a limited way in developing assessments and care plans. Of the remaining patients awaiting discharge almost a quarter had been in MAH for more than 20 years and one person for more than 40 years. About a third of this group had also had one or two previous trials in community placements, although there was little evidence of how lessons were learnt from these unsuccessful moves. However, in the 12 months from June 2021 to June 2022 the population in MAH awaiting resettlement had reduced by 20%, and the trajectory of future resettlements by NHSCT and SEHSCT should mean that between September 2022 and March 2023 the population will reduce by a further approximately 50%, leaving around 19 people in MAH awaiting resettlement.

1.8 Whilst progress at the beginning of the review had been slow HSC Trusts have recently reviewed their approach to consider alternative options that have potential for more timely discharge. The review team were pleased to see that this has improved the resettlement trajectory which anticipates that the population will reduce to between 15 and 19 by the end of March, 2023.



1.9 A key element of the review was the operational delivery of provision to meet the needs of this cohort and the wider LD population. There is an impressive range of provision across registered care and supported living settings providing approximately 2,500 places for people with LD in the community. There was a tendency of commissioners and resettlement teams to not engage with providers to consider potential existing opportunities, although this has changed in recent months. The overall trend within supported living schemes is to smaller size provision, with the largest number of schemes offering 3 places. The biggest single issue and risk facing the range and quality of the provision was workforce, and the DoH are now sponsoring work regionally to try to address this challenge which will report in 2023. The quality of care within the independent sector is regulated and inspected by RQIA, and the overall quality is good. There is some very innovative practice emerging within the independent sector, with a strong commitment to the use of Positive Behaviour Support (PBS) models, with some examples of transformational care being provided to individuals in their own new homes. Where provision was strongest there was a strong partnership between providers and local HSC Trust commissioning/care management and clinical services, so that individuals had access to a wide range of highly responsive services.

1.10 The Trust's commissioning of schemes of registered care provision to meet their respective resettlement cohorts was variable. The NHSCT and SEHSCT demonstrated a more proactive and consistent approach to planning of this provision, and consequently have reached a stage where 2 substantial new care settings, along with some smaller scale provision will over the next 6 months provide new homes to approx. 80% of their remaining MAH residents. The BHSCT have over the last 3 years been scoping 3 potential new schemes, but these have never got beyond the most preliminary stages of planning. The review team are more encouraged that the new leadership group responsible for LD within that Trust are now considering other options, including some existing provision which could have the potential to be rapidly re-purposed. In general, and at variance with statements that the Trusts have a learning culture, there has been little rigorous evaluation of the successes and failures within the resettlement programme. The review team heard a rich tapestry of stories from families about their lived experience, and this should form the basis of some qualitative work, but in addition there should be some review of the clinical and social benefits derived by people who have gone through resettlement.

1.11 For families, safeguarding continues to be an abiding concern, which is overshadowed by a loss of trust and confidence in MAH and health and social care systems more generally. The oversight of adult safeguarding will be strengthened when the new adult safeguarding arrangements come in to place, and it is encouraging that an Interim Adult Protection Board (IAPB) was established in 2021. There continue to be issues of concern in relation to the use of physical intervention, and surveillance by CCTV, and for the families the review team met, how these are addressed in community settings is central to the success of placements. There is a need for further consultation with

individuals, families and providers to inform regional policies on these important areas moving forward. Family members were clear with the review team that after community placement they would continue to play a key role in assuring and ensuring the safety of their relative, and therefore wanted to see open and flexible access to care environments. Care providers were clear about safeguarding responsibilities but expressed a concern that they experienced considerable variation in the application of thresholds in relation to investigation of safeguarding concerns, and families expressed concern that in some situations investigations were not progressed in a timely fashion.

1.12 Families were an incredibly rich source of evidence to the review team, and their lived experience tells a tale of both success and failure. The full report includes aspects of these accounts. The review team strongly believe that individual families need to be at the centre of these processes and fully engaged within all aspects of the resettlement, but they also need to be able to influence policy and strategy so that their expertise by experience can inform best practice. The review team were struck by the extent to which trauma and distress featured within the experience that was shared, and that all of the professionals working with these individuals and families need a good understanding of trauma informed practice. Trusts were all considering and developing their advocacy and other supports for individuals and families, and they need to further consider how they can put in place opportunities to ensure better communication and engagement and opportunities to organise carer support events such as group gatherings.

2. Terms of Reference

2.1 Terms of Reference: The terms of reference for the review were agreed with the HSCB and DoH, after consultation with senior leaders in learning disability services from the 5 HSC Trusts.

2.2 Purpose of Review: The purpose of the review built on a stated intention from DoH and HSCB to strengthen the existing oversight arrangements for the resettlement of patients from MAH (MAH) and other learning disability hospitals whose discharge plans have been delayed. The review team were required to work with stakeholders to identify both good practice and barriers and develop an action plan to ensure that the needs of the patients are being considered and are met. The review was to include consideration of the effectiveness of planning and delivery for the proposed supported living and alternative accommodation schemes which were in development to support the resettlement plans for these individuals.

2.3 The review team were to work collaboratively with stakeholders, with the commitment of the Chief Executives and the Directors, engaging appropriately with relevant staff, agencies, families and service users.

2.4 Timescale: The timetable for the work was to take place over a 6 month period which began in effect in November 2021.

2.5 The Review Team were required to give particular consideration of the current care plans for all the service users in MAH and critically analyse the actions taken to identify and commission suitable community placements. In addition they were asked to look specifically at the following areas:-

- Length of time patient has been in MAH and where they were admitted from
- Ascertain if resettlement has already been trialled
- Summarise the policy and practice evidence base in relation to resettlement programmes.
- Identify those individuals where plans are absent or weak in relation to their resettlement
- Work with leaders in the appropriate Trusts to ensure that suitable resettlement plans are developed.
- Critically evaluate the progress of resettlement plans as devised by the responsible Trust for the identified individuals.
- Business cases which have been completed or are still in process identifying any positive outcomes and any strategic or operational barriers. Make recommendations for actions that would strengthen or accelerate the delivery of proposed pipeline schemes.

- Review to what extent the engagement strategies employed individually by Trusts, and collectively by the system as a whole have been effective in supporting the delivery of the MAH resettlement programme.

2.6 Inter-Agency Working : The review team were asked to consider whether/how the agencies and professionals involved in resettlement of patients, have worked effectively with each other at each and every stage of the process.

2.7 Parental/Carer Engagement/Advocacy: The review team were also asked to consider as a critical factor whether and to what extent the families of the patients were engaged in decision making around resettlement. In this context the review team were also asked to explore whether and to what extent, independent advocacy and support was provided.

2.8 Outside of Scope: Whilst there are Issues relating to children and young people with learning disability/Autism who may be subject to delayed discharge in other settings, this population were not included within the terms of reference for this review.

3. Methodology

3.1 The HSCB in appointing the review team intended to ensure that an objective, critical appraisal was undertaken of the existing programme of resettlement for individuals with learning disability/autistic spectrum disorder with a primary focus on the remaining population of people who were awaiting discharge from MAH to new homes.

3.2 The review team decided to adopt an approach for the review based on 'appreciative inquiry' (1) this is a strengths-based positive approach to leadership development and organisational change. This approach seeks to engage stakeholders in self-determined change, and incorporates the principle of co-production.

3.3 By adopting this approach the review team were both 'observers' of the system and how it was delivering the required outcomes for people identified for resettlement, but also as 'agents' by helping to seek solutions that would assist key stakeholders to improve the resettlement programme in Northern Ireland.

3.4 The review team adopted the following methods to progress the key lines of inquiry:

- Direct observation and participation in key processes
- Direct interviews with a wide range of stakeholders
- Gathering and analysing data relevant to the resettlement process
- Focus groups – both face and face and digital engagement.

3.5 The initial engagement with the statutory health and social care agencies was through the leadership meetings established by the HSCB to develop and oversee the delivery of effective services for people with a learning disability/ASD. This included the Learning Disability Leadership Group comprising the senior social care leaders from the HSCB, the 5 Trust Directors of Mental Health and Learning Disability Services, along with representation from the DoH and RQIA. Additionally the review team participated in a range of operational and strategic meetings with programme leads for learning disability services within the HSCB and HSC Trusts. Some of these processes were inter-agency and included NIHE representation.

3.6 The review team sought data and documentary evidence from a wide range of organisations including the DoH, HSCB, the 5 HSC Trusts, NIHE, RQIA and other agencies. Information was sought through direct requests and through questionnaire response.

3.7 The review team held an extensive range of engagement sessions with a range of external stakeholders. This included the following:

- Northern Ireland Housing Executive - NIHE
- Regulation and Quality Improvement Authority – RQIA
- Northern Ireland Social Care Council – NISCC
- Patient and Client Council – PCC
- Royal College of Psychiatrists – NI/Learning Disability Division - RCPsych
- ARC Northern Ireland
- Independent Health Care Providers [NI) – IHCP

3.8 The review team felt it was of primary importance that the lived experience of individuals with learning disability/ASD and their carers/families who had been engaged in resettlement had to be well represented within the review. They met with individuals and groups of carers who had either been through or were still going through the resettlement process. This provided some of the richest detail of how the system was working, or not working, for people who wanted to have the opportunity to live in a setting outside of hospital with as much independence as possible.

4. Legislative, Strategic and Policy Context.

In this section we will critically evaluate the legislation and strategic policy across England, Scotland, Wales and the Republic of Ireland to identify models of good practice in reducing delayed discharge patients and preventing hospital admission.

4.1 MAH opened as a regional learning disability hospital in 1949 and by 1984 the in-patient population had grown to 1,428.

4.2 The scale of resettlement between 2007 and 2020 was significant, with reduction in the population at MAH to 46 patients by June 2021. During the period of this review, the Muckamore Abbey population has reduced further to 36 in-patients by July 2022. It is encouraging that further discharges have been achieved however, 10 of the delayed discharge population are from the original Priority Target List (PTL), which relates to patients living in a long stay learning disability hospital for more than a year at 1st of April, 2007, and have been discharge delayed between 16 and 45 years. The impact of institutionalisation for a small number of long-stay patients has been a barrier in transitioning to the community. The complexity of need and range of co-morbidities of recent admissions many of whom have been impacted by previous community placement breakdown, has made discharge particularly challenging. However, the review team visited community resettlement schemes successfully supporting individuals with very complex needs equivalent to the needs of those people delayed in discharge. These examples of good practice highlight that the models of care and support required to build sustainable community placements for individuals with complex needs are already operational in Northern Ireland and the success factors need to be scaled up and embedded in commissioning and procurement processes.

4.3 The pace of progress in relation to finding new homes in recent years has been disappointing, with an increasing number of judicial reviews progressed by patients or their family carers in regards to the failure of HSC Trusts to commission an appropriate community placement for people delayed in hospital. Legal judgements have highlighted that delayed discharge breaches are incompatible with obligations pursuant to section 6 of the Human Rights Act 1998. (Ctrl Click) and Article 8 of the European Convention on Human Rights (Ctrl Click)There is therefore an ethical, strategic and legal imperative to complete resettlement.

4.4 The policy direction in Northern Ireland and Great Britain changed in the 1980's and from that time there have been a series of targets set to reduce the number of in-patients in Learning Disability hospitals and develop resettlement options.

However, targets and deadlines for achieving this have been missed, ignored and repeatedly reset.

4.5 The 1992/97 Department of Health and Social Services (DHSS) Regional Strategy,' Health and Wellbeing into the New Millennium'[1] established a commitment to reduce the number of people admitted to traditional specialist hospitals and a commitment that care should be provided in the community and not in specialist hospital environments. In 1995, a decision was taken by the Department of Health and Social Services to resettle all long-stay patients from the 3 learning disability hospitals in Northern Ireland. The target set by the Regional Strategy for the resettlement of all long-stay patients from learning disability hospitals by 2002 was not met.

4.6 The 2002 Bamford Review of Mental Health and Learning Disabilities represents the key strategic driver shaping delivery of services for individuals with learning disabilities and or Autistic Spectrum Disorder (ASD) over the past 25 years.

4.7 The second report from the Bamford review 'Equal Lives' published in 2005 sets out a compelling vision for developing services and support for adults and children with a learning disability. Equal Lives concluded that progress needs to be accelerated on establishing a new service model, which draws a line under outdated notions of grouping people with a learning disability together and their segregation in services where they are required to lead separate lives from their neighbours. The model of the future needs to be based on integration, where people participate fully in the lives of their communities and are supported to individually access the full range of opportunities that are open to everyone else. This will involve developing responses that are person centred and individually tailored; ensuring that people have greater choice and more control over their life; that services become more focused on the achievement of personal outcomes, i.e., the outcomes that the individuals themselves think are important; increased flexibility in how resources are used; balancing reasonable risk taking and individuals having greater control over their lives with an agency's accountability for health and safety concerns and protection from abuse.

4.8 The Bamford review 'Equal Lives' published in 2005 (ctrl click) included a target that all people with a learning disability living in a hospital should be resettled in the community by June 2011. A priority target list (PTL) of those patients living in a long stay learning disability hospital for more than a year at 1st April 2007 was established to enable monitoring of progress on the commitment to resettlement of long-stay patients. In 2005, the Hospital had 318 patients and a target was set to reduce to 87 patients by 2011.

[1] *Health and personal social services: a regional strategy for Northern Ireland 1992-1997.*

4.9 'Transforming Your Care' was published by the Minister for Health in 2011(ctrl click) which further strengthened the commitment to close long stay institutions and complete resettlement by 2015. A draft Strategic Implementation Plan was developed to drive forward the recommendations in terms of learning disabilities with a focus on resettlement, delayed discharge, access to respite for carers, individualised budgets, day opportunities , advocacy and Directly Enhanced Services (DES) Whilst this resulted in the development of additional community services the resettlement target was again missed.

4.10 DHSSPS Service Frameworks aimed to set out clear standards of health and social care that service users and their carers can expect. They are evidence based, measurable and are to be used by health and social care organisations to drive performance improvement, through the commissioning process. The Service Framework for Learning Disability was initially launched in 2013 and revised in January 2015 (ctrl click). It sets out 34 standards in relation to the following key thematic areas; safeguarding and communication; involvement in the planning and delivery of services; children and young people; entering adulthood; inclusion in community life; meeting physical and mental health needs; meeting complex physical and mental health needs; a home in the community; ageing well and palliative and end of life care. The standards provide guidance to the sector on how to: improve the health and wellbeing of people with a learning disability, their carers and families, promote social inclusion, reduce inequalities in health and social wellbeing and improve the quality of health and social care services, by supporting those most vulnerable in our society.

4.11 RQIA Review of Adult Learning Disability Community Services Phase II October 2016 (ctrl click) reviewed progress made by the 5 Health and Social Care (HSC) Trusts, in the implementation of 34 standards, relating to Adults with a Learning Disability in the Department of Health (DoH) Service Framework. The review found that none of the 5 community learning disability teams in HSC Trusts demonstrated an evidence base for the model of service configuration they have put in place. The RQIA review concluded that community services have developed more as a result of historic custom and practice in each Trust area, with little sharing of practice noted regionally regarding models of care used by each team. It was difficult for the review team, therefore, to effectively compare and contrast the models of service provision across Northern Ireland. The RQIA review found that there is no agreed uniform model for behavioural support services across the 5 Trusts.

4.12 This review team noted that these findings still apply. Community services are at different stages of development in each of the 5 HSC Trusts and the terminology used to describe similar services varied across HSC Trusts which makes it

difficult to compare and contrast services. It is still of concern that there is no agreed model for behavioural support services. Each Trust and care provider organisation have adopted differing accredited programmes with training programmes available only on licence which limits the portability of staff working flexibly across HSC Trusts and the independent sectors. It is of note that consideration was given by a HSC Trust to deploy Trust staff to supplement the care provider workforce to expedite a resettlement however, the barrier to this innovation was that the staff in the Trust and staff in the provider organisation had been trained in different therapeutic interventions and could not work in the same team unless re-trained. It is critical that standardisation of positive behaviour approaches and therapeutic intervention methodologies is considered to maximise collaboration and enable mutual aid at times of crisis.

4.13 'Systems, Not Structures – Changing Health and Social Care' (The Bengoa Report) (DoH, 2016) (ctrl click) Guided by 'The Triple Aim': to improve the patient experience of care (including quality and satisfaction); improve the health of populations and achieve better value by reducing the per capita cost of health care. The report provides a succinct transformation model relevant and useful in the development of the learning disability service model and driving the system towards Accountable Care Systems with the provider sector taking collective responsibility for all health and social care for a given population.

4.14 Health and Wellbeing 2026 – Delivering Together (DoH, 2017) (ctrl click) is the policy response to the Bengoa Report and aligns to Draft Programme for Government with increasing focus on outcomes.

4.15 The emergence in 2017 of allegations of abuse at MAH, resulted in an independent Serious Adverse Incident (SAI) review of safeguarding practices between 2012 and 2017 at MAH. The SAI report exposed not only significant failings in the care provided to people with a learning disability while in hospital and their families, but also gaps in the wider system of support for people with learning disabilities.

4.16 The final 'Way to Go' report (ctrl click) was shared with key stakeholders in December 2018 and a summary of the report was published in February 2019. This resulted in a further public commitment to the families of MAH patients by the DoH Permanent Secretary in 2018 that patients delayed in discharge would be resettled by December 2019. This commitment has not been met.

4.17 The DoH established a Muckamore Departmental Assurance Group (MDAG) to provide assurance in respect of the effectiveness of the Health and Social Care System's (HSC) actions in response to the 2018 independent Serious Adverse Incident (SAI) review into safeguarding at MAH and the Permanent Secretary's subsequent commitment on resettlement made in December 2018. The DoH

recognised the need for the HSC system to work together in a co-ordinated way to deliver a coordinated programme of action to manage the planned and safe resettlement of those patients not currently under active assessment or treatment into accommodation more appropriate for their needs. Some of the MDAG actions have not yet been achieved.

4.18 The 'Review of Leadership and Governance at MAH' (ctrl click) was established to build upon the SAI review and the report published in July 2020 highlighted system-wide issues and a failure in the care provided to some of the most vulnerable members of our society. The findings highlighted the need to provide a clear and coordinated regional learning disability pathway similar to that in place for mental health services. HSC Trusts were remitted to carry out a full re-assessment of the needs of their patients in MAH and prepare discharge plans for all those delayed in discharge. The review found that HSC Trusts had not yet completed a full reassessment of all patients and that discharge plans had not been prepared for all patients.

4.19 Many of the findings and recommendations from both the 'Way to Go' report and the 'Review of Leadership and Governance at MAH' (ctrl click) remain relevant and outstanding and will be reiterated in this review. The' Way to Go' report made 2 overarching recommendations; a renewed commitment to enabling people with learning disabilities to have full lives in their families and communities and the development of a Learning Disability strategic framework focused on contraction and closure of the long-stay hospital and a vision for a full lifecycle pathway across children's and adult services. The Leadership and Governance review findings highlight that Discharge of Statutory Function (DSF) reports provided annually by the Trust to the HSC Board, were largely repetitive and did not provide the necessary assurance with insufficient challenge from Trust Board and the HSC Board. This review found that this remains an area of concern and that limited progress has been made in regard to the strengthening of governance to ensure a greater challenge in regard to reporting and accountability arrangements.

4.20 The review team reviewed the strategic policy for Learning Disability services across England, Scotland, Wales and the Republic of Ireland to identify best practice and the learning from actions taken by other regions in regard to learning disability resettlement and avoidance of hospital admission. The review team identified common themes in the strategic direction for Learning Disability services across England and Scotland with focus on hospital avoidance through development of intensive care and support in the community. The following sections provide a high level summary of the key policy and practice evidence which should inform the strategic direction for learning disability services and the resettlement programme in Northern Ireland.

4.21 Despite the evidence base on concern about safety and quality in institutional settings, there has been a lack of progress in the closure of long-stay beds. This issue has been addressed across all jurisdictions over many years and it is important to learn from these experiences and actions. Our review found a striking alignment across all nations in regards to strategic direction with a focus on a Human Rights and person-centred approach. The 2007 Bamford Review of Mental Health and Learning Disabilities has been the key strategic driver shaping the delivery of services for individuals with learning disabilities and/or autism in Northern Ireland. The principles and values underpinning the Bamford review, remain relevant to current policy direction and are in keeping with the strategic direction of other UK nations. Feedback to the review team from a range of stakeholders however, highlighted the effectiveness of the Mental Health strategy in building upon Bamford and the need for refreshed strategic policy for learning disability services.

4.22 The Bamford Review of Mental Health & Learning Disability in 2002 (ctrl click) recommended a comprehensive legislative framework for new mental capacity legislation and reformed mental health legislation for Northern Ireland. The Mental Capacity Act (Northern Ireland) 2016 (ctrl click) has been partially commenced and currently provides a new statutory framework in relation to deprivation of liberty. Part 10 of the MCA will set out the provisions for people in the criminal justice system when enacted. Mental health legislation is complex most especially relating to patients with a forensic history. The review team noted a lack of clarity across the HSC system in regards to patients who have been stepped down from detention in hospital under Art 15 leave. The review team recommends a review of the needs and resettlement plans for all forensic patients.

4.23 There have been a series of high profile scandals following investigations identifying abuse to residents in HSC facilities over the past decade. MAH is the largest adult safeguarding investigation across the UK. On 8th September 2020, the Health Minister announced his intention to establish a Public Inquiry into the allegations of abuse at MAH. The MAH Public Inquiry commenced the hearing sessions of the Inquiry in June 2022 which will run until December 2022

4.24 The Care Quality Commission report (2011) (ctrl click) after inspection of Winterbourne View found a “systemic failure to protect people” Evidence of maltreatment of patients in specialist hospitals in England continued to emerge and eight years later, The Care Quality Commission report on Whorlton Hall (2019) (ctrl click) found people in learning disability hospital being failed and the Care Quality Commission (2019) found evidence of unsafe patient care and abusive treatment by staff at Eldertree Lodge, an in-patient facility for adults with learning disabilities and autism. These scandals have prompted development in strategic policy and a renewed focus on implementation plans to address the

long-standing issue of over-reliance on admission to hospital resulting in delayed discharge and institutionalisation.

4.25 Strategic Policy in England- Building the Right Support: A National Plan NHS England et al (2015) (ctrl click) placed emphasis on the "highly heterogeneous" or diverse characteristics of the population referred to as 'people with a learning disability and/or autism' This challenge has not been sufficiently addressed in learning disability policy in Northern Ireland to date. The majority of people with learning disability live with their families supported if required by a range of community services. The smaller percentage of those with a range of very complex needs requiring coordinated care and support across justice, housing, mental health, and the range of learning disability provider organisations need to be integrated into future strategic policy and commissioning direction.

4.26 There have been a range of reports on the issue of delayed discharge however, there has been a lack of robust and independent evaluation of what has worked well. England, Scotland and Wales are further developed than Northern Ireland in refreshing the approach needed. This review has identified a number of key themes across the revised strategic policy in England and Scotland that should inform revised strategic direction and short and medium term actions required for Northern Ireland.

4.27 'Transforming Care England' – Oct.2015 (ctrl click) - Good practice guidance covers strategic, operational and micro- commissioning and describes what 'Good looks like' with nine Golden threads-core principles. Key actions include;

- Provide enhanced vigilance and service coordination for people displaying behaviours which may result in harm or placement breakdown.
- Establish a Dynamic Support Database to provide focus on individuals at risk of placement breakdown and development of proactive rather than reactive crisis driven response- Target those escalating in need/ at risk of admission- risk stratification.
- Important that experts by experience have been involved in all of the panels. One of the issues has been language – such as database rather than risk register
- Establish a 'Change Fund' from the centre for development of admission avoidance 24/7 intensive support teams
- Positive Behaviour Service framework and provider engagement
- Housing Needs Assessment
- Effective Assessment tools/ Discharge planning meetings- Complex care co-ordinators to focus on transition plans
- More detailed tracker tool to support analysis and performance management to create a master database-history of discharges, re-admissions and trends.

- Fortnightly meetings on each individual patient with clear projections about the trajectory for discharge and progress over time.
- Specialist LD beds should be increasingly co-located within mainstream hospital settings rather than in isolated stand-alone units.
- The success lies not within systems and processes but within sustainable human relationships and collaboration highlighting the need for system leadership, collaborative working to build a one team approach.

4.28 The NHS 10 Year Plan was published in England in January 2019, and made specific commitments to the improvements to be progressed for people with learning disability and ASD. These included:

- Improve community-based support so that people can lead lives of their choosing in homes not hospitals; further reducing our reliance on specialist hospitals, and strengthening our focus on children and young people
- Develop a clearer and more widespread focus on the needs of autistic people and their families, starting with autistic children with the most complex needs
- Make sure that all NHS commissioned services are providing good quality health, care and treatment to people with a learning disability and autistic people and their families. NHS staff will be supported to make the changes needed (reasonable adjustments) to make sure people with a learning disability and autistic people get equal access to, experience of and outcomes from care and treatment
- Reduce health inequalities, improving uptake of annual health checks, reducing over-medication through the Stopping The Over-Medication of children and young people with a learning disability, autism or both (STOMP) and Supporting Treatment and Appropriate Medication in Paediatrics (STAMP) programmes and taking action to prevent avoidable deaths through learning from deaths reviews (LeDeR)
- Continue to champion the insight and strengths of people with lived experience and their families in all of our work and become a model employer of people with a learning disability and of autistic people
- Make sure that the whole NHS has an awareness of the needs of people with a learning disability and autistic people, working together to improve the way it cares, supports, listens to, works with and improves the health and wellbeing of them and their families.

4.29 'Same as You' (2000) (ctrl click) was the catalyst for Scotland's long-stay closure programme. 'Keys to Life' 10-year Learning Disability Strategy **(**2014) (ctrl click) acknowledged wider system failure in the challenge of expediting discharges and developed a National framework agreement for procurement for specialist residential based care with a focus on the outcomes and rates that will apply. The 'Coming Home' report (2018) commissioned by the Scottish Government (ctrl click) highlighted that a significant number of people remained delayed discharge.

A short life working group was set up to undertake a focused piece of work in relation to complex needs and delayed discharge and published their 'Coming Home Implementation report in February 2022 (Gov.Scot) (ctrl click) . The findings and recommendations are broadly similar to the actions arising from Transforming Care England.

- Engagement with experts by experience and wider stakeholders is critical
- First step is accurate data on Needs Assessment at both population and individual level. Quality of assessments were found to be too generic and quality variable and not sufficiently co-produced with families
- Establish a community living change fund over the next 3 years to be used to design community based solutions running concurrently with disinvestment planning.
- Develop a National Dynamic Support Register to create greater visibility in terms of strategic planning and to allow performance management of admissions to hospital supported by a National panel that can troubleshoot individual cases
- Develop a Positive Behaviour framework-
- Produce a guide to support commissioning and procurement of complex care packages and establish detailed understanding of revenue costs of different care packages. The report highlighted a lack of effective scrutiny of data.

4.30 The Welsh Government published a Learning Disability Action Plan 2022- 2026 in May 2022. The plan builds on and incorporates the Improving Lives Programme (2018) (ctrl click) actions with a focus on reducing admissions through increased community based crisis prevention, access to specialised care and highlights the need to promote Positive Behavioural Support and Trauma Informed care.

4.31 The Irish Government published a national policy 'Time to Move On' 2011 (ctrl click)which sets out the way forward for a new model of support in the community The report highlighted that the model is simple in approach but noted significant challenges to delivery. Integral to the strategy was the 'We Moved On' stories of successful transition and promoting the voice to include advocacy, self-advocacy and family advocacy. The review team met with the HSE National lead who advised that bridging funding through a multi-annual investment plan for 5 year period has been established alongside a value for money and policy review of high cost placements to establish the level of funding per person. Robust Needs assessment was also identified as a priority.

The review team found significant learning from engagement with policy leads in England and ROI which have informed this review and findings.

4.32 Tackling the closure of long-stay beds has been a long standing problem for many decades across all UK nations. Recent strategic policy has recognised that the focus should now be on what is achievable rather than being paralysed by the challenges. There has been growing consensus nationally on solutions and next steps. It is critical that a one system approach is developed in Northern Ireland to address the silo working and duplication that remains across the 5 HSC Trusts. Adopting an accountable care approach will drive collaboration between HSC Trusts and the range of organisations involved in supporting individuals who are currently 'stranded' in learning disability hospitals.

4.4 Recommendations

- DoH should develop the strategic policy for learning disability services, updating the recommendations arising from the Bamford review to reflect the needs of the highly heterogeneous Learning Disability population and inter-connectedness with the Mental Health and Autism strategies.
- There should be an evaluation of the experience of people who have been resettled to understand what has worked well and what needs to change for the better and a regional programme to tell the positive stories of those who have moved on.

5. Leadership & Governance

In the last chapter we consider the policy and strategic context for the delivery of the resettlement programme in Northern Ireland, and in this chapter we want to explore how the leaders within Northern Ireland engaged with this challenge.

5.1.1 Within the chapter we will look at how we gathered evidence of leadership and impact, and then go on to consider it under the following areas: strategic leadership and governance; leadership for the operational delivery of resettlement outcomes for individuals awaiting discharge following lengthy periods in hospital; and finally how people who use services and their representatives were engaged in this complex arena.

5.1.2 Evidence Gathered: The review team were pleased that in addition to having access to a raft of documentary evidence that we also had direct access to meet with many of the leaders within the system at all levels, and to observe or participate in key meetings within the leadership framework.

5.1.3 Amongst the documentary evidence that we accessed included strategic and policy documents, Trust Board minutes and Trust Corporate Risk Registers. We also attended the Muckamore Departmental Assurance Group (MDAG) and had access to their more recent action plans and minutes. We also had sight of material related to the Delegated Statutory Functions Reports including the composite reports and action plans.

5.1.4 A very rich area of evidence related to engagement with leaders through direct meetings. This included the Mental Health & Learning Disability Strategic Leadership Group (Directors and other senior officers from HSCB/SPPG & Trust Directors); Regional Learning Disability Operational Group (Trust Assistant Directors and Commissioning & Finance Leads in HSCB/SPPG, along with representation from NIHE and RQIA. We had 'challenge and support sessions with Trust LD Leadership Teams We have tried to represent the statutory leadership framework diagrammatically – *see below*

5.1.5 The review team were particularly grateful for the extensive and generous sharing of views and experiences from a broad range of stakeholders. Importantly this included parents and carers of people who had direct experience of the resettlement process along with charities that represent them such as Mencap. We also met with leaders from other agencies including housing, provider organisations in the independent sector, regulators for services and the social care workforce, and clinical leadership through the RCPsych. (NI) – Learning Disability Faculty.

5.1.6 An important factor needs to be acknowledged from the outset in considering the leadership challenge in relation to the resettlement programme during recent years, and relates to the context from 2019 to 2022. The global pandemic had a massive impact on the capacity and capability of leadership teams to maintain momentum on 'business as usual' priorities, as a determined focus to tackle Covid was required. Similarly during the same period the impact of MAH being identified at a national level as a hospital where patients had not been well safeguarded meant that the operational day to day logistics of maintaining safe practice in relation to sufficient and stable staffing was a significant challenge in itself. Additionally, during this period there has been an extended period of significant organisational change as the regional commissioning functions previously undertaken by the Regional HSCB were 'transitioned' back within the DoH under the Strategic Planning and Performance Group, with the new arrangements coming in to effect from the 1.4.22. Whilst these and other factors impacted directly on the progress of resettlement and offers something in way of mitigation for the poor progress of resettlement plans, it cannot entirely explain leaders' failure to deliver timely alternatives to residence in MAH in the context of the long term planning in this area. The individuals in MAH didn't

'suddenly' need new homes; there had been a lengthy 'gestation' to this situation, and many opportunities for earlier action.

5.1.7 The review considered leadership in three separate contexts. The first was strategic leadership at the most senior level of the organisations involved, including senior leaders in public service, both executive and non-executive. Strategic leadership focuses on establishing the vision and strategic direction, and ensures effective governance, oversight and scrutiny of delivery of strategic objectives. The second is senior operational leadership to ensure that plans for delivery are robust and achieved, and requires effective partnership working between commissioners, providers – both statutory and non-statutory. The third area that we wanted to consider in relation to effective leadership and governance was the extent to which people at the centre of resettlement, particularly those who were being moved to their new homes and their family members, were engaged and involved in the process, and how effectively they could shape and influence leadership. Central to this is the need to understand leadership at all levels, and how this intersects. What the review team were looking for is sometimes referred to as 'the golden thread, that should weave through all the layers of leadership to ensure that there is a seamless route from strategic vision to effective delivery, and that the best outcomes are delivered in the most efficient and cost effective way, with transformational impact on the lived experience of the people who are being resettled from institutional care to new homes within the community.

5.2 Strategic Leadership & Governance

5.2.1 Strategic leadership and governance has been central to the successes and failures within delivery of the learning disability resettlement programme in Northern Ireland. The policy context since the Bamford Review and before was clear that long stay specialist learning disability hospitals should never be someone's permanent home. Whilst the ambition was clear, and some progress was made, the goal was slow to achieve and by July 2021 46 people remained living in MAH, and more than 5 of these had been in the hospital for between 30 and 45 years. The emerging picture of extensive institutional abuse in MAH in 2018 re-focused attention on the lives of people living in MAH both in terms of the day to day safety of people who were living there, and the need to push harder to find new homes for those remaining individuals within high quality community settings. Whilst this was a significant challenge, it wasn't a new one, and had been a stated health and social policy objective in Northern Ireland since 2005, so it had to be asked why it hadn't yet been achieved.

5.2.2 In order to achieve the significant change required in improving the lives of all people with learning disability and ASD, there was a consistent acknowledgement for the need to update the strategic policy. This was a priority recommendation from the previous Independent Review Panel, which required "an updated strategic framework for Northern Ireland's citizens with learning disability and neuro-developmental challenges which is co-produced with self-

advocates with different kinds of support needs and their families. The transition to community-based services requires the contraction and closure of the hospital and must be accompanied by the development of local services."

5.2.3 The response to this recommendation was that there should be a co-produced model for Learning Disability Services in Northern Ireland to ensure that adults with learning disability in Northern Ireland receive the right care, at the right time in the right place; along with a costed implementation plan, which will provide the framework for a regionally consistent, whole system approach. This significant task was to be progressed by the HSCB/PHA, and they commissioned a consultation with a wide range of stakeholders which led to the production of a consultation response entitled "We Matter". The final draft of the "We Matter" Learning Disability Service Model was formally presented by the HSCB to officials at the DoH in early October 2021, but to date this has not resulted in the issuing of the long awaited updated strategic framework. It remains important that this work is brought to completion but equally its delay should not have been a reason for a failure on the part of the HSCB and individual HSC Trusts to expedite the resettlement process.

5.2.4 In the next chapter we will explain how in 2019/20, further to a direction from the Permanent Secretary, the regional commissioning framework clearly stated that the resettlement of people from MAH and other LD specialist hospitals remained a strategic priority.

5.2.5 In the context of the significant concerns about MAH the DoH established a Muckamore Departmental Assurance Group (MDAG). The Muckamore Departmental Assurance Group was established to monitor the effectiveness of the Health and Social Care System's (HSC) actions in response to the 2018 independent Serious Adverse Incident (SAI) review into safeguarding at MAH following allegations of physical abuse of patients by staff, and the Permanent Secretary's subsequent commitment on resettlement made in December 2018. The Group is jointly chaired by the Chief Social Services Officer and the Chief Nursing Officer, and is made up of representatives from HSC organisations and other key stakeholders, and representatives from families of Muckamore Abbey Hospital patients. It was good to see such a broad constituency, including the families of people living in MAH being brought together. The group undertook considerable work which was organised and monitored through a comprehensive action plan; this was updated and monitored regularly. The plan covered areas such as leadership and governance, safeguarding, resettlement and workforce. In relation to resettlement, after three years of the MDAG operating, all of the actions relating to resettlement continued to be rated as 'red' in relation to delivery. So whilst there was a robust mechanism for holding the system to account and monitoring what had been achieved, in relation to resettlement there was an inertia which represented slow or negligible progress. This led to some considerable frustration across the system, which was evidenced through a number of families launching judicial reviews against health and care organisations to challenge a failure to deliver resettlement

outcomes for their loved ones. Despite a well-articulated call to action there was an absolute lack of urgency and focus in the delivery of the resettlement programme.

5.2.6 Within the MDAG action plan the Director of Social Care and Children (DCSC) was the identified lead for all actions in relation to the delivery of the resettlement programme. In order to deliver this the (DCSC) worked with the Trust Directors through a Mental Health and Learning Disability Strategic Leadership Group. The commissioning plan for 2019/20 was clear about the HSCB/PHA strategic priorities and intentions for resettlement and the required Provider Response (set out in Chapter 6; 6.4.6, 6.4.7, 6.4.8). In order to deliver the required action a number of groups were established to progress at pace the resettlement programme, and further explore this under the next section. However, the DSC & C/HSCB also held a responsibility for ensuring that the individual Trusts were held to account in relation to the delivery of their delegated statutory functions (DSF's), and a specific responsibility for performance management in relation to the delivery of the key strategic targets. Whilst there were fully formalised processes for accountability meetings, with remedial action proposed where performance was weak in relation to the delivery of DSF's, this rarely achieved the significant improvement required. In particular in relation to the resettlement programme, the actions taken by senior officers of the HSCB often represented at best performance monitoring, rather than effective performance management.

5.2.7 Effective performance management relies on the provision of valid data, analysis of performance measures, responsible challenge in relation to under-performance, and effective support to address broader barriers that stand in the face of objective achievement. The absence of fully effective performance management allowed for significant drift in the delivery of strategic priorities which directly impacted on the broader issues relating to the continued concerns around the safety of MAH. There has been significant organisational change since the Minister announced the closure of the HSCB, and the transfer of many of the strategic commissioning and performance management functions have reverted to the Strategic Planning and Performance Group within the Department of Health. We have seen a change in tone and approach in relation in the execution of performance management responsibilities both immediately prior to the transfer to SPPG on the 1.4.22 and subsequently. A number of additional senior appointments have been made within the social care team which should strengthen capacity. In light of these changes the review team are hopeful that the challenge and support function essential to effective performance management will continue to improve.

5.2.8 Belfast Health and Social Care Trust are central to the strategic leadership and governance in relation to the care and treatment of people in MAH, as well as to the resettlement process from the hospital. Their leadership responsibility needs to be set in the context of two important reports commissioned by the

Trust. The first of these was “A Way To Go” (2018) which undertook a review of safeguarding within MAH between 2012 and 2017, which identified extensive evidence of catastrophic failings and found that there was a culture of tolerating harm within MAH. The authors went on to express grave concern that it was “shattering that no-one intervened to halt the harm and take charge”. The CCTV evidence which supported the findings within this report also became central to the subsequent PSNI investigation of allegations against significant numbers of staff within the hospital. The second important report was the Review of Leadership and Governance at Muckamore Abbey Hospital completed in July 2020. This report described the leadership team at MAH as dysfunctional, with a lack of clarity about leadership, and a sense of dis-connectedness with the BHSCT as a whole. The report concluded that the changes in senior management resulted in confusion for front line staff; there was little evidence of practice development and quality improvement in MAH; that there was insufficient challenge from the Trust Board and HSCB in relation to the DSF reporting, and that feedback provided to the Trust from the HSCB related to failings in meeting resettlement targets. The report also reported on limited escalation of key events or concerns to the Trust Board, and also that “The resettlement agenda at the hospital meant that focus on the hospital as a whole was lost: - relatives/carers of patients and hospital staff’s anxieties about closure were not addressed in a proactive way to reinforce the positives associated with patients’ transition to care in the community. There was insufficient focus on the infrastructural supports required to maintain discharged patients safely in the community” In the final section of the report its’ final recommendation is that, “The size and scale of the Trust means that Directors have a significant degree of autonomy; the Trust should hold Directors to account.”

5.2.9 In relation to this recommendation the review team undertook some desk top review of the Trust Board minutes over the preceding year. It was clear that update reports were being brought by the responsible Director in relation to all aspects of the services at MAH. However, we had some concerns about how effective the overview and scrutiny of Trust Board was in relation to certain key elements. In particular there was an acceptance of assurances given that the 16 remaining patients awaiting resettlement from MAH who were the responsibility of the BHSCT had robust plans in place for resettlement. However this was contingent on the proposed service developments which would deliver new homes, and as we will detail in later sections of the report there was no confidence that robust plans were in place for the delivery of such schemes, and that even if in train the earliest date for delivery would have been 2025/2026. In light of this the review team would consider that the Trust Board accepted reassurance from senior leaders, rather than driving for solid assurances which would underpin effective delivery.

5.2.10 One year on from the publication of the Leadership and Governance Review, which recommended that BHSCT consider sustaining the significant number of managerial arrangements instigated following events of 2017 pending the

wider Departmental review of MAH services. The current review team looking at the situation through the lens of resettlement find that there appears to have been only limited progress in relation to the changes that were called for. There continues to be some instability in relation to the leadership arrangements, in that during the last 6 months there have been changes of Director, Co-Director, Lead Social Worker and Lead Nurse; and some of these posts are appointed only on an 'interim basis' implying that they may only be temporary appointments, and with none of the incumbents bringing recent senior operational leadership experience in the field of learning disability. Whilst the review team accept the principle of the transferability of skills and that this is particularly important within senior roles, there is also a need to have a sound understanding of the 'business' particularly in the context of risks and opportunities. However the review team also acknowledge the clear commitment that these newly appointed leaders bring to their responsibilities, which could bring significant opportunity to move on at greater speed.

5.2.11 The review team could see that within BHSCT there had been a real vigour, both by Trust Board and the Executive Team, to address the issues that had emerged as the full extent of the institutional abuse at MAH became clear. This posed them with the linked challenges of rapidly improving the quality and safety of care for the patients within MAH whilst ensuring that there was progress at pace to achieve more resettlement. The review team could see that to some extent the former was contingent on the latter, i.e. that the more quickly the population reduced in the hospital through resettlement the sooner that the issues related to safe staffing levels could be addressed as assuming the staffing establishment was retained and the patient population reduced then the nurse:patient ratio improved accordingly. The review team felt that this balance wasn't maintained and that the importance of getting the hospital back to a safe and stable position diverted attention away from the importance of steady and consistent progress in relation to moving patients who were deemed medically and multi-disciplinary 'fit for discharge' to new homes. Therefore as will be laid out in subsequent sections the progress of the proposed schemes to be led by BHSCT effectively slowed almost to a standstill, and so other than for a small number of individuals who were able to move to existing provision there were very few people moved. This is in contrast with the NHSCT and SET who have secured new provision which will shortly become fully operational in the next 6 months and consequently a much higher proportion of their clients have plans where there is confidence that they will move in the near future.

5.2.12 BHSCT had a wider responsibility than the other Trusts as they were managing MAH, and had responsibility for the dedicated resettlement teams located at the hospital who had a pivotal role in being the link and liaison with the local teams within the MAH resettlement team had a pivotal role with all 3 Trust community teams including for the BHSCT, NHSCT, and SEHSCT who ultimately would assume responsibility for the clients upon transition to their new homes. However all three of these Trusts had a shared responsibility for the overall

delivery of the resettlement programme. Given the high profile concerns about the safety of MAH, and the linked urgency to find alternative homes for the remaining patients as soon as possible, the review team were concerned that not all Trusts had included resettlement of people with LD/ASD on their Corporate Risk Registers, although in some cases they were on Directorate Risk Registers. Again this may have hampered the ability of Trust Boards to assure themselves that all of the appropriate actions were being progressed to ensure swift actions were being delivered to address the significant risks.

5.3 Leadership in Operational Delivery of the Resettlement Programme

5.3.1 Within the system delivery relies on having senior executive and operational leaders who can take policy and strategy, and ensure that the linked objectives are delivered in practice, and that the outcomes that follow improve the lives of the people with learning disabilities and their families.

5.3.2 Within the HSC system in Northern Ireland this covers a broad range of leaders in senior roles in commissioning, and within statutory and non-statutory provider organisations. We have already mentioned the role of the Mental Health and Learning Disability Leadership Group which comprised Directors across the HSCB and HSC Trusts with input from other key agencies such as PHA and RQIA. It should be noted that some of these Directors had strong clinical and professional backgrounds, and had been well established within an executive role, whilst others were relatively new to role and may have come from other service domains. There was certainly a positive set of working relationships within the group, and whilst there was a well-articulated commitment to work collectively and collaboratively this was not always then evident in the subsequent partnership working. Below this group sat the RLDOG which was chaired by the HSCB, but comprised primarily Assistant Directors/Co-Director from the 5 Trusts. At times it was unclear what role the HSCB held within the RLDOG – whether their role was as convenor and facilitator, or to lead the co-ordination process and take a performance management role within the group. This contributed to a lack of clarity about leadership within RLDOG, and this meant that the commitment and engagement of senior staff from the HSC Trusts could be variable. More clarity about leadership within the RLDOG, with a clearer focus on achieving progress and delivering improved outcomes would have been more helpful. Whilst RLDOG was expected to work on a broader range of service developments and priorities across the learning disability domain, during the 6 months that the review team were involved it primarily focused on resettlement and access to assessment and treatment services within specialist LD hospitals.

5.3.3. The learning disability resettlement programme in Northern Ireland did not have an over-arching programme or project plan. Whilst it was in the commissioning plan as a strategic priority for 2019/20, and Trusts were expected to respond

accordingly, this meant that individual Trusts developed their own approaches to addressing the needs of their cohort of patients within the remaining MAH population. Some Trusts addressed this positively and developed fairly robust plans over time, but overall there was a sense that the programme was fragmented. There was certainly some evidence that HSC Trusts were planning in relative isolation. There were examples of Trusts entering discussions with providers about developing services in other Trust areas, without the 'host' Trust being informed or consulted. The HSCB convened another group called Community Integration Programme (CIP) which had a sole focus on the resettlement but it was unclear how this group's role differed from that of RLDOG, particularly given the significant overlap of membership. The HSCB had developed what they called the MAH template which HSC Trusts were asked to complete in relation to their MAH populations and plans for individuals. The review team supported the social care officer responsible for CIP to make some improvements to this so that it could be used more effectively as a 'tracker tool' and then this could support a performance management approach.

5.3.4 In general we found that across significant elements of the HSC system there was poor management grip in relation to the learning disability agenda and this resulted in a lack of momentum and a sense of inertia. The system seemed more pre-occupied with process and there was insufficient focus on solution finding and achieving positive outcomes quickly. The system was also prone to adopting 'crisis-management' approaches linked to pressures escalated from BHSCT in relation to difficulties within staffing or access to admission at MAH. This meant that the system was primarily reactive rather than proactive. We give further examples of how poor leadership hampered progress in delivery in later sections.

5.3.5 Overall the review team felt that the learning disability resettlement programme would have benefitted from an effective project managed approach, which we have seen used to good effect in other similar situations. This would have more effectively co-ordinated the efforts of the system as a whole, and ensured less variation in the overall delivery of agreed outcomes. It also would have facilitated more effective opportunities to engage with providers within the social care market in order to streamline the service developments required to support the resettlement process in a timelier way, and would have brought provider-informed solutions forward for consideration.

5.4 Leadership Engagement with People who Use Services and their Carers.

5.4.1 The review team met with the Chief Executive and Patient Client Council (PCC) senior leadership team who are undertaking the role of Advocate to the Public Inquiry and supported families during feedback on the findings of the Leadership and Governance review team. PPC advised that in their engagement, families talked about the invisibility of learning disability and expressed anger and a lack of trust in the HSC system. PCC also found in their

engagement with families that safeguarding was foremost in their concerns. PCC advised the review team that the pain and trauma for families was palpable and that a trauma informed approach would be needed to engage and support families who had been let down so badly.

5.4.2 The feedback from PCC concurs with the feedback the review team received in our own engagement with families in the BHSCT, NHSCT and SEHSCT and sets the context for consideration of leadership engagement with people who use services and their carers across the HSC system. The review team will address the issue of carer engagement in more detail in a chapter 10.

5.4.3 Families reported that they felt learning disability was invisible at government and policy level and comparison was made by some families to the profile of mental health services resultant from the Mental Health strategy and appointment of a Mental Health Champion. Many families reported their fatigue, the emotional toll of life long caring and battling for resources and services over many years.

5.4.4 The Welsh Government 'Improving Lives Programme (2018) placed particular emphasis on communication and effective working relationships at all levels across the system, what they referred to as the softer skills required to drive transformation and improve lives. The importance of and necessity to build trusted relationships was evident at strategic and operational leadership levels but more so in relation to building effective partnership working with individuals and families with lived experience of using services.

5.4.5 It is clear that across the HSC system there is recognition of the need for engagement and involvement of people with lived experience in both the planning and delivery of services however this is easier said than done. Two MAH carer representatives are members of MDAG and the review team observed both carers influencing and holding senior leadership to account through constructive challenge. However, the review team did not see evidence of effective engagement of people who use learning disability services or their family carers influencing the numerous other learning disability work streams established by HSCB/SPPG to contribute to and influence the resettlement agenda. The review team acknowledge that HSCB and the 5 Trusts had significant engagement with individuals with a learning disability and family carers in the development of the draft service model' We Matter'. However this level of contribution was issue specific and has not been sustained.

5.4.6 The review team noted some tensions in the relationships between Trust Directors due to the pressures associated with the challenge of accessing an acute learning disability bed when required. The establishment of a regional bed manager as agreed at MDAG would have significantly mitigated the tension however, there was significant delay by HSCB/SPPG in the actions required to establish this post. The review team were pleased to see and wish to

acknowledge that the three Directors co-dependent on MAH have recently committed to working collaboratively with a focus on the mutual aid required to respond to challenges at MAH but also to expedite the remaining resettlement challenge. The Directors have held solution focused workshops establishing time and space for reflection and the development of the trusted relationships that will be required to further enhance a one team approach.

5.4.7 Engagement events with family carers highlighted the importance of continuity of key workers in building effective working relationships at case work level but families also referred to a trusted key worker as their go to person when they had to navigate through different parts of the HSC system or when they were facing challenge or difficult decisions. The turnover of staff at both key worker and managerial level was reported by carers to directly impact on their trust in the HSC system. Relationship based HSC practice and continuity of key worker would significantly improve the experience of people at the centre of resettlement and their family members.

5.4.8 The impact of the turnover at HSC senior management level was raised by external agencies, both external statutory and independent sector provider organisations that generally have experienced stability in senior leadership teams. NIHE Supporting People leaders advised that there has been a loss of memory for HSC Trusts due to the turnover in senior leadership. Voluntary sector leaders also advised the review team that the turnover in Trust HSC leadership is challenging and highlighted variation across Trusts regarding being respected as valued partners with significant expertise. The voluntary and independent sectors are key stakeholders in the delivery of community-based services and will be central to the accountable care approach needed to meet growing demand and challenge. The review team acknowledged that each Trust has held engagement events with provider organisations but the review team saw it as a missed opportunity not to have collaborated given that many care providers deliver across all 5 Trusts.

5.4.9 At operational level, all Trusts have made significant efforts to establish effective engagement strategies as detailed in chapter 10 however, these are at an early stage of development. BHSCT has established a robust infrastructure mapping engagement from Trust Board level with a Non-Executive Director undertaking the role of learning disability lead at Board level, through dedicated forums in MAH and community learning disability services. It is significant that only a very small number of MAH families are in attendance at the MAH Forum meeting. This would suggest a level of disengagement of MAH families. Some MAH families told the review team that they are not willing to attend meetings as they have been led up the hill too many times and only now wish to engage if there is a concrete and viable plan for their loved one's discharge.

5.4.10 Effective engagement requires trust and openness and this has been seriously impacted due to the allegations of abuse at MAH which has made engagement more challenging. Some families have such a level of distrust that they are not willing to engage with the Trust. It is important that Trusts give this matter consideration. The review team saw missed opportunities for Directors to reach out to families who had raised specific concerns relying instead on delegating to other managers.

5.4.11 The review team had the opportunity to spend time with individual families actively listening to their experiences with some families advising that this made them feel respected and their experience valued. Families also advised that at case planning level they are not always respected as experts by experience.

5.5 Conclusions and Recommendations.

The voice of people with a learning disability and their family carers was not sufficiently evident within leadership processes addressing resettlement. The review team did not see evidence of effective co-production in strategic or operational service planning and delivery.

- Consideration should be given to the development of a Provider Collaborative to bring together the range of organisations delivering specialist learning disability care with statutory HSC leaders.
- HSC system should establish an effective programme and project managed approach for the learning disability resettlement programme
- People with a learning disability and their family carers should be respected as experts by experience with Trusts building co-production into all levels across the HSC system HSC Trust

6. Strategic Commissioning, Planning and Inter-Agency Working

In this chapter we will consider the models and approaches to commissioning and how this can support effective inter-agency working.

6.1 Prevalence of Learning Disability.

6.1.1 At the foundation of good commissioning is understanding the target population and their needs both collectively and individually. Whilst the review was primarily focussed on the population of people experiencing delayed discharge within MAH, this group of individuals with very specific needs based on their experience of living with a disability and in addition their experience of living in institutional care for an extended period of time, it is important to consider them in the context of the wider population of people with learning disability or intellectual disability in Northern Ireland.

6.1.2 The 2021 Northern Ireland (NI) Census data will include data on health and disability, but this element of the data will not be published before September 2022. However the University of Ulster and others undertook data analysis funded by the ESRC (Economic and Social Research Council), which was supported by health and social care organisations, both statutory and non-statutory in Northern Ireland. The research focussed on access and analysis of existing administrative data relating to learning disability in Northern Ireland between 2007 and 2011. Their key findings included prevalence data and demonstrated that within the overall Census Population the prevalence of learning disability was 2.2%; the prevalence rate amongst those aged 15 or younger was 3.8%, whilst the prevalence rate amongst those over 16 was 1.7%. Overall prevalence of learning disability ranged from 1.9% in the NHSCT to 2.5% in BHSCT. From the Census data they found that learning disability was also associated with greater deprivation. Within their conclusions the researchers comment that there is burgeoning international research which continues to detail the extreme disadvantages that are disproportionately faced by those in society living with a learning disability. Additionally they comment that learning disability specifically, at a population level, has either remained unrecorded and undetected or has been camouflaged/hidden/buried within general health data, that have referred to limitations in day-to-day activities or inability to work as a result of health problems or disability. Learning Disability Data & Northern Ireland, Ulster University, *'Enhancing the visibility of learning disability in NI via administrative data research'* Ctrl Click

6.1.3 Mencap is a charity which works across the UK with and for people with learning disabilities and their families. They have published figures calculated using learning disability prevalence rates from Public Health England (2016) and from the Office for National Statistics [2020). They estimate there are approximately 1.5 million people with a learning disability in the UK, indicating that approximately 2.16% of the UK adult population have a learning disability. They indicate that there are 31,000 adults with a learning disability in Northern Ireland, and 11,000 children with a learning disability (0-17).

6.1.4 In simple terms what we know about the 31,000 adults is that the vast majority live in their local communities either independently or semi-independently with support from their families, friends, and support services. Less than 10% of them live in registered care or supported accommodation schemes, and in most circumstances, these are still either within or close to their local communities. At the time of writing there were only around 60 people with learning disabilities in specialist hospital in Northern Ireland which equates to approximately 0.2 % of the total LD population, and of this small group about three quarters were awaiting resettlement or discharge to new permanent homes. In considering the needs of this last group of people we have needed to look at how the system works to meet the needs of the larger population, and to look at how those commissioning services and those providing services ensure positive outcomes for this important group of individuals in our society.

6.1.5 We have commented in a previous section about the importance of developing a regional strategy and service model for services for people with learning disabilities in Northern Ireland. This strategy will need to describe this community and their diverse and varied needs so that regionally work can be completed to develop a strategic commissioning plan which can support the service delivery for this group of people. You will see later in this section that work was commenced by the HSCB and PHA on the development of a Learning Disability Service Model in 2019/20, which resulted in the co-production of a report called " We Matter " which is currently being considered by the DoH and will contribute to the production of the final strategy.

6.2 Commissioning Models

6.2.1 Whilst there are numerous models of commissioning the one that we have chosen to identify primarily is "Integrated Commissioning for Better Outcomes" which (ctrl click) was developed by NHSE, the LGA and ADASS as a practical tool for local authorities and NHS commissioners to support improving outcomes through integrated commissioning. It was published in 2018 to support health and social care economies to transform their services through a person centred approach to commissioning which is focussed on the needs of the local area. It

emphasises that effective commissioning relies on a strong focus on people, place and population.

The framework identifies what matters most to people:

- *Being the person at the centre, rather than the person being fitted into services.*
- *Citizens, people who use services, patients and carers are treated as individuals.*
- *Empowering choice and control for those people.*
- *Setting goals for care and support with people.*
- *Having up-to-date, accessible information about services.*
- *Emphasising the importance of the relationship between citizens, people who use services, carers, patients, providers and staff.*
- *Listening to those people and acting upon what they say.*
- *A positive approach, highlighting what people can do and might be able to do with appropriate support, not what they cannot do.*

6.2.2 The framework draws on a definition of commissioning developed by the Cabinet Office and Commissioning Academy in its statement about public sector commissioning.

"*We commission in order to achieve outcomes for our citizens, communities and society as a whole; based on knowing their needs, wants, aspirations and experience.*"

6.2.3 The second example is designed to help the voluntary sector work with the statutory sector and is based on the well-known commissioning cycle model. It describes the 4 stages of commissioning within the commissioning cycle as:

Analysis: this stage aims to define the change that is needed by defining the need – the problem that needs solving – and the desired outcome.

Planning: involves designing a range of options that will work to address the issues identified against the desired outcome.

Securing services: is the process of funding the option or range of options agreed to deliver the defined outcome via an agreed funding method – grant funding, contracting, etc.

Reviewing: entails evaluating the chosen option(s) to see what has worked well and what can be improved further.

Model of Commissioning

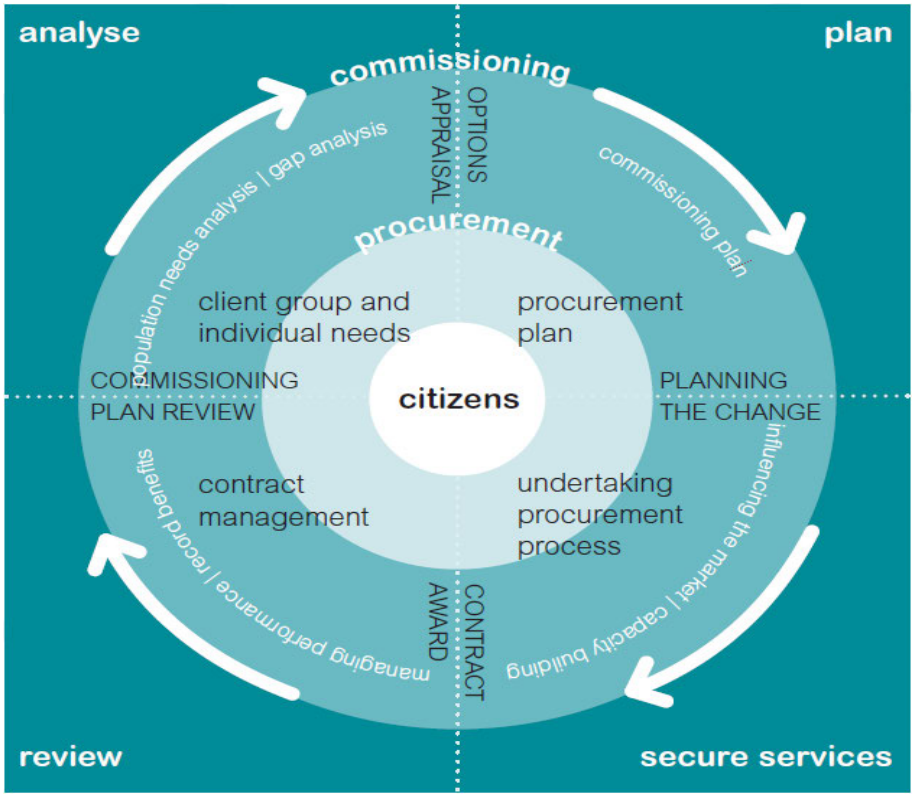


Fig 1

6.2.4 It is important to understand that commissioning activity will be essential at all levels within the health and care system. Strategic commissioning needs to support a population based approach underpinned by a strong assessment of needs, which is delivered by senior strategic leaders in partnership with other parts of the system. Locality based commissioning requires HSCT's to ensure that at a local level these strategic ambitions are delivered through the effective purchase and supply of a broad range of directly delivered and commissioned services from providers across the independent providers, both private and charitable/" not for profit". This locality-based commissioning should ensure a sufficient supply of key services including access to registered care in nursing and residential homes, and access to accommodation providing care and support for people with significant needs. Both of the above need to relate closely to 'micro-commissioning' which is where care and support is commissioned in a bespoke way for the needs of an individual through a detailed understanding of their specific needs and requirements, resulting in a personalised care solution. Micro commissioning is directly aligned to the individualised care planning which is described in a later session, and must be underpinned by a commitment to co-production with the individual and as appropriate with the involvement of family.

6.2.5 The review team needed to look at how this broad approach to commissioning had been applied to the needs of the cohort population of people who remained in MAH and who required to be discharged to appropriate community-based accommodation with access to ongoing care and support appropriate to their needs. The approach we took was to review the programme that had been developed in England to address the needs of a similar population; to consider the framework for commissioning both health & care and housing services; and to review how these arrangements had been applied in practice to support the resettlement of the group of people who had been prioritised through direction from the Permanent Secretary.

6.3 Transforming Care in England.

6.3.1 "Transforming Care for People with Learning Disabilities - Next Steps" was published in January 2015 by NHS England, Local Government Association, and Association of Directors of Adult Social Services (ADASS). The report identified a significant change in direction in the policy and practice in relation to gatekeeping admission to specialist learning disability settings, alongside dedicated strategies for admission avoidance and more effective discharge planning. The report relied heavily on a report commissioned by NHS England from Sir Stephen Bubb which reviewed how to accelerate the transformation of key services that people with learning disabilities and their families were looking for. The catalyst for this reform came after the shocking expose by Panorama/BBC in 2011 of institutional abuse of people with learning disabilities and/or autism at Winterbourne View, an independent private hospital at Hambrook in South Gloucestershire. The key organisations committed to strengthen the Transforming Care delivery programme by creating a new delivery board, bringing together the senior responsible owners from all organisations.

6.3.2 Central to the approach within Transforming Care was **a commitment to empower people with learning disability and their families**, and to strengthen people's rights within the health and care system. A key recommendation from Sir Bubb was for NHS England to introduce a "right to challenge "by providing a Care and Treatment Review (CTR) to any inpatient or inpatient's family which requested one. CTR's were to be embedded as "business as usual". Early evidence showed that the use of CTR's was effective in speeding up and strengthening discharge planning for those individuals in specialist learning disability hospitals.

6.3.3 A guiding principle in the approach was to ensure that people get the right care in the right place, and to ensure that people with learning disabilities and/or autism were discharged into a community setting as soon as possible. In

parallel there would be the development of robust admission gateway processes so that where an admission to hospital was considered from someone with a learning disability and/or autism, that a challenge process would be in place to check that there is no suitable alternative. The ambition was to reduce the number of people in inpatient settings, reduce their length of stay, and ensure that there was better quality of care both in hospital and community settings. Critically the process also required that where an individual is identified as requiring admission to a specialist learning disability inpatient facility that they have an agreed discharge plan from the point of admission. Work was undertaken in parallel to ensure that services for people with learning disability and/or autism who also have a mental illness or behaviour that challenges were improved both within inpatient and community support provision.

6.3.4 The above approach was supported through strategic commissioning by NHS and local authorities who had a shared responsibility to fund care and support throughout the pathway. This required the health and care system to develop quality standards and outcome metrics which were reflected within the NHS Standard Contract and were then applied with assurance processes undertaken by clinical commissioning groups at a local level to ensure that there were robust arrangements to monitor that individuals were receiving the right care in the right place. To support this strengthened commissioning there was a refocus on the quality of data and information so that those implementing commissioning intentions had access to the right information to ensure effective analysis and decision support.

6.3.5 Within Transforming Care there was a renewed commitment to strengthen regulation and inspection. The Care Quality Commission (CQC) were required to further refine its inspection methodology for mental health and learning disability hospital services, and to ensure that regulatory action is taken. Central to this was an explicit commitment that CQC would work with other partners to develop a clear approach for ensuring that unacceptable mental health and learning disability services were closed through use of its enforcement powers.

6.3.6 In 2017 NHS England followed up with model service specifications within the Transforming Care Programme in the context of “Building the Right Support – National Service Model “ as a resource for commissioners, The model service specifications particularly focussed on (1) enhanced and intensive support, (2) community based forensic support, and (3) acute learning disability inpatient services. These 3 aspects of the service model describe the specialist health and social care provision aimed specifically at supporting people with a learning disability who display behaviour that challenges.

6.3.7 The review team subsequently met with senior officers from the Kent and Medway Integrated Care System who had been responsible for implementation of Transforming Care within their system as strategic commissioners. Their overall conclusion was that Transforming Care had been effective in ensuring a more targeted approach particularly in relation to admission avoidance through more effective gate keeping, and the provision of the dynamic support framework, which was delivered through an inter-agency forum to ensure effective strategies were in place for individuals identified at risk of admission. Additionally, they had received funding from NHSE to improve access to 24/7 intensive support teams. Transforming Care had also ensured that there were fortnightly reviews of all inpatients with a clear focus on the trajectory and progress over time for the individual.

6.3.8 In Kent and Medway there had been a renewed effort in terms of governance with the development of a new governance framework and an oversight board to ensure that partners were accountable for commitments and performance. However even with this strengthened focus 66% of the original population identified still were awaiting resettlement. They reported that there had been some issues in relation to effective working with the Ministry of Justice in relation to those individuals who were within justice domain, and in some situations local authorities had been slow to undertake and progress housing needs assessments. Positives had been the development of a Positive Behaviour Support framework of accredited providers, and a central source of capital funding to support bids for discharge plans for individuals who had specialist accommodation needs. More recently in the early part of 2022 they had found an increase in crisis referrals which they felt could be an acuity surge related to the aftermath of Covid.

6.3.9 At a national level organisations such as Mencap and the Challenging Behaviour Foundation monitor the monthly published data from NHSE and provide a commentary on progress. This reflects a view that whilst Transforming Care has provided an effective framework for the delivery of enhanced services to people with learning disabilities and/or autism whose behaviour can challenge the improvement has been slower than originally hoped for within specified targets, and there is a concern nationally about the growing number of young people being treated within inpatient settings.

6.4 Commissioning of Health and Social Care services in Northern Ireland.

6.4.1 Up until April of 2022 the responsibility for the commissioning of health and social care services sat with the Regional Health and Social Care Board (HSCB) and the Public Health Agency (PHA) in partnership. These bodies set their key priorities and areas for action within a commissioning plan, in response to a Commissioning Plan Direction issued by the Department of Health.

6.4.2 For our purposes we wanted to look particularly at the commissioning plan for 2019/2020, as this identified some actions which were required in light of the exposure of significant abuse of individuals living in MAH which was managed by the BHSCT. The commissioning plan also identifies how resources will be allocated to Health and Social Care Trusts and other providers to maintain existing services and develop new provision.

6.4.3 There are a few general points of note in relation to the 2019/20 commissioning plan. There was little reference in the earlier sections of the document to the needs of people with learning disability in terms of emerging issues or key policy and strategy. It did refer to the production of the “Power to People “Report in 2017 looking at the possible solutions to the challenges facing the Adult Social Care and Support System in Northern Ireland. Additionally, it highlighted the continued commitment of strategic commissioners to supporting Personal and Public Involvement to improve patient and client experience. Central to this would be the embedding of co-production within collaborative working of health and social care systems, including the adoption of co-production and co-design models for the development of new and re-configured services.

6.4.4 In terms of the financial resources made available to Trusts and other providers to meet the needs of people with learning disabilities and their families this amounted to 6.58% of the total allocation for health and social care in Northern Ireland, which comes to approximately £342 million. It should be noted that these allocations may not meet the full cost of services and there may be additional cost pressures emerging for certain groups.

6.4.5 In terms of the specific commissioning commitments in relation to learning disability services made within the 2019/2020 HSCB & PHA Commissioning Plan, these are laid out in a separate short chapter of the overall report. There is a commitment to continue to adopt the Bamford Report principles when developing services for people with learning disabilities, with a particular emphasis on supporting integration, empowerment and ‘ordinary lives’. There was also commitment to co-produce with a broad range of stakeholders including people with learning disability and their families, a Learning Disability Service Model (LDSM) based on a regional review of services. Within the population sections of the plan there was no specific reference to the numbers

of people with learning disabilities, although the plan did note that, “the number of people with a learning disability and the levels of accompanying complex physical and mental health needs continues to grow in Northern Ireland.”

6.4.6 There were 2 strategic priorities identified which are of relevance to the resettlement programme for people with learning disabilities. The first states “Effective arrangements should be in place to address deficits in assessment and treatment in LD inpatient units as highlighted by the Independent Review of MAH (and other incidents affecting NI patients in private LD hospitals). In relation to this priority the Provider Requirement was, “Trusts should demonstrate plans to develop community based assessment and treatment services for people with a learning disability with a view to preventing unnecessary admissions to LD hospital and to facilitate timely discharge. (CPD2.8)”

6.4.7 The second of the strategic priorities was, “Effective arrangements should be in place to complete the resettlement and address the discharge of people with complex needs from learning disability hospitals to appropriate places in the community (CPD 5.7). In relation to this priority the Provider Requirement stated, “Trusts should demonstrate plans to work in partnership with service providers and other statutory partners to develop suitable placements for people with complex needs.”

6.4.8 In addition there was a specific Skills Mix/Workforce area identified within the commissioning plan for action. This highlighted that, “Effective arrangements should be in place to develop multi-disciplinary services in community settings to address the actions required within the Independent Review of MAH.” The Provider Response required in relation to this area was that “Trusts should demonstrate plans to recruit multi-disciplinary teams to build the community infrastructure to support people with a learning disability outside of hospital settings. Trusts should demonstrate plans to work with their independent sector partners to build the skills and capacity of their workforces to enable them to support and sustain people with complex needs in their community placements.”

6.4.9 These elements of the HSCB’s commissioning plan clearly laid out the expectations of both the Department through its directive and the HSCB/PHA response to progress actions directly relevant to the delivery of the resettlement programme in Northern Ireland. HSCT’s would have been expected to reflect these within their Trust Delivery Plans (TDP’s) so that commissioners had an understanding of the actions Trust’s proposed which could then be monitored at a regional level for progress.

6.4.10 In subsequent sections we will look at how these clear commissioning intentions were executed and to what extent these requirements were delivered.

6.5 Commissioning of Specialist Housing with Support for People with Learning Disabilities in Northern Ireland.

6.5.1 In order to consider how the Trusts were to meet the objectives laid out above it is important to understand the role of the Northern Ireland Housing Executive (NIHE) and housing associations/charities in terms of the provision of specialist housing with support for adults with learning disabilities. The NIHE is the largest social housing landlord in Northern Ireland; it is required to regularly examine housing conditions and housing requirements; it is also required to draw up a wide ranging programme to meet these needs. For individuals with housing needs that have additional support needs this is addressed through the Supporting People Programme. The Supporting People Programme helps people to live independently in the community and is administered by the NIHE in Northern Ireland on behalf of the Department for Communities. The Supporting People Programme grant funds approximately 85 delivery partners that provide over 850 housing support services for to up to 19,000 service users across Northern Ireland, with the total programme operating an annual budget of £72.8m in 2021/22. In relation to schemes for people with learning disability, the current provision has the potential to support 1334 individuals in 149 accommodation-based schemes. With an annual budget of £16.3 million.

6.5.2 The 2015 review of Supporting People recommended the introduction of a strategic, intelligence led approach to identify current and future patterns of need. Consequently, the NIHE and partners developed a Strategic Needs Assessment (SNA). This provides a comprehensive picture of housing needs for people who require additional care and support. It highlighted that people who are living with learning disability mostly require accommodation-based support rather than floating support as their disability is lifelong. A time-bound floating support intervention in these cases is not deemed an adequate intervention. Although floating support services offer the opportunity to allow individuals to remain in their own homes, respondents noted that this does not negate the need for accommodation services for those living with a greater complexity of need.

6.5.3 In terms of the SNA for people with learning disability they conclude that the analysis of current need suggests that there is an undersupply of 224 units. Research previously commissioned by the NIHE (2016) in reference to the resettlement of individuals living with learning disabilities from long stay

institutions highlighted that for these people there are several elements of supported housing services that are important:

- location or at least access to public transport network,
- safety
- Integration into the community.

6.5.4 These are important to the individuals to allow for their own independence and the feel of being part of a community. It is apparent from their research that the demand for learning disability services and in particular autism services has increased due to improved diagnosis and treatment services, which in turn will lead to an increased demand on housing support services. As the future calculations show, it is estimated that there will be an undersupply of 479 units for this cohort within a ten-year period.

6.5.5 Additionally, the SNA highlights the important issue of access to capital for housing development. Some providers have highlighted that capital investment would allow them to provide the required level of service to meet the growing demand as well as a wider range of housing support services.

6.5.6 It also refers to some early joint planning work between the NIHE, HSCB and HSCT's in relation to improving planning for the needs of people with learning disabilities. The information gathered and analysed in 706 person pilot conducted by HSCB with HSCTs for people with learning disability the report identifies could help inform future strategic needs assessment particularly if standardised approach were developed.

6.6 How commissioning operated in practice to deliver the resettlement programme for the people awaiting resettlement from MAH.

6.6.1 The commissioning plan from the HSCB/PHA had made an explicit requirement for the resettlement of the remaining people awaiting discharge to be progressed at pace.

6.6.2 In order to progress the HSCB convened a number of groups to support this process. There was a Mental Health/Learning Disability Strategic Leadership Group comprising senior leaders from the Directorate of Children and Social Care in the HSCB and the Directors responsible for learning disability services in each of the Trusts. This group had a leadership role across the whole of mental health and learning disability services, and held a collective strategic responsibility for the delivery of resettlement. This group sponsored 2 subgroups which comprised officers of the HSCB and senior operational staff

from the Trusts, including the Assistant Directors/Co-Directors responsible for learning disability services. Initially this only included representation from Belfast, Northern and South Eastern Trusts as the remaining people in MAH awaiting discharge were the responsibility of these organisations by virtue of the individual's original place of residence. These subgroups were (1) the Regional Learning Disability Operational Group (RLDOG) which included some representation from NIHE, and other agencies such as RQIA, and (2) Community Integration Programme (CIP) which looked more specifically at the issues pertaining directly to the resettlement programme.

6.6.3 The review team were able to observe and participate in all of the above groups and in addition had specific meetings with each of the Trust's senior leadership teams responsible for learning disability resettlement.

6.6.4 It was positive that the HSCB had created a structure of groups and meetings to progress the resettlement programme and address related issues, particularly in relation to access to learning disability hospital beds for assessment and treatment. There was a clear commitment from senior leaders to support the delivery of the resettlement programme and to work jointly to face and address the significant challenges.

6.6.5 However we felt that overall the commissioning of services was poorly framed and lacked effective performance management. This meant that the HSCB (and more recently SPPG) has struggled to achieve timely impact in ensuring the Trusts secured new homes for the people awaiting discharge from MAH.

6.6.6 There were a number of particular weaknesses which the review team identified. The HSCB were using a basic table to monitor the status of the individuals in the target population, which the review team assisted with re-design. Updates on this revised 'tracker tool' were sometimes only provided after chase up, and often not validated by the respective Trust AD/Co-Director, so may not have been reliable. Attendance at these key meetings was generally poor and inconsistent, contributed to in some instances by the too frequent changes in personnel in significant delivery or planning roles. Hopefully this report will be a catalyst for the SPPG to review with its partners the effectiveness of both CIP and RLDOG.

6.6.7 Whilst colleagues from other agencies – NIHE and RQIA – were involved in RLDOG it was sometimes unclear how they were expected to engage in the activity to progress schemes and proposals at speed. In particular the housing professionals held a wealth of information and data about activity in the existing system and had expertise in both design and delivery of housing schemes which wasn't always drawn on by colleagues from health and social care. Housing colleagues described how they felt the inter-agency working had

become less evident and effective in recent years, partly due to the lack of stable leadership and management arrangements at times in health and social care. They felt that some of the current senior staff lacked the understanding of the housing and Supporting People sector that their predecessors had demonstrated.

6.6.8 Whilst there was a verbalised commitment to working collaboratively, this was sometimes hampered by poor communication between the key partners. This was especially significant where a lead Trust was developing or planning a scheme which had the potential to provide accommodation for individuals from other Trusts. In some instances plans had not been shared with other partners which meant they weren't sighted on proposals for developments to be located in their Trust area, without their involvement in the planning, which had potential to place demand and pressure on local learning disability and other services.

Perhaps the most significant area of concern was the scrutiny of the proposed accommodation schemes and the supporting business cases to develop those schemes by the HSCB and individual Trust Boards. This rarely involved rigorous assurance that the planning for schemes would deliver new accommodation for individuals awaiting resettlement within a reasonable timescale. Subsequently the stated ambition that all people awaiting discharge from MAH would be resettled by the end of 2019 was completely missed, with slow progress verging on inertia beyond that point.

6.6.9 Having set out the regional landscape for strategic commissioning of health, social care and housing we will move in the next sections to look at how Trusts have progressed the individualised care planning (Chapter 7) and local commissioning of new provision to progress the resettlement plans developed for individuals.(within Chapter 8)

6.6.10 Across the system the review team were concerned that there were significant examples of poor or slow decision making, limited communication to support a fully collaborative approach, and weak management grip to address practical barriers that delayed positive outcomes being achieved – an example of this was transition/discharge plans being delayed for sometimes lengthy periods because required adaptations to property had not been completed, or legal advice in relation to placement matters had not been satisfactorily addressed.

6.6.11 There were a few legitimate challenges faced by the HSC system which we acknowledge compromised delivery within agreed timescales. The obvious challenge across the whole system was the global pandemic and the significant impact this had on capacity. This impacted further on workforce issues which all parts of the system described as placing them under real difficulties. Less likely to have been anticipated were the issues in relation to building and

estates , as new providers experienced unprecedented pressures in relation to the escalating cost and reduced supply of building materials which slowed the delivery of some schemes.

6.6.12 It is worth noting that all of the Trusts had engaged with some of the well-known providers in the not-for-profit sector, several of whom had a well-tested track record of meeting community demand for care and support to individuals with learning disability and behaviour that can challenge. This had resulted in a small number of resettlements being achieved through the design and delivery of high-quality singleton placements. Some of the families that we had engaged with told us stories of truly transformational and life changing experiences when their relative moved on from hospital to these schemes, and we will return to this in Chapter 8 when we look at the Operational Delivery of Care and Support.

6.6.13 However, it should also be noted that generally the review team found that Trusts often initiated planning for proposed new accommodation schemes without fully exploring the opportunities for potential provision within either existing or re-designed provision. If this had been possible then options for resettlement could have been developed in a much more speedy way.

6.7 Shaping the Independent Health and Social Care Market for People with Learning Disability

6.7.1 In the last few decades across the UK and more widely we have seen a significant shift away from hospital based long term care for people with learning disability towards community based provision. This shift has been driven by a clearer commitment to respecting the human rights of people with learning disabilities which has been enshrined in health and social policy.

6.7.2 Large scale institutional care has been replaced by a mixed economy of alternative care arrangements ranging from large scale group living to individualised specialist housing with dedicated care and support.

6.7.3 In England the responsibilities for market shaping are enshrined in the Care Act (2014) which states that each local authority “Must promote the efficient and effective operation of a market in services for meeting care and support needs with a view to ensuring that any person wishing to access services in the market:

- Has a variety of providers to choose from who (taken together) provide a range of services
- Has a variety of high quality services to choose from

- Has sufficient information to make an informed decision about how to meet the needs in question."

6.7.4 The Care Act reinforces that commissioning should be at the heart of personalised care and support. This includes commissioning with health and care organisations but goes further to include engagement with community development and working with other agencies, for example the community sector.

6.7.5 Whilst a similar statutory responsibility is not placed on HSC Trusts, they do have legal responsibilities to provide services, and should do this not only through direct provision but also by purchasing services from independent sector providers. Implicit within these broader responsibilities is a need to support and shape the market to ensure robust supply and to secure value for the public purse.

6.7.6 The review team found that health, social care and housing agencies held significant data on the current market provision relating to services for people with learning disability. RQIA hold information on each registered provider of nursing or residential care and can provide information not just on the capacity of those providers but also can provide quality information through a highly regulated inspection process. In addition, they are responsible for registering the domiciliary care element of supported living schemes which are responsible for providing the support element. We were impressed by the data that the NIHE hold relating to the 149 accommodation based supported living schemes which included both activity and financial data relating to both housing and HSC investment in these schemes, where the balance of the funding for each scheme is based on a functional analysis of the housing support vs care needs of the clients within the scheme.

6.7.7 However, the review team found that this data was not routinely shared by partners across the sector and that there was no strategic overview of what the market was providing for adults with learning disability across Northern Ireland, and at what cost. Given the availability of significant data we would expect that both strategic and local commissioners of care and housing would undertake some analysis to develop a 'supply map' of care and specialist housing for people with learning disability in Northern Ireland. This could inform strategic commissioning and market shaping, but it would also be of benefit to care managers, individuals seeking care and their families so that they understood the options available to them which could promote choice. This should be a live and dynamic picture of supply.

6.7.8 The review team gathered information from a range of sources, and undertook some analysis to establish an initial supply map, and identify commissioning trends. We will address within the recommendations. Below is a table which shows the overall range and location of registered care settings and supported living schemes in Northern Ireland. This sector provides accommodation capable of meeting a diverse range of needs, all located within the community. In total there are somewhere in the region of 2,500 places in the community for people with learning disabilities and a significant minority of the schemes have been devised to accommodate individuals who additionally have mental health difficulties or behaviour that can challenge. The cost of care across the sector is highly variable and is linked directly to the level of support and care required. For those individuals who live in the registered care sector all of the care costs are met by health and social care (although there could be a small number of 'self-funders'). HSC Trusts purchase places in registered care setting either through block contract or on a 'spot purchased' basis for individuals.

	Learning Disability	Residential Care Places		Supported Living	
	Disabilty /Nursing Home places	Statutory	Independent	Statutory	Independent
BHSCT	4 N-Homes/103 Places	6 RCH/39 Places	4 RCH/40 Places	7 Schemes	18 Schemes
NHSCT	8 N-Homes/247 Places	2 RCH/15 Places	6 RCH/58 Places	6 Schemes	27 Schemes
SHSCT	6 N-Homes/166 Places	0 RCH/0 Places	6 RCH/57 Places	13 Schemes	11 Schemes
SEHSCT	2 N-Homes/ 55 Places	2 RCH/15 Places	11RCH/180 Places	5 Schemes	38 Schemes
WHSCT	1 N- Homes/ 35 Places	5RCH/55 Places	6 RCH/ 88Places	2 Schemes	15 Schemes
Total	21 N- Homes /606 Places	15RCH/123 Places	33 RCH/423 Places	33 Schemes	109 Schemes
				Total of SP = 1420 Supporting People Tenancies/144Schemes	

(RCH – Registered Care Home) Fig 2

6.7.9 For those living within the housing with support provision the individual is usually funded through a combination of rental income which is commonly paid through housing benefit, an element for housing support paid from Supporting People funds, and then a care element paid for by the placing HSC Trust. Obviously in the case of supported living, the financial costs are spread more across 2 government departments – communities and health – and then arranged through the NIHE and HSC Trusts. In supported living the individual will have a secured tenancy, which ensures rights as a tenant under the relevant housing legislation. Additionally, the individual will be eligible to apply for

personal benefits and therefore could have more disposable income which can support greater financial choice.

6.7.10 The review team undertook a preliminary analysis of the market and in this context there were some interesting features of the market in Northern Ireland which merit some note. There are vacancies across all sectors, although the data on this wasn't readily held or available when we asked for it from Trusts, yet when talking to providers they all reported some level of vacancy across provision. For some providers in the private sector this was a particular issue in terms of sustainability, and they stated a willingness to work with local commissioners to adapt their services to be more appropriate to need and demand both now and in the future. Across the supported living sector there was somewhere in the region of 5% vacancy, which whilst relatively small did provide some opportunities to meet emerging demand, although the SNA completed by the NIHE indicates that they believe there is under provision for people with learning disability at present.

6.7.11 HSC Trusts continue to be a major direct provider of services to this client group both in registered care and supported living. Trusts operate 31% of the registered care settings for people with learning disabilities accounting for almost a quarter of the registered care places. In the supported living accommodation schemes 24% of the schemes were operated by the local HSC Trust. There is considerable variability in the extent to which Trusts continue to operate as providers. For instance, the SHSCT operate 55% of the supported living schemes in its area, but the WHSCT operates 11% of the supported living schemes in their area. This raises some interesting questions which the review team haven't fully explored in terms of the delineation of roles for Trusts both as commissioners and providers of care.

6.7.12 In relation to the registered nursing home sector these are all private sector operators. There are 21 specialist learning disability nursing homes in Northern Ireland, and the majority are operated by local providers some of whom have entered the market because of a family related interest in learning disability care or are led by professionals who previously worked within statutory services. However, 60% of the specialist nursing homes are located within 2 Trust areas of the NHSCT and SHSCT, with the majority in the NHSCT.

6.7.13 Further strategic inquiry is merited in relation to the type of need being met by statutory versus non-statutory as anecdotally this appeared to be based on historical context rather than based on strategic decisions. There could be a rationale for the HSC Trusts continuing to be such a significant provider, especially if this was to meet a category of need that the market for social care had struggled with, but again anecdotally this didn't appear to be the case.

Providers pointed out that as statutory providers were using Agenda for Change terms and conditions in employment arrangements within their direct provision, this placed Trusts at a tactical advantage in terms of recruitment and retention of staff. We will return to this issue in the later section on workforce.

6.7.14 Engagement with Private Sector Providers: we engaged with provider sector providers through a number of focus group sessions organised by 2 of the network organisations representing providers across the independent sector. These were ARC (NI) and Independent Health Care Providers (IHCP). The sector engaged very readily in the review and were keen to give their views and share their experiences of working within the wider system. Generally, providers, especially those in the private sector, felt that the resettlement teams and HSC Trusts had not engaged them in a strategic discussion about the sector's potential in meeting the needs of people awaiting discharge from long stay institutions. Several providers described that whilst they may not have been considered in the first instance, there were several occasions where they had been asked to consider and had admitted some individuals who had experienced unsuccessful placements elsewhere. In these cases several of the subsequent placements had gone on to be both successful in terms of client outcomes and stability over time.

6.7.15 Generally, providers expressed concern about the lack of effective partnership between commissioners and providers. In particular they felt that HSC Trusts were unwilling to engage in negotiations around 'risk-sharing' in terms of contractual measures that ensure a reasonable level of income to support the borrowing necessary to allow capital development and borrowing. This was more of an issue for smaller providers who were newer to the market. Providers also expressed a general view that whilst there was extensive engagement with HSC Trusts care management staff and contracting teams in relation to contract review, there was little discussion about forward planning or potential for service development. Additionally, several providers worked with a number of commissioning agencies or HSC Trusts and commented on the variability in processes and overall approach. Given the size of Northern Ireland there definitely should be consideration given to the development of a commissioning collaborative operating under a single commissioning framework. Nursing and independent residential care providers commented that they were being expected to operate under out of date nursing/residential care contracts with amendment through letter of variation, and these arrangements were not fit for purpose. This proved unsatisfactory, particularly in the context of the complexity of need of some of the clients.

6.7.16 The statutory sector within health and social care have organised their activity through the Social Care Procurement Board (SCPB) which was chaired by the

Director of Children and Social Care at the HSCB/SPPG with representation from each of the 5 Trusts and legal services. The SCPB has been going through a 'refresh' process to review its role and how it operates. Its revised draft terms of reference include:

The Social Care Procurement Board will:

a) Develop a Social Care Regional Procurement Plan that places all approved procurement projects within the overarching strategic commissioning landscape and includes the rationale for each procurement project being taken forward.
b) Ensure any request for a regional procurement project is only approved when the project can demonstrate a clear and unambiguous link with the Programme for Government and strategic commissioning plan for a related programme for care.
c) Establish a Social Care Procurement Project Delivery sub group for the operational management of the Social Care Regional Procurement Plan, with the Chair of the sub group to be a member of the Social Care Procurement Board.
d) Establish additional specialist sub groups in response to strategic commissioning needs.

6.7.17 Whilst it is encouraging to see this renewing of the SCPB it is imperative that they engage effectively in broader strategic engagement with providers so that commissioning strategies are informed and shaped with intelligence from the sector itself. There needs to be a recognition that the commissioned services with independent sector constitute a multi-million pound investment which has a massive impact on the lives of people with disability. Additionally, as elsewhere in the rest of the UK and Europe there is a growing recognition of the demographic shift in the population of adults with learning disability/ASD and behaviour that challenges leading to massive increases in demand which are related to the exponential growth in numbers of people diagnosed with LD and ASD, and the improved life expectancy of people with learning disability.

6.7.18 Several Trusts have provided us with information about provider engagement events or have established regular provider forums, to improve their partnership working. This would be best progressed through greater regional collaboration which could be supported by the SCPB's prioritisation of this important area of work.

6.7.19 Critical to this work will be developing an understanding of the pricing structure for care, and in particular the significant variation in costs across the sector. It will be important to understand both financial viability and financial sustainability of this relatively small cohort of specialist providers.

6.8 Finance and Value for Money

6.8.1 Commissioners, both strategic (regional) and local (within Trusts) have a broad duty to ensure value for money in relation to all expenditure within the public purse. This responsibility is scrutinized by the Northern Ireland Office who can pursue Value for Money Audits in relation to key areas of work.

6.8.2 The review team were not required in the context of the terms of reference for this review to undertake a detailed analysis of the costs associated with the resettlement programme, but there are a number of observations that we would make in the context of strategic commissioning.

6.8.3 The review team have had discussions with finance officers within the HSCB regarding the commissioning of learning disability services, including the services provided at MAH and the alternatives being proposed through the resettlement schemes.

6.8.4 The costs associated with the funding of MAH is linked to the funding of the resettlement costs. In the past a 'dowry' system applied where each individual being resettled from a long stay hospital received an allocated sum to support their resettlement, but there was a broad acceptance that the dowry was often insufficient to cover the costs of the placement. Whilst the dowry was person specific once it was no longer required to support that named individual, then it could be incorporated in to the base funding for future community placements at some point.

6.8.5 In more recent years this has been replaced with a requirement that the HSCB would receive costed proposals for the resettlement of an individual, directly linked to the cost of a placement or place within a newly developed scheme, and there is an approval process. This requires the HSC Trust to submit a client specific business case for each individual with complex needs, in which the Trust is required to lay out provisions for capital and on-going revenue costs, and should demonstrate value for money to the public purse. The business case must also demonstrate what elements, if any, are funded through sources of funding outside of health, usually housing/supporting people funds. This include access to personal benefits – housing and welfare payments, rental costs, or Supporting People funding towards housing support and some elements of management costs within schemes.

6.8.6 In broad terms the costs associated with the funding for MAH is linked to the funding of the resettlement costs. There would have been an assumption that a certain proportion of resettlement costs were linked to an expectation of ward closure and decommissioning of beds as the patient population reduced. In reality there should have been a decommissioning plan agreed between the BHSCT and HSCB linked to the resettlement programme, but this doesn't appear to have been put in place.

6.8.7 In recent years the number of patients leaving the hospital has been relatively low. However in addition the number of patients remaining in MAH is substantially lower that the commissioned beds. Costs within MAH have

escalated dramatically as there has been an increased reliance on funding of substantial agency staff to replace staff who have been placed on suspension during the course of the PSNI investigation.

6.8.8 This has meant that in the last several years the BHSCT has had to seek additional funds non-recurrently from the HSCB to cover these additional substantial cost pressures.

6.8.9 The other factor to consider is the cost of the alternative homes that are being commissioned for people moving on from MAH through resettlement. Through the 'tracker tool' the Trusts have reported on discharge planning for each individual and where there is a scheme either nearing completion or with a costed business case approved they provide indicative costs. Not all Trusts provide this information, but based on the return from the NHSCT the annual costs of the new provision range from £212k to £500k per annum for the majority of clients. It should be noted that there was one client who had costs significantly higher than has been quoted in the range but as this was deemed an exceptional individual with what could be considered the most complex needs that individual hasn't been included in the range.

6.8.10 As stated previously the SCPB will need to consider benchmarking the costs of these specialist community placements so that SPPG, HSC Trusts and others can establish what 'value for money' looks like in this domain. Additionally it has to be recognised that the community placements should provide significant quality of life benefits to those individuals who have previously lived in MAH.

6.8.11 Whilst the review team did not have access to detailed cost per bed data for MAH, based on our discussions with finance officers it would appear that the cost of hospital bed in MAH per annum currently is significantly higher than even the highest costed placement within the range of placements provided by NHSCT, and substantially higher than the estimated average cost of a community placement. In addition it has to be considered that for placements in specialist supported living schemes, a proportion of the costs will be shared with housing.

6.8.12 In the context of the position laid out above there needs to be consideration of the opportunity costs in this situation. A simple definition of 'opportunity cost' is "opportunity cost is the forgone benefit that would have been derived from an option not chosen or pursued". The review team consider that if the resettlement of the target group of patients had been achieved more quickly and within the timescale of the original directive from the Permanent Secretary in 2018, then there were opportunities for cost efficiencies in relation to the cost of community placement relative to the cost of continuing hospital placement for these individuals. This may be open to alternative interpretation and debate, but there is certainly merit in considering this as part of any more formal evaluation of the resettlement programme.

6.9 Recommendations

In summary the conclusions and recommendations from this chapter are:

- The DoH needs to produce an overarching strategy for the future of services to people with learning disability and their families, to include a Learning Disability Service Model.
- In the context of the overarching strategy the SPPG will develop a commissioning plan for the development of services going forward. This should include the completion of resettlement for the remaining patients awaiting discharge from MAH, and progress the re-shaping of future specialist LD hospital services.
- Strategic commissioners within health, care and housing should convene a summit with NIHE, Trusts, Independent Sector representatives, and user/carer representation to review the current resettlement programmes so that there is an agreed refreshed programme and plan for regional resettlement.
- The SPPG and NIHE/Supporting People should undertake a joint strategic needs assessment for the future accommodation and support needs of people with learning disability/ASD in Northern Ireland
- The Social Care Procurement Board should urgently review the current regional contract for nursing/residential care and develop a separate contract for specialist learning disability nursing/residential care.

7. Individualised Care Planning

In this section we will review the policies, and discharge planning guidance in place nationally to identify good practice; critically review the individualised care planning arrangements in place in each of the 5 HSC Trusts and assess their effectiveness.

7.1.0 As part of evidence gathering, the review team issued a questionnaire to all 5 HSC Trusts requesting confirmation of the assessment tools and care planning procedures and processes relied on to support discharge planning.

7.1.2 Engagement with family carers and provider organisations, provided rich information to the review team in regards to the effectiveness and experience of discharge planning and this feedback highlighted a gap between the perception of statutory HSC Trust teams leading the discharge planning and the experience of other stakeholders.

7.1.3 The review team analysed the information returned by HSC Trusts and completed a review of research and available guidelines and best practice relating to individualised care planning. The review of policy and guidelines highlighted the need to plan discharge from the moment of admission. The Care Quality Commission- Brief Guide; discharge planning from Learning Disability assessment and treatment units August 2018, (ctrl click) provides a useful checklist of what needs to be in place for effective discharge planning;

- At the point of admission, the care plan should include a section on 'when I leave hospital' and the discharge plan discussed at each meeting
- Ensure family and the individual are involved with clear goals agreed
- Discharge plans need to contain a date, an identified provider and discharge address
- Evidence that the person is being supported to develop skills for independence and living in the community
- Evidence that information is shared appropriately with providers to prepare for discharge with the outcomes of assessment and treatment clearly stated.

7.1.4 There are a range of relevant Guidelines to inform effective assessment and care planning. NICE guidelines- 'Challenging Behaviour and Learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges' (ctrl click) highlights the importance of understanding the cause of behaviour and need for thorough assessments so that steps can be taken to help people change their behaviour The DoH Guidance 'Positive and Proactive Care: reducing the need for restrictive

interventions (2014) (ctrl click) is also based on a positive and proactive care approach The Care Quality Commission, Brief Guide: Positive behaviour support (PBS) for people with behaviours that challenge (2018) (ctrl click) provides the policy position and helpful good practice case examples.

7.1.5 Promoting Quality Care' Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability services(May 2010) (ctrl click) states that a crisis plan should be included in the care plan and specify triggers and warning signs with explicit proactive and preventative strategies in the care plan. Effective assessment and care planning is central to supporting the transition of individuals from hospital to the community who have highly individual communication and support needs. Guidance and policy highlight that an essential lifestyle plan alongside the positive behaviour support plan should be central to discharge planning in addition to core assessment tools. The Centre for the advancement of PBS-(BILD) (ctrl click) advocate a whole organisational approach to embed PBS with all staff having a basic understanding of PBS and its value base. The learning from resettlement placements that have broken down and feedback from families and care providers highlights that positive support plans have not always been in place and that further work is required to ensure regional standardisation in regards to the quality of assessments and the tools used.

7.1.6 Questionnaires returned by HSC Trusts highlighted a lack of consistency regionally in the documentation used to develop care plans supporting a person's transition from Learning Disability hospital to the community. HSC Trusts use a range of assessment templates which are not always collated into one document. All HSC Trusts used the Northern Ireland Single Assessment Tool (NISAT) DoH Procedural Guidance- February 2019 (ctrl click). However, this comprehensive care management assessment tool is generic and not sufficiently person centred. Some Trusts, appropriately supplemented the NISAT with a range of assessment tools, including 'Essential Lifestyle plans 'Promoting Quality Care assessment, Functional assessment, Motivation assessment scale and Behaviour support plan. If a person is displaying challenging behaviours, a functional assessment can help uncover the reasons behind that behaviour. Knowing the function, allows changes to be made that reduce challenging behaviour. It is essential that discharge planning is person centred and that the information is accessible and available to all the stakeholders involved in supporting the person to move on from hospital. This highlights that assessment tools will only be effective if the organisational culture is based on positive behaviour support for people with behaviours that challenge and staff trained to understand and evaluate communication and to implement proactive and preventative strategies in response to triggers and warning signs to avoid escalation and crisis. Review of strategic policy across

England, Scotland and ROI confirmed that all prioritised the development of a positive behaviour framework.

7.1.7 The review team recommend that HSC Trusts collaborate to standardise their assessment and discharge planning tools to improve the quality and effectiveness of care plans. The review team recommend that the learning disability strategy / learning disability service model to be progressed by DoH takes the evidence base for PBS and learning from other UK nations into consideration.

7.1.8 The discharge process requires sufficient flexibility to ensure agility and prevent the process being risk averse, however, an overarching pathway that maps out who does what at critical stages of the process is required. The review found that there is no overarching resettlement/ discharge policy that informs the roles and responsibilities of the range of organisations, teams and individuals involved. Indicative timelines for case transfers between teams and organisations is required so that individuals and their families know what to expect at each stage of the transitions pathway. The review team recommend that HSC Trusts collaborate with all stakeholders to develop a resettlement pathway and operational procedure.

7.1.9 Most Trusts were clear that it is the community HSC Trust that has the lead role for discharge planning rather than the hospital team however, this was not consistently applied regionally. The review team worked with all HSC Trusts throughout the period of the review with agreement reached that the community HSC Trust held responsibility and accountability to lead resettlement planning once the patient had been identified as ready for discharge. The community HSC Trust will be reliant on the MAH team who have the contemporaneous experience of caring for the patient to provide clinical information and input to the care plan however the community HSC Trust should hold a challenge function in addressing any discharge delay.

7.1.10 The MAH resettlement co-ordinator has a central role in facilitating meetings and coordinating the information the hospital team need to share with community Trusts and provider organisations. Provider organisations had to develop their own care plans from information shared by the MAH team and the assessment completed by the relevant HSC Trust, whilst getting to know the patient during in-reach. They reported significant weaknesses with this approach.

7.1.11 It was generally recognised that it is a complex task to develop care plans for community living based on behaviours and triggers evident in an institutional setting. This highlighted that the community teams should lead the discharge

care planning processes with active collaboration with families and provider organisations which was not always evident in the review.

7.1.12 Learning from failed placements and engagement events with provider organisations and with families, highlighted that not all care plans were robust in highlighting the key issues and risks for the individual. Families shared their experience of resettlement placements breaking down within weeks and months of the trial placement with recurring themes; staff not knowledgeable or trained in Positive Behaviour approach, inexperienced staff relying on physical interventions and care plans that did not reflect the level of support that would be required in the community.

7.1.13 Families were confused by the process of handover between teams due to a lack of clarity regarding the roles of the community learning disability team, the dedicated resettlement team and the MAH team when a patient is discharged on trial. Families were unclear of the process for standing down the resettlement team and transitioning to the community learning disability team. Some families who had experienced placement breakdown during trial resettlement felt that the process was too focused on the MAH multi-disciplinary team for advice and support rather than involvement and wraparound services from the community learning disability team. Some families expressed the view that their loved family member was returned to MAH at the first challenge when more should have been done to sustain the community placement. There should be a clear process mapped out through the resettlement pathway providing clarity of roles and mapping out indicative timeframes for transitions between teams for patients and families long the resettlement pathway.

7.1.14 Care providers reported a negative experience of care planning due to gaps in the information that should have been provided by HSC Trusts. Assessments were stated to be based on the current behaviours in an institutional setting and not on the hopes and dreams that should be central to strength based person centred planning

7.1.15 There was insufficient evidence of the learning from things going wrong being used to improve discharge planning regionally and no evidence provided that the learning is shared with care providers. Care providers also highlighted that the focus tends to be on what has gone wrong rather than on what is going right and that the HSC system should collate the learning from successful placements. The review team recommend that HSC Trusts collaborate with key partners to share the learning when things have gone wrong as well as the success factors when resettlement has worked well and celebrate positive resettlement stories.

7.1.16 The review team were tasked to review the care plans for all the service users in MAH and critically analyse the actions taken to identify and commission suitable community placements. The terms of reference asked the review team to look specifically at the MAH population profile by the length of time the person has been in MAH, where they were admitted from and if resettlement has already been trialled. The analysis of the thirty six current in-patients and 4 patients on extended leave is presented in the following charts.

Table 1.1 MAH current population by length of stay (Inclusive of 36 in-patients and 4 patients on extended leave).

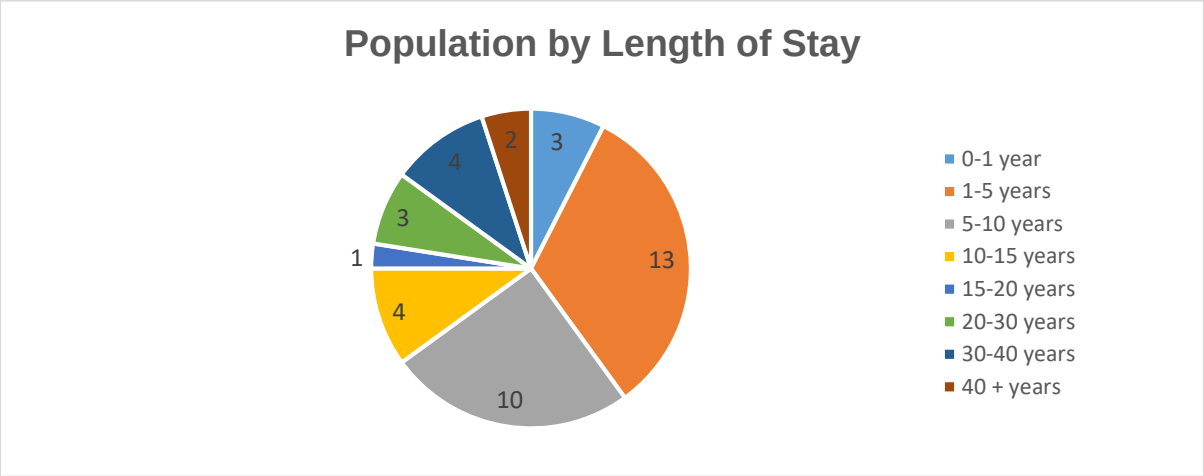


Fig 3

7.1.17 The original Patient Target List (PTL) was established to target long-stay patients for resettlement who had been in-patient at MAH for more than one year in 2007. The analysis of length of stay of the current in-patient population identified ten patients from the PTL list who have not been resettled of whom six have been in MAH over thirty years and 2 in MAH over forty years. The range of lengths of stay for the remaining 16 delayed discharge patients not on the PTL list, varies by HSC Trust. SEHSCT range between 2 and 4 years. BHSCT range between 2 and seven years and NHSCT range between 2 and ten years.

7.1.18 The hospital has been virtually closed to admissions over the past 2 years however, it is of note that the 3 admissions in the past year were all BHSCT patients. Two of these admissions were from a respite facility managed by BHSCT and one from a facility managed by an independent sector provider. It is clear that HSC Trusts are responding to a higher level of acuity and risk in the community than previously however, further action is needed to embed hospital avoidance measures through community treatment and intensive support to prevent further admissions and adding to the delayed discharge population.

7.1.19 The impact of new admissions on a long stay population is significant due to the challenge of managing very diverse and competing needs. The majority of patients in MAH are NOT on active treatment and should be progressing on a skills development and transitions pathway. Unplanned new admissions have the potential to impact on the opportunities and quality of life for longer stay patients if the focus in the hospital is on managing risk and crisis response. It is critical that community based crisis response and intensive support services are further developed to prevent crisis admissions.

Table1.2 MAH Admitted From

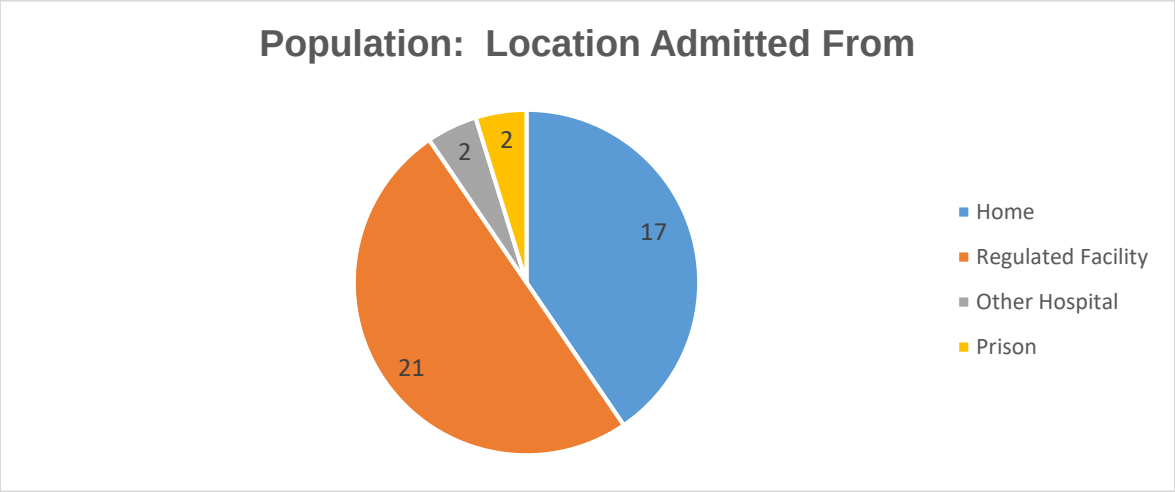


Fig 4

7.1.20 Patients with longer lengths of stay were more likely to have been admitted from home, but those admitted in more recent years were likely to have been admitted from a range of regulated facilities. Two patients transferred from prison and 2 of the MAH patients transitioned from the children's inpatient facility the Iveagh centre. Children & Young People with learning disability were not in scope for this review however, feedback from family carers stressed that a lifecycle approach to planning is essential to effectively project and plan for transitions and that children, young people and their family carers should have a say and input into planning adult services as a key stakeholder. Analysis of the data relating to where patients have been admitted from, highlights that recent admissions have all been from regulated learning disability facilities managed by both statutory and independent sector providers. The review team did not see evidence of the learning from these crisis admissions however, the evidence base and policy/commissioning direction in England and Scotland highlights the need to step up wraparound intensive support services to meet the needs of the individual but also to wraparound the staff teams often struggling to respond.

7.1.21 The review team had the opportunity to visit people in supported living environments who had previously been transferred to medium secure hospital in the UK and were now successfully returned to their home community. The success factors in sustaining the placement reported by both the Independent sector provider and the Trust was the level of collaboration, responsive and pro-active interventions by the Trust Learning disability forensic team. The independent sector care staff talked about the importance of building relationships and trust with statutory colleagues. The Welsh Government's 'Improving Lives Programme (2018) placed particular emphasis on communication and effective working relationships at all levels across the system. The emphasis on these 'softer' skills within the Improving Lives programme of change is significant. The review team received feedback from statutory, independent sector providers and from families highlighting concerns about the lack of openness, trust and respect in relationships. Families reported that lack of continuity of key workers has impacted on developing trusted relationships alongside the fact that their trust in the HSC system has been broken due to the allegations of abuse at MAH. Care Providers and HSC Trusts expressed negative experiences in the contracting and monitoring of services due to a lack of trust.

7.1.22 It is critical that community based intensive wraparound services are developed to prevent placement breakdown and prevent hospital admission. However there is also a need to get back to basics and spending time repairing and building relationships which should be informed by the values underpinning the HSC Collective leadership strategy (ctrl click) to ensure effective person centred planning and collaboration with all relevant stakeholders

Table1.3 MAH current population Number of previous trial placements

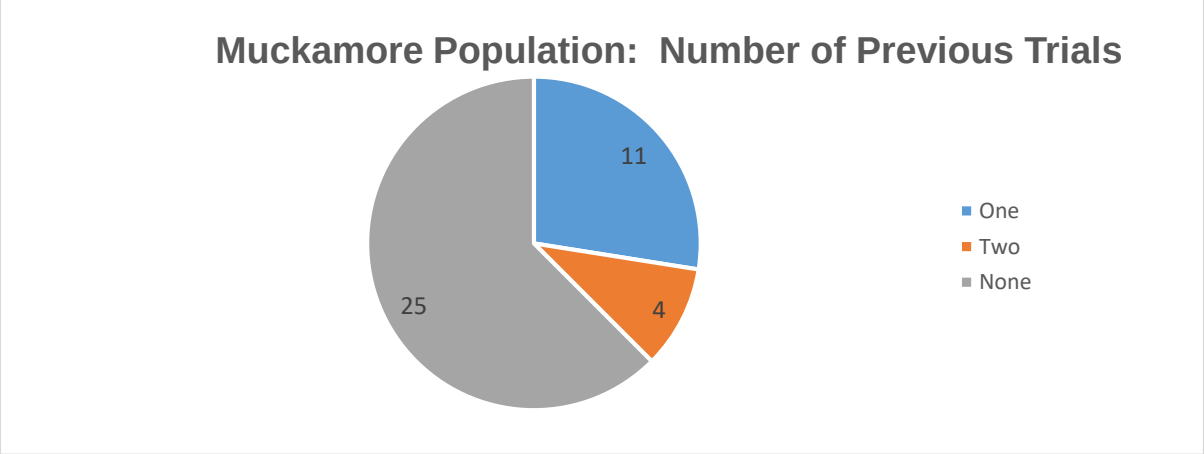


Fig 5

7.1.23 In regards to previous trial resettlement, the analysis confirmed that all PTL long-stay patients had at least one previous trial placement with one PTL patient

who had been offered 2 placements but would not leave the hospital. A small number of patients who had become institutionalised by having lived most of their adult lives in hospital were distressed by the experience of trial resettlement, which were then unsuccessful. This is a key reminder that whilst we should be ambitious for timely resettlement the primary importance is getting the resettlement right first time in order to prevent further breakdown causing trauma and distress. The majority of patients who have not yet had a previous trial placement are the more recent admissions or the small number of patients subject to a hospital order with restrictions with step down from detention requiring collaboration with the Department of Justice.

7.1.24 MAH serves 3 HSC Trusts, the BHSCT which manages the hospital, the NHSCT and SEHSCT. The WHSCT has its own Learning Disability in-patient beds at Lakeview Hospital and the SHSCT has its own Learning Disability in-patient beds at Dorsey hospital. There are a few out of area placements. SHSCT has one patient in MAH. NHSCT has one patient in Dorsey and one patient in Lakeview.

7.1.25 At commencement of the Review of Resettlement, there was a total of sixty Learning Disability in-patients delayed in discharge regionally; 46 at MAH, 8 in Dorsey Hospital and 8 in Lakeview Hospital.

7.1.26 The review team established the baseline MAH Population in June 2021 and updated the population baseline as of 11th July 2022. It is encouraging to note that there have been ten discharges between June 2021 and July 2022 however 3 admissions. The NHSCT had the highest in-patient numbers at commencement of the review however, BHSCT now has the highest number of in-patients.

Table 1.1: Patients by HSC Trust – June 2021

Trust of Residence	Number of In-Patients
NHSCT	21
BHSCT	16
SEHSCT	8
SHSCT	1
WHSCT	0
Total	**46**

Fig 6

Table 1.2: - Patients by HSC Trust-11th July 2022

Trust of Residence	Number of In-Patients
NHSCT	14
BHSCT	15
SEHSCT	6
SHSCT	1
WHSCT	0
Total	**36**

Fig 7

7.1.27 The review team critically evaluated the progress of resettlement plans as devised by the responsible Trust for each patient in MAH and reviewed all business cases which have been completed or are still in process, to identify any strategic or operational barriers and make recommendations for actions to accelerate the delivery of proposed pipeline schemes. The review team reviewed the data submitted by all 5 Trusts on the monthly tracker to HSCB/SPGG and met with Northern Ireland Housing Executive, Supporting People leads to validate information relating to Supporting People schemes. Through this analysis, the review team identified individuals where plans are absent or weak requiring alternative plans.

7.1.28 At the outset, the review team met with the Director and senior management team of each of the 5 HSC Trusts to discuss their approach to discharge planning, to clarify the specific plans in place for each patient and the business cases being progressed directly by the Trust or reliance on schemes being progressed by another HSC Trust. The review team assessed discharge plans against deliverability and timescale for discharge. There were common issues raised by all HSC Trusts with the key challenge to discharge noted as workforce recruitment and capability alongside gaps in the community services infrastructure required to maintain community placements.

7.1.29 Tracking resettlement from the 1980's, has seen a clear move over the years from large institutional settings to smaller nursing and residential homes in the community and progression to supported living models based on single tenancy or small number of people sharing

7.1.30 The focus currently has moved to new build bespoke schemes that have a minimal design to delivery timeline of between 2 and 5 years which has become a significant delay factor. BHSCT has 3 capital schemes in the pipeline. Minnowburn which was a BHSCT only scheme for 5 patients and the On-Site and Forensic schemes to accommodate patients from all 3 HSC Trusts. The timelines for the new build schemes have drifted and most are still at an early stage of development. The review team view the uncertainty of

projected discharge dates for these capital schemes as unacceptable and highlighted the requirement for alternative options to be pursued.

7.1.31 The review team were concerned that robust needs assessments had not been completed for patients identified for the On-Site and Forensic schemes resulting in a lack of clarity about the appropriate service model and whether registration of the On-Site scheme should be for a nursing home or residential facility. Robust Needs assessment should be the basis for any procurement or service development. It was a recurring issue throughout the review that insufficient attention has been given to needs assessment at individual case and population level.

7.1.32 The review team obtained information from Supporting People and data from RQIA in regards to regulated nursing and residential schemes which highlighted vacancies in current schemes. Feedback from provider organisations suggests that Trusts have not worked sufficiently with provider organisations to explore how current capacity could be customised to meet need with view to speed of implementation. This requires fresh thinking and imagination based on robust needs assessment. It would appear that the HSC system has become risk averse and focused on bespoke new build schemes.

7.1.33 HSC Trusts need to be clear about risk appetite based on robust Assessment of Need/Risk and analysis of what is working for similar needs in the community. Delivering this challenging agenda also requires a corporate and regional approach to ensure the relevant skill set promotes fresh thinking and delivery.

7.1.34 HSC Trusts narrative and reporting in relation to resettlement plans was repetitive, providing reassurance rather than assurance based on evidence. Trust Boards should have challenged the timelines presented for resettlement and queried contingency arrangements for expediting earlier discharges. At the commencement of the review, all HSC Trusts reported that discharge plans were in place for the majority of their patients however the review team's analysis identified that most plans were still at scoping stage and therefore lacked the robustness and detail required to establish a reliable trajectory for tracking performance. Delegated Statutory Function reports for all HSC Trusts focused on the lack of community living options, rather than on breach of Human Rights and did not provide the assurance required. There was insufficient challenge by Trust Boards and the HSCB/SPGG.

7.1.35 Four discharge placements had already been commissioned and had been available from commencement of the review including 3 planned discharges to Cherryhill (BHSCT Supported living). One of the Cherryhill discharges was delayed due to the wait for minor adaptation work. This matter should have

been escalated for urgent approval through senior management rather than rely on routine processes. Three of the Cherryhill discharges were delayed due to staffing shortfall and requirement to recruit additional staff. In light of the fact that discharge placements for 3 patients were available, there should have been a more strategic approach taken in regards to deployment of the workforce with view to reducing the MAH in-patient population. BHSCT had a strategic focus on the stability of the MAH workforce with daily monitoring and reporting given the reliance on agency staff. This appeared to impact on decision making about using agency staff to transition with the patient until sufficient staff could be recruited and trained. The bigger picture of reducing the population through more flexible utilisation of the workforce to expedite the discharges was raised by the Co-Director but not progressed. The complexity of the logistics associated with workforce allocation cannot be underestimated however, the delay and drift in discharging 3 patients added to the staffing pressures in MAH. Prioritising a consultation with legal services in relation to the fourth patient who had a placement already commissioned by community LD services was agreed but not actioned, resulting in drift. In this specific case, the community HSC Trust and the BHSCT should have been working more collaboratively to an agreed action plan. It was concerning to note the drift in these specific cases despite the opportunities being highlighted to the involved HSC Trusts by the review team. Whilst there are recognised delays associated with new build schemes there should have been more focus on those discharges that could have been expedited more speedily.

7.1.36 The review team completed an analysis of resettlement plans, revised the performance tracker tool and provided advice to HSC Trusts on the immediate actions required to accelerate resettlement and strengthen reporting and accountability arrangements.

- Advice to Trusts to rethink the deliverables to focus on speed of implementation given the unacceptable timelines for new build schemes still at initial development stage
- Advice to BHSCT to extend the TOR for the On-Site project chaired by Director to include the Forensic scheme given the inter-dependencies for the NHSCT and SEHSCT on both schemes
- Advice to NHSCT to engage the care provider for the new build scheme Braefields, to agree concurrent admissions rather than the eighteen month phased implementation as planned.
- Advice to Trusts to review available capacity in the nursing home and residential/ supported living schemes and agree how placements could be tailored to meet need
- Advice to Trusts to urgently re-assess patients identified for the Forensic scheme and bring forward individual discharge solutions.

- Advice to all Trusts to prioritise the focus on individual cases with an increased potential for early discharge rather than focus on new build schemes.

7.1.37 The landscape changed throughout the period of the review, with HSC Trusts revising their plans in recognition of the long lead in time for new build schemes. The review team welcome the fresh thinking and renewed collaboration between the Belfast, South Eastern and Northern Trusts evident from April 2022 resulting in solution focused workshops to address the long standing challenges associated with delayed discharge. Consideration was given to the development of an interim model on the MAH so that patients pending discharge to community placements would be cared for in a social care model as part of transition planning. However, due to the continuing pressure on workforce availability and capability which is evident in MAH, the thinking is rapidly changing with re-focus on building individual placement discharge options rather than on an interim on-site social care solution. The review team completed a stocktake of all plans at commencement and end of the review fieldwork and will present the analysis on progress on a Trust by Trust basis and summarise the projected discharges by end March 2023.

7.1.38 The SEHSCT was reliant on the BHSCT and NHSCT new build schemes for 5 of their patients and are now pursuing alternative plans to replace reliance on the forensic and on-site schemes. Discharge plans in development for 4 patients appear to be realistic and deliverable. The Trust plans to discharge 2 patients in August 2022 and a further patient in September 2022. The Trust does not yet have plans in place for their 2 forensic patients but have plans in development for the other patients. The profile of the SEHSCT remaining delayed discharge population highlights very diverse needs ranging from 1 patient who has lived in MAH for 45 years, 1 patient on a Hospital Order with restrictions and 1 young person who transferred from a children's facility.

7.1.39 The NHSCT's discharge planning was based on 2 new build schemes and a number of individual bespoke placements. The NHSCT was reliant on the BHSCT delivering the On-Site scheme for 1 patient and the forensic scheme for 1 patient. The NHSCT has robust plans in place for six NHSCT patients to transfer to the Braefields scheme from August 2022 and for 4 patients to transfer to Mallusk new build scheme between August 2022 and March 2023. Two patients have commissioned placements at named schemes with discharge dates agreed by end July 2022. The NHSCT has progressed planning for their patients delayed in discharge across all 3 learning disability hospitals in Northern Ireland and have definite dates agreed for discharge of patients from Dorsey and Lakeview In summary the NHSCT has made

significant progress in developing robust discharge plans with progress hindered by challenge with recruitment to the Mallusk scheme and challenges in the building supply chain that slowed building work moving the handover date of the Braefield scheme from end April to end August 2022.

7.2 BHSCT – Regional Role as the Trust Responsible for MAH

7.2.1 Reducing the MAH population is a strategic priority and should be a significant measure in providing assurance about safe and effective care in MAH. Reducing the population would defacto reduce workforce challenges and support the remodelling of the hospital site with view to re-establishing patient flow and acute admissions. The Leadership and Governance report (2020) highlighted that the Trust focus on resettlement came at the cost of scrutiny of the Safety and Quality of care of those in-patient. Given that BHSCT has the lead role for the management of MAH as well as the delivery of 2 schemes that other HSC Trusts were co-dependent on, namely the Forensic and On-Site schemes, a review of BHSCT Board agenda and minutes for 1 year, 2020/21 was completed by the review team to identify the level of scrutiny and challenge to address the delayed discharges from MAH.

7.2.2 The analysis of Trust Board minutes confirmed that MAH is a substantive standing agenda item at each Trust Board with update report and papers on safety metrics and workforce presented by the MH/LD Director. Updates on the number of patients in MAH are provided however, there was limited scrutiny in regards to the resettlement plans for BHSCT patients or the capital business cases in development.

7.2.3 The review team found that the pendulum appears to have swung to a primary focus at Belfast HSC Trust Board on the development of safety metrics and workforce stability with limited challenge to the timelines proposed for resettlement of BHSCT in-patients.

7.2.4 The following updates on the MAH population and resettlement plans were provided to Belfast Trust Board by the Director of Mental Health and Learning Disability services.

- Oct 2020 Director reported 43 patients, 2 on trial and 1 on home leave. Further 5 BHSCT discharges expected to proceed.
- Dec 2020 Director reported- 47 patients – 3 on trial. NHSCT-20, BHSCT-17, SEHCT-8, SHSCT-1, WHSCT-1
- April 2021- Number of patients noted as 43 - 2 on trial resettlement and 1 on extended home leave. Expect another 5 discharges of BHSCT patients in the next 6-months by September 2021.

The Executive Director of Social Work reported satisfactory compliance with requirements specified in the Delegated Statutory Functions Scheme of delegation. The DSF report- noted 6 successful discharges and further 5 on trial resettlement with plans in place for a further 16 resettlements. The report noted a lack of community placements for LD impact on delayed discharge.

- Nov 2021- Director for strategic development updated on planning for On-Site business case.4 patients meet criteria. Outline specification drawn up and shared with capital panning team. Design team secured to complete feasibility study of the MAH site. Steering group has held 4 meetings.
- January 2022- Director update- 39 patient- 4 on trial and 1 on extended leave only 2 on active treatment. Chairman sought clarification on timeframe for the On-Site resettlement business case. Director reported that the timeframe for the On-Site scheme was 2024/2025. Further business case to be developed for forensic scheme- Requires identification of appropriate site.
- BHSCT's Delegated Statutory Functions report 2021/22 lacked scrutiny from Trust Board. It is of note that BHSCT reported that resettlement plans were in place for 15 patients and no plan in place for 1 patient.

7.2.5 Analysis of the regular updates to Belfast HSC Board and through the Delegated Statutory Function reports in regards to progress on resettlement, highlight the repetitive narrative based on plans in the early stages of development which were not robust enough to provide assurance in regards to projected discharge dates.

7.2.6 Whilst the Chairman of the BHSCT sought clarification on timeframe for the On-Site resettlement business case on 1 occasion and Director advised that the timeframe for scheme completion was 2024/2025, this appears to have been accepted rather than discussed or challenged.

7.2.7 BHSCT's dedicated resettlement team was funded for 2 community integration co-ordinators and a Social Worker to develop Essential Lifestyle plans. The Social Work post and 1 of the coordinator posts are vacant. A senior manager post established to review SEA's and develop an action plan on the lessons learned is also vacant.

7.2.8 BHSC Trust had 16 patients in MAH at commencement of the independent review and still has 15 patients in MAH at 11th July 2022. Our analysis of the current position for BHSCT in regards to revised planning is that BHSCT has robust discharge plans in place for 2 patients to transition to current nursing home and supported living vacancies by September 2022. However, the plans for the remaining 13 patients have not been confirmed in regards to named scheme or estimated discharge date and remain plans in development. There are 3 major challenges for revised plans, Workforce recruitment, re-registration

of schemes and most significantly the time required to engage and gain agreement from family carers. This is a dynamic environment and the summary and trajectory provided by the review team reflects the position at 11th July 2022.

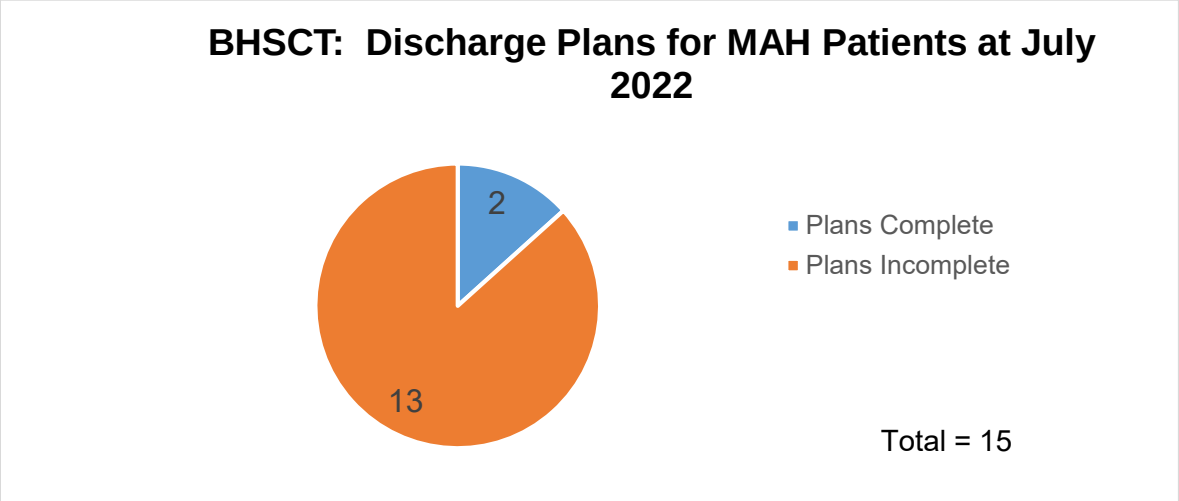


Fig 8

7.2.9 The review team considered in detail how the Trusts developed plans, proposals and accommodation services to meet the aggregated needs of this group as identified through their individual care plans in Chapter 8.

7.3 SEHSCT - Resettlement plans

7.3.1 SEHSCT completed a number of capital business cases some years ago significantly reducing the Trust's long-stay in-patient population to eight patients at commencement of the review and 6 in- patients at 11th July 2022.

- The Trust was reliant on the BHSCT and NHSCT new build schemes for 5 of their patients and The Trust is now pursuing alternative plans to replace reliance on the forensic and on-site schemes. Discharge plans in development for four patients appear to be realistic and deliverable. The Trust plans to discharge two patients in August 2022 and a further patient in September 2022. The Trust does not yet have plans in place for their 2 forensic patients but have plans in development for the other patients. The profile of the SEHSCT remaining delayed discharge population highlights very diverse needs ranging from one patient who has lived in MAH for 45 years, 1 patient on a Hospital Order with restrictions and one young person who transferred from a children's facility.

- SEHSCT has a new build scheme in development in partnership with a care provider but recognised that this will not be a viable option for MAH discharges given the long lead in time
- It is of note that one SEHSCT patient has been on extended home leave with an extended support package from March 2020 with family taking the patient home at the onset of the Covid pandemic. BHSCT also had one patient on extended home leave for similar reasons. An evaluation of how the extended home leave placements have been maintained for this lengthy period without return to MAH should be completed to inform future support models aimed at admission avoidance.

7.3.2 The review team have used the Care Quality Commission - Brief Guide; definition that a discharge plan needs to have an identified care provider, an address and a discharge date to be agreed as a discharge plan. The review team used this definition to assess the robustness of the SEHSCT updated discharge plans. SEHSCT has a confirmed placement at Mallusk scheme for one patient with discharge expected in August 2022. The Trust has commissioned a nursing home placement for one patient with discharge date in August 2022. SEHSCT expect an additional patient to transfer to a specialist facility in the Republic of Ireland with discharge expected by September 2022. Three of the SEHSCT 6 patients have robust discharge plans and imminent discharge dates. A plan is in development for one patient and 2 patients do not have a robust plan.

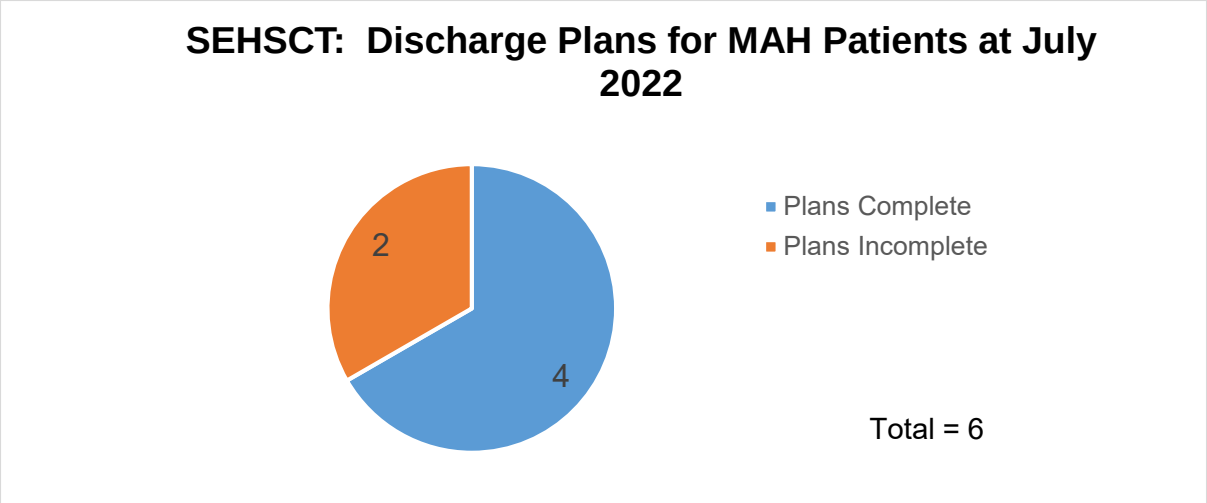


Fig 9

7.4 Northern HSC Trust – Resettlement plans

7.4.1 Historically the NHSCT has been reliant on hospital admission resulting in the highest number of patients to resettle regionally. At the outset of the independent review, the NHSCT had nineteen delayed discharge patients in

Muckamore Abbey Hospital, 1 patient delayed in Lakeview Hospital and 1 patient delayed in Dorsey Hospital

7.4.2 The Northern HSC Trust's discharge planning was based on two new build schemes and a number of individual bespoke placements. The Northern HSC Trust was reliant on the Belfast HSC Trust delivering the On-Site scheme for one patient and the forensic scheme for one patient. The NHSCT has robust plans in place for 6 NHSCT patients to transfer to the Braefields scheme from August 2022 and for 4 patients to transfer to Mallusk new build scheme between August 2022 and March 2023.Two patients have commissioned placements at named schemes with discharge dates agreed by end July 2022. The NHSCT has progressed planning for their patients delayed in discharge across all three Learning disability hospitals in Northern Ireland and have definite dates agreed for discharge of their patients from Dorsey and Lakeview Hospitals. In summary the Northern HSC Trust has made significant progress in developing robust discharge plans with progress hindered by challenge with recruitment to the Mallusk scheme and challenges in the building supply chain that slowed building work for the Braefields scheme moving the handover date from end April to end August 2022.

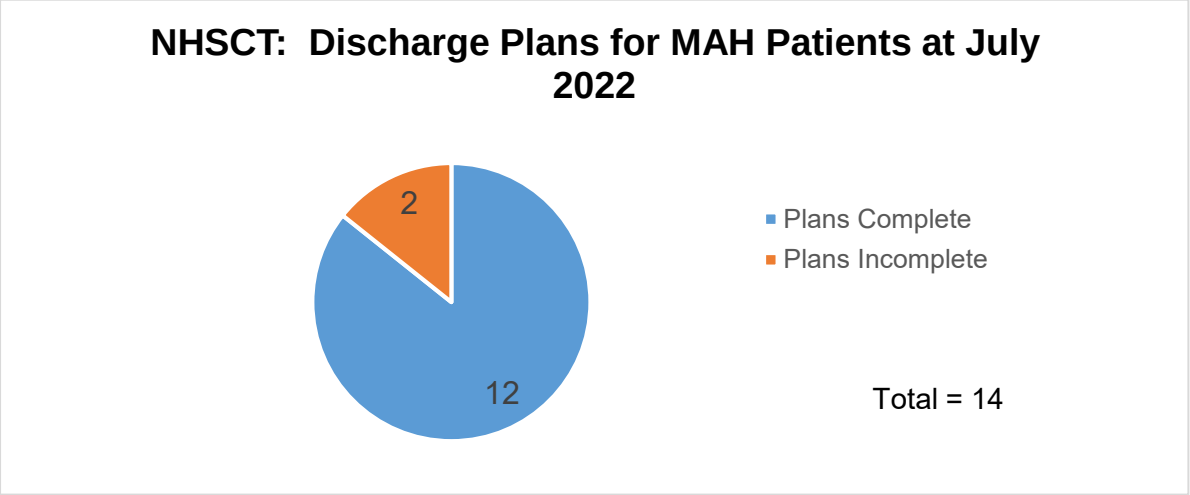


Fig 10

Key findings; the analysis of the review of Individualised care planning has highlighted a number of concerns and themes

- HSC Trusts were not responsive to data requests with responses missing deadlines and monthly performance monitoring templates not being robustly completed with key data missing or not updated.
- The narrative from HSC Trusts was repetitive and had not been sufficiently challenged by HSC Trust Executive teams, Trust Boards or the HSCB/ SPPG resulting in significant delay in identifying and challenging the lack of progress.

- Proposed discharge plans were not assessed against an agreed definition for a discharge plan, namely that a plan requires a confirmed care provider, confirmed scheme address and confirmed estimated discharge date to be agreed as a robust discharge plan.
- HSC Trusts were asked by the review team to validate the data supplied by RQIA and Supporting People and provide additional data on housing with support placements not captured in the NIHE and RQIA data sets. A questionnaire was developed by the review team to collate data from HSC Trusts to establish a regional supply map. The response from HSC Trusts was poor and not reliable. The HSCB/SPGG completed an exercise in 2020 to complete Needs assessment for Housing with Support. The variation regionally in demand reflected the poor quality of the information returned by HSC Trusts based on a range of interpretations of the questions.
- There is a need to get back to basics to ensure effective person centred planning and collaboration with all relevant stakeholders in the development of discharge plans. There appeared to be a lack of dialogue between HSC Trusts and providers to share the lessons learned from failed placements. The learning from trial placement breakdowns should inform discharge planning and will only be achieved through an integrated care approach based on partnership and collaboration.

Recommendations

- SPPG needs to strengthen performance management across the HSC system to move from performance monitoring to active performance management holding HSC Trusts to account.
- SPPG should establish a regional Oversight Board to manage the planned and safe resettlement of those patients not currently under active assessment or treatment
- Consideration needs to be given to building highly specialist community based crisis response support teams to promote admission avoidance.
- A regional positive behaviour framework should be developed with the standard of training for all staff working in learning disability services made explicit in service specifications and procurement.
- Learning disability strategy / service model to be progressed by DoH should incorporate the evidence base for PBS and learning from other UK nations
- HSC Trusts should collaborate with all stakeholders to develop a resettlement pathway and operational procedure.
- HSC Trusts should ensure that the lived experience of the person and their family is effectively represented in care planning processes and the role of

family carers as advocates for their family member is recognised and respected.

- HSC Trusts should collaborate to standardise their assessment and discharge planning tools to improve the quality and effectiveness of care plans

8. Operational Delivery of Care and Support

In the previous chapters we have talked about the strategic and commissioning framework for services, and also have considered the importance of good individualised care planning. In this chapter we need to consider the delivery of care and support and the experience of the individuals who have gone through resettlement and their families.

It is worth briefly revisiting what the current mapping of accommodation, care and support services looks like. There are 21 specialist LD nursing homes in NI offering a total of 606 places; there are a total of 48 residential care homes (15 statutory and 33 independent) offering a total of 546 places (123 statutory residential care places and 423 independent residential care places); and there are 149 accommodation based supported living schemes for people with learning disabilities offering a total of 1334 places across Northern Ireland.

8.1 Range of provision available:

8.1.1 There is a really impressive array of different types of homes for people with learning disabilities, and this diversity reflects the heterogeneous nature of the learning disability who will have a wide range of needs and wishes that need to be considered for each individual. This diverse picture also reflects significant variation in the cost of care, again dependent on a range of factors but primarily the needs of the individual and the staffing associated with those needs to ensure a safe and stable quality of care can be routinely delivered. In this context schemes which are designed and very bespoke to the particular needs of an individual will be higher than for those living in group living environments, where there may be 'economy of scale' factors to reduce the care costs. There has to be a recognition that for some individuals living with other people poses too significant a challenge and their needs can only be met in living alone situations, although there is always a need to ensure that these individuals have access to social relationships and community interaction as appropriate. Some providers have moved to try some innovation through congregated settings, but with separate living accommodation.

Range of provision available throughout Northern Ireland

Fig 11

8.1.2 The broad thrust within the Bamford Review had been towards smaller group living options, and away from large congregated community settings. The bar chart below shows the spread of size within accommodation-based supported living schemes funded through Supporting People and HSC funding agreements, and the general trend is in favour of smaller schemes. Whilst this is a welcome change of direction the emerging policy and strategic positions in relation to both learning disability and adult social care within Northern Ireland will need to address the sustainability of funding as demand increases linked to the demographic changes that we can expect for this population.

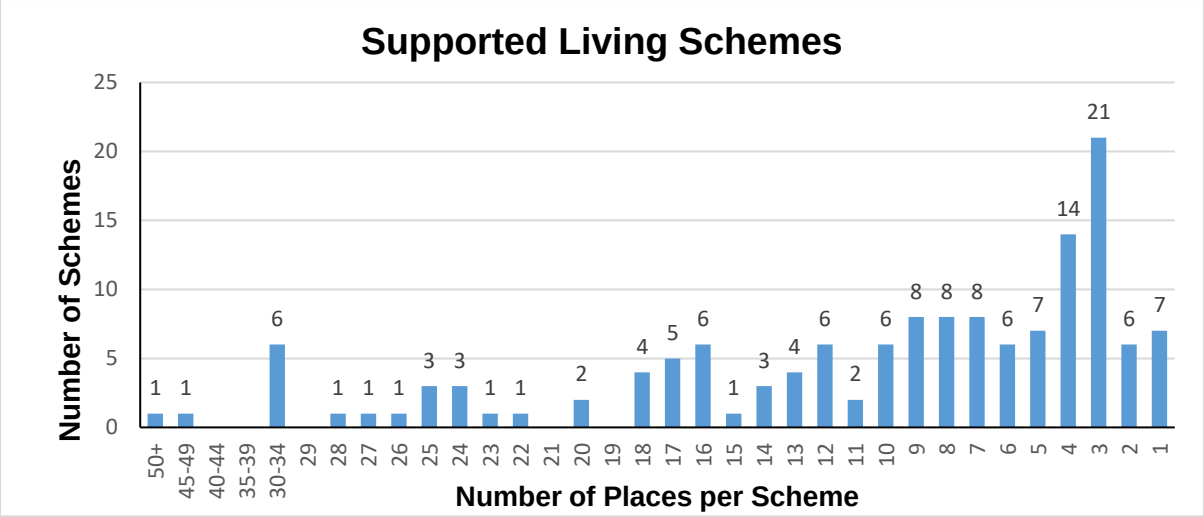


Fig 12

8.1.3 It is also important to recognise that within the independent sector it is highly probable that in the current population of residents and tenants within their settings that there will be individuals with similar needs profiles to those individuals who are awaiting resettlement from hospital. The sector has already demonstrated a readiness to meet the needs of individuals with complex needs often relating to co-morbidity of learning disability and mental health issues along with behaviour that can challenge. We heard several success stories which should be a strong foundation for understanding what works well for this group of especially vulnerable individuals.

8.2 Workforce

8.2.1 It is fair to say that across all stakeholders workforce was the single biggest concern, both in terms of the existing and future provision. Providers and NISCC as the regulator of the social care workforce expressed concern about the continuing need to develop a skilled and stable workforce across the sector. The inability to both recruit and retain a social care workforce was a massive risk for the sustainability of the existing provision and the most significant barrier for the proposed new developments. This has seriously hampered progress of several of the resettlement schemes which it is hoped will provide new homes for existing people living in MAH.

8.2.2 The models supporting the development of many of the new schemes are psycho-social rather than medical. Therefore the workforce will need to have skills in the delivery of psychological and social interventions, along with an understanding of the need to re-refer to specialist clinical services as and when appropriate. Most providers were now adopting Positive Behaviour Support as central to their service offer, although we heard concerns expressed by the

Royal College of Psychiatrists about the 'fidelity' of this approach which was often variable in both delivery and positive outcomes. There was certainly some anecdotal evidence to suggest that in some settings some of the least qualified and experienced staff were working with some of the clients with most complex needs. This sometimes resulted in poor continuity linked to high turnover of staff.

8.2.3 However the workforce issue was also a mixed picture. Some of the more established providers with a longer track record of service provision had better ability to recruit and retain staff, and some of the not for profit organisations had also recruited specialists in psychology or positive behaviour support to provide consultancy and support to their own provision. We also heard some providers describe how they had expanded the skill base within their teams by recruiting professionals from other disciplines such as teaching or youth and community work. Similarly we were impressed that some of the private providers described very stable teams, who were generally recruited from the local community with high rates of retention.

8.2.4 We have commented in an earlier section about the issues related to differential rates of pay, and particularly the disparity between statutory and non-statutory services in terms of Agenda for Change profiled pay in services provided by HSC Trusts. Whilst rates of pay are going to vary across the sector there needs to be some discussion within the sector to ensure that this isn't operated in a way that becomes a barrier to stability within the workforce. An integrated workforce strategy that looked at staffing across the whole landscape of learning disability services should be linked to the Learning Disability Strategy and Service Model, and should provide better learning and developmental opportunities as well as supporting greater mobility across sectors and roles. The review team are encouraged that MDAG has oversight of a regional workforce review across adult learning disability teams and services. This review has a wide scope of the learning disability workforce across statutory, private and independent sectors. A multi-disciplinary team has been put in place to undertake this important piece of work which is expected to complete in 2023; a survey has been undertaken to establish the baseline of the current workforce as of 31st March 2022.

8.3 Quality of Care within Services

8.3.1 Given the size and nature of the sector it has to be recognised that quality could be variable. However, there was certainly encouraging signs that would suggest that services were of good quality in many settings. RQIA have a responsibility to inspect registered care settings and in doing so seek the views of residents and staff. Generally in most registered care settings these are positive, with

positive comments about compassionate and caring staff in many settings. Whilst it could be argued that these may be more subjective than objective observations, RQIA are working with ARC and PCC through projects like “Tell It Like It Is” to ensure that there are a range of ways of accessing the views of people living within these settings and their families.

8.3.2 The review team were able to visit one particularly innovative example of a bespoke placement for a young man who was living with learning disability and ASD, and who was being supported to live on his own with 24/7 on-site support. He had successfully been transitioned back from a long term specialist placement in another part of the UK. The staff team supporting him were especially attuned to designing support appropriate to his needs and tolerances, as well as addressing the significant risks both within his home setting and when accessing the community.

8.4 Resettlement Process and Outcomes:

8.4.1 Broadly speaking the resettlement process could be split in to 3 phases – (1) pre-placement which included assessment and consultation to identify suitable placement opportunity; (2) transition phase which focuses on the planned move and immediate monitoring and support intensively immediately after placement; and (3) ongoing post placement support, including contingency plan to manage ‘crisis’.

8.4.2 One area of concern was that the region didn’t appear to have developed a regionally agreed resettlement/transitions pathway for people who were transitioning from hospital settings. Several stakeholders raised this as a concern. Families felt that they were insufficiently involved in developing these plans at times of a critical move. We asked the BHSCT as the lead Trust in terms of resettlement to provide us with the resettlement pathway, and after a gap of several weeks they issued us with a ‘draft resettlement pathway’ which we believe was produced without consultation with other Trusts, families or providers. Whilst it was good to see a willingness to develop an agreed pathway, we would have expected it to have previously been in place and to have gone through a co-production process. Consequently there was a great deal of variability to the quality of pre-placement arrangements and transition plans.

8.4.3 There were key issues which an agreed pathway and protocol could have resolved. Central within this would be where the primary responsibility for resettlement lay – especially what role the hospital multi-disciplinary team had in relation to the process relative to the role and responsibilities of the receiving/home Trust who would have on-going responsibility for supporting the

placement. We certainly were told of a concern that the hospital teams held an overly prominent level of sway in terms of choice of placement and the parameters of moves, including the extent to which 'leave' was extended for lengthy periods beyond the point where the individual had left the hospital. Several providers commented that the assessment of the client's needs provided by the hospital was sometimes not fit for purpose in terms of how they would devise a plan of care and support appropriate to the new care setting. Often the hospital had limited experience or understanding of how the client might be in other community-based settings. There was a general view that hospital perspectives could be overly risk averse, and rarely acknowledged the significant experience of the more established providers. The review team drew a conclusion that it was imperative that Community Learning Disability Teams/Services of the receiving/home Trust needed to take the lead during the transition phase and to act as an effective bridge between the hospital at the point leading up to discharge and the provider as they accepted the client.

8.4.4 Sadly several of the families that were willing to share their experience had gone through a process of placement break down, and we heard some harrowing accounts of how placement disruption was handled. However it is important to note that for many of these individuals and their families the system continued to support them and ultimately they found suitable new homes.

8.4.5 In terms of the third phase of post-placement support, again we heard of a very mixed picture from providers. Some providers talked about a lack of clarity between the roles of different teams.

8.4.6 Where systems described placements going well there were a number of key features which are worthy of note. The extent to which the 'new' staff supporting the client had an opportunity to begin to establish a working relationship and understand the individual and how best to meet their needs was an important foundation stone. Plans that had considered contingency if things started to go wrong were more robust, and in particular access to additional dedicated support from local Trust services at times when a crisis was emerging was particularly important. There is some variability between HSC Trusts in relation to the extent that they have been able to develop these specialist levels of support, although all are making moves in that direction. One provider described that their ability to support some individuals with very high levels of challenge and potential risk because of the responsiveness of the Trust services when they 'put up the flag'. In this scenario it was the strong and established partnership between the provider and the Trust services – clinical and commissioning – that gave them the resilience to support a number of individuals with the highest levels of need. In this situation there was clear evidence of effective communication, joint working and mutual respect and

support, all of which was focused on keeping the client at the centre of the process.

8.4.7 Whilst in all areas we heard about providers and local commissioners having engagement through contract review processes, there didn't appear to be well established broader engagement across the sector to support more effective partnership working. We felt that at a time when the health and social care system is committed to further development of integrated care systems, that there could be some work done here to support an integrated care pathway for these individuals with significant complexity of need.

8.5 Local Commissioning by HSC Trusts of Accommodation Schemes to address the needs of Individual Resettlement Plans

8.5.1 In chapter 7 the review team laid out what we found in relation to the evidence for good individualised care planning and the current level of practice. In order to find accommodation solutions for the individuals awaiting resettlement the Trusts needed at a local level to commission, either singly or jointly, new schemes that could meet the requirements for this clearly identified population.

8.5.2 There was distinct variation in relation to how effectively the development of new accommodation schemes was executed by individual Trusts.

8.5.3 Positively the NHSCT had worked well with a small number of trusted providers to develop several schemes which then had the potential to accommodate most of their remaining patients from MAH. At the time of the review this had ensured that business cases had been approved for social care and housing funding as appropriate, and the development of these schemes had reached completion of the buildings and were now moving to transition planning contingent on successful recruitment and staffing of the schemes.

8.5.4 Historically the NHSCT had historically been reliant on hospital admission resulting in them having the highest number of patients to resettle regionally. At the outset of the independent review, the NHSCT had 19 delayed discharge patients in MAH, 1 patient delayed in Lakeview Hospital and 1 patient delayed in Dorsey Hospital

8.5.5 The NHSCT's discharge planning was based on 2 new build schemes and a number of individual bespoke placements. The NHSCT was reliant on the BHSCT delivering the On-Site scheme for 1 patient and the forensic scheme for 1 patient. The NHSCT has robust plans in place for six NHSCT patients to transfer to the Braefields scheme from August 2022 and for 4 patients to transfer to Mallusk new build scheme between August 2022 and March 2023. Two patients have commissioned placements at named schemes with

discharge dates agreed by end July 2022. The NHSCT has progressed planning for their patients delayed in discharge across all 3 learning disability hospitals in Northern Ireland and have definite dates agreed for discharge of patients from Dorsey and Lakeview In summary the NHSCT has made significant progress in developing robust discharge plans with progress hindered by challenge with recruitment to the Mallusk scheme and challenges in the building supply chain that slowed building work moving the handover date of the Braefield scheme from end April to end August 2022.

8.5.6 The Mallusk new build scheme was completed 2021 with 2 admissions to date with significant and unacceptable delay in the care provider recruiting sufficient staff to support further admissions to the remaining six places. This scheme will accommodate another 4 NHSCT patients and 1 SEHSCT patient.

8.5.7 The Braefields new build scheme for seven places has been developed to accommodate six patients from Muckamore and 1 NHSCT patient in Lakeview hospital. The NHSCT patient in Dorsey. Hospital is in the process of transitioning to a vacancy in a community scheme by end July 2022.

8.5.8 The NHSCT plans to discharge twelve MAH patients prior to end March 2023 to named and commissioned placements. These plans are viewed as robust – 6 to Braefields, 4 to Mallusk and the other 2 patients to named supported living and nursing home vacancies. The plans for the remaining 2 MAH patients are in development and not yet robust. The review team remain confident that the Mallusk and Braefields schemes will come to completion within the coming 6 – 9 months, and that this would allow the majority of the NHSCT clients to transition to their new homes. Whilst there had been some slippage in the time scale, their robust plans had supported effective review and senior leaders within the Trust engaged effectively with providers to challenge poor progress against agreed timescales.

8.5.9 SEHSCT completed a number of capital business cases some years ago significantly reducing the Trust's long-stay in-patient population to eight patients at commencement of the review and six in- patients at 11th July 2022.

8.5.10 The SEHSCT, by working effectively in tandem with the NHSCT had been able to support the delivery of a number of schemes that would offer new homes to their remaining patients/clients. SEHSCT had the smallest number of clients remaining and relied on a mix of engagement with the collaborative inter-Trust schemes, and singleton or bespoke solutions. This allowed them to demonstrate that they had robust plans with a realistic potential of positive outcomes, although again recruitment difficulties for providers tended to be the limiting or constraining factor which delayed delivery.

8.5.11 The SEHSCT was reliant on the BHSCT and NHSCT new build schemes for 5 of their patients and are now pursuing alternative plans to replace reliance on the forensic and on-site schemes. Discharge plans in development for 4 patients appear to be realistic and deliverable. The Trust plans to discharge 2 patients in August 2022 and a further patient in September 2022. The Trust does not yet have plans in place for their 2 forensic patients but have plans in development for the other patients. The profile of the SEHSCT remaining delayed discharge population highlights very diverse needs ranging from 1 patient who has lived in MAH for 45 years, 1 patient on a Hospital Order with restrictions and 1 young person who transferred from a children's facility.

8.5.12 SEHSCT has a new build scheme in development in partnership with a care provider but recognised that this will not be a viable option for MAH given the long lead in time, and therefore will be likely to meet future emerging need.

8.5.13 It is of note that 1 SEHSCT patient has been on extended home leave from MAH with an extended support package since March 2020 with family taking the patient home at the onset of the Covid pandemic. BHSCT also had 1 patient on extended home leave for similar reasons. An evaluation of how the extended home leave placements have been maintained for this lengthy period without return to MAH should be completed to inform future support models aimed at admission avoidance.

8.5.14 The Belfast HSC Trust (BHSCT) was an outlier in terms of its ability to successfully progress robust plans to deliver resettlement outcomes for the 15 patients who were their responsibility. However, it is worth making a few contextual comments in relation to the Belfast Trust's system wide responsibility. BHSCT had management responsibility for the provision of the hospital services provided at MAH, which dated back over an extended period of time. This meant that the Director and Co-Director in BHSCT responsible for learning disability services were balancing the ongoing delivery of the MAH hospital services, which faced significant safeguarding and staffing issues following the allegations of abuse, alongside the responsibility to support the resettlement not only of their own clients, but also of the patients in MAH who originated from other Trust areas. It should be noted that the HSCB had funded some additional dedicated staff posts within BHSCT to support the regional resettlement programme(detailed in chapter 7), and that the HSCB had provided substantial additional non-recurrent funding in light of the financial pressures associated with the heavy reliance on agency staffing within MAH staffing levels. The review team acknowledge that this placed the leadership team in BHSCT under considerable pressure, and it is to be regretted that this appears to have hampered their commitment to delivering the overarching resettlement requirements.

8.5.15 The BHSCT had through its planning processes proposed that the majority of its clients could be resettled through a number of dedicated new schemes. The primary focus of the new schemes was around 3 groups of patients. The first of these was patients who had been described as having a 'forensic' profile and required specialist provision specific to their needs. The second group was a small number of patients, most of whom had lived in MAH for several decades, and for whom it now appeared there should be a dedicated 'on-site 'provision' that would allow them to remain in situ but within a new or re-purposed accommodation on the hospital site. The third group were 5 patients, all from the BHSCT area, who had been identified for a new provision within the Belfast.

8.5.16 To meet the needs of these 3 distinct group of patients within MAH BHSC Trust's resettlement plans centred on 3 new build schemes in development since 2019. The 3 capital build schemes were planned to accommodate ten of the BHSCT patients. One patient for the On-Site scheme, 4 patients for the forensic scheme and 5 patients for the Minnowburn scheme which was a proposed development but not projected to be ready until at least 2025. The review team met with Northern Ireland Housing Executive's Supporting People leads in regards to the planning process for the Belfast Trust's Supporting People schemes in development and the strategic outline case (SOC) submitted for the forensic scheme and the process and timelines for full business case and delivery. Supporting People also provided update on discussions with BHSC Trust in regards to their plans for the Minnowburn proposal. The review team analysed the SOC submitted by the Trust and minutes of the Strategic Advisory Board meetings chaired by NIHE Supporting People Director. The review team noted confusion and drift in the range of schemes submitted by BHSCT as strategic outline cases. The SOC was drafted and submitted by a senior planning manager with extensive experience of previous resettlement schemes. When this manager retired it would appear that both organisational memory and experience were lost when he left, resulting in drift with SOC not progressing to full business cases as agreed.

8.5.17 At commencement of the review, the plan for the forensic scheme was a 12 place extension to an existing scheme, Knockcairn/Rusyhill. The original plan was for a twelve placement scheme to accommodate both MAH patients and BHSCT community clients and a strategic outline case (SOC) was submitted to Supporting People. Further analysis concluded that this design would not meet the needs of the remaining forensic population. Supporting People advised the review team that the full business case for the forensic scheme was anticipated in October 2019 but not received- Supporting People also highlighted that no funding from Supporting People has been ring-fenced therefore BHSCT will require to fund both capital and revenue funding.

8.5.18 BHSCT then asked a Housing Association to identify a suitable site for a new build scheme. Seven sites were identified however, location of the majority of sites were unsuitable for a forensic scheme due to proximity to high density areas. Preferred sites were identified in both the NHSC Trust and SEHSCT areas with the second confirmed as the most suitable. Given the inter-dependencies of the NHSCT and SEHSCT on this scheme all 3 HSC Trusts should have been collaborating on decision making but this was not the case, and the other Trusts were unaware of these proposals. Given the delays in progressing the business case, the NHSCT and SEHSCT are now scoping alternative individual placements with view to agreeing more timely discharge dates for their forensic patients.

8.5.19 The Belfast Trust Co-Director has now advised the Housing Association to take no further action to purchase a site pending further discussion in relation to needs assessment and current demand for a forensic new build scheme. The forensic scheme has been in development since 2019. Priorities have changed over the 3 years the outline case has been in development undermining the planning assumptions underpinning the proposed scheme. The process highlights confusion and drift and illustrates poor planning and delivery.

8.5.20 Minnowburn scheme for 5 BHSCT patients. The Minnowburn scheme requires disposal of a current BHSCT property/ site through Public sector trawl with an eight stage process and earliest delivery timeframe 2024/25 Whilst this scheme is in development it will not be ready until at least 2025. Alternative individualised discharge plans are now required given the long lead in time for project delivery.

8.5.21 MAH On-Site Provision: The picture in relation to the ‘on-site’ provision was particularly confused. The DoH had made it clear to Trusts that there should be consideration given to an on-site re-provision for those individuals for whom MAH had effectively been the only home they had known as adults. Whilst the letter from the DoH refers to a small number anticipated to be less than 10, at the point where the review team were considering the revised plans for individuals, only 4 patients had been identified as potentially requiring the onsite facility. The letter was clear that this provision should be separate from the assessment and treatment provision within the hospital. Four long-stay patients met the criteria identified; 1 BHSCT client, 1 NHSCT client and 2 SEHSCT clients. A project team was established chaired by the BHSCT Director and membership included SEHSCT and NHSCT representatives along with other key stakeholders. A design team was appointed to compete a feasibility study. In our meetings with senior staff responsible for learning disability services at the time in BHSCT there was a lack of clarity as to what type of provision was required, in terms of models of nursing provision, or social care and housing.

There seemed to be lengthy delays in establishing the feasibility of re-purposing some of the existing hospital estate and the associated indicative costs. In recent months due to the escalating concerns about the delay in the progression of plans for this provision by BHSCT the 2 other Trusts responsible for 3 of the 4 targeted clients have decided that the proposed on-site provision no longer represents the best option for their individuals and are pursuing other potential solutions. In light of this the BHSCT will need to consider how best to meet the needs of the 1 remaining patient who was in the cohort of 4.

8.5.22 Whilst all of these schemes had been in development since 2019 or earlier, at the point of the review in early 2022 none of these schemes had progressed beyond the most preliminary stages and given the dynamic position in terms of changes in the needs of the broader population the rationale underpinning the original cases for the schemes became unsustainable. In reality there were not credible plans in place for delivery of these schemes, and both capital and revenue funding had not been secured.

8.5.23 We have previously referenced the significant changes in leadership and planning roles, which was particularly apparent within BHSCT. This meant that there never seemed to be a maintained momentum for delivery of these proposed schemes through a rigorous project management approach. Given these difficulties and delays the projects failed to progress beyond the drawing board stage, and in the most recent discussions the other Trusts have indicated that they are pursuing alternatives to the proposed joint venture for a forensic scheme and on-site provision; they now want to consider separate provision on a smaller scale for their own clients. This has effectively meant that the considerable time and effort expended in the original proposals have not delivered and were ineffective. Additionally, it means that the assurances provided to the BHSC Trust Board regarding the robust plans being in place for the individuals concerned was not underpinned by realistic and deliverable planned schemes.

8.5.24 However, the recent ‘refresh’ of the senior operational leadership within the Learning Disability Team at BHSCT has brought some encouraging signs of a new approach. They are urgently reviewing all their plans, in the context of the rapidly changing picture as other Trusts review and accelerate plans for individuals. The additional catalyst for this revised approach and more rapid progress relates to the significant supply and financial pressures that the staffing situation in MAH is creating. In this context the BHSCT has shown a real willingness to look at re-purpose and re-design of some existing provision as an alternative to new build options. This could significantly improve the speed of the resettlement for the BHSCT residents who are patients in MAH, although these proposals are at a very early stage of consideration and have

yet to be tested fully in terms of feasibility, and acceptability to the individuals who will be offered these accommodation options, and their families.

8.5.25 Recent contingency planning due to staffing pressures at MAH and request to HSC Trusts to bring forward alternative plans to replace the capital schemes with lengthy and unpredictable delivery dates, has changed the discharge planning position for the 3 HSC Trusts with patients in MAH. BHSCT are responding positively to this new challenge and are scoping discharge options. The Trust has identified supported living schemes in the BHSCT area with under occupancy which may provide viable discharge options. These plans are in an early stage of development but show promise. The Care Quality Commission- Brief Guide; discharge planning from Learning Disability assessment and treatment units (August 2018), highlights that a discharge plan needs to have an identified care provider, an address and a discharge date. The review team have used this as the basis for judging if the discharge options proposed by all HSC Trusts are robust enough to provide confidence and predictability in regards to timeline for discharge.

8.5.26 BHSC Trust had 16 patients in MAH at commencement of the independent review and still has 15 patients in MAH at 11th July 2022. Our analysis of the current position for BHSCT in regards to revised planning is that BHSCT has robust discharge plans in place for 2 patients to transition to current nursing home and supported living vacancies by September 2022. However, the plans for the remaining 13 patients have not been confirmed in regards to named scheme or estimated discharge date and remain plans in development. There are 3 major challenges for revised plans, Workforce recruitment, re-registration of schemes and most significantly the time required to engage and gain agreement from family carers. This is a dynamic environment and the summary and trajectory provided by the review team reflects the position at 11th July 2022.

8.6 Lessons Learnt and Evaluation:

8.6.1 We know that many stakeholders within the overall system are committed to supporting a learning culture, which adopts a ‘lessons learnt approach’. Organisations like RQIA have supported the adoption of Quality Improvement [QI] methodologies in supporting providers to promote continuous improvement within their services, and as previously identified the work that RQIA, ARC and the Patient and Client Council are doing within the ‘Tell It Like It Is' Project are encouraging. However, we were disappointed that there didn’t appear to have been any systematic evaluation of the experience of individuals who had been resettled, both successfully and unsuccessfully. It felt that there were opportunities to undertake some audit activity and also to consider whether

there is scope for pre and post placement Quality of Life measures to be applied so that there is some empirical evidence of the improvement in individual's lives. Although many people told us stories, both good and bad, of the experience of people during the resettlement process we didn't come across any evidence of this being properly documented, and consequently the voices of the people at the centre of this process often went unheard. There is undoubtedly potential for a more formal evaluation of the experience of those who have been resettled contributing to a better understanding of what works well and what doesn't.

8.6.2 On a positive note leaders and citizens across the system talked passionately about the need for better sharing of good practice models, and the need to ensure that the stories about the valued lives of people with learning disability must be communicated through a positive narrative available to the public and society at large in Northern Ireland. This laudable ambition is one that we believe everyone involved in this process would willingly support.

8.7 Recommendations

- The sector should be supported to develop a shared workforce strategy, informed by the consultation being undertaken by the DoH as part of the workforce review, to ensure that it there is a competent and stable workforce to sustain and grow both the sector in terms of size and quality, so that it is responsive to significantly changing demand.
- HSC Trusts should urgently agree a regional pathway to support future resettlement/transition planning for individuals with complex needs.
- HSC Trusts should establish a local forum for engagement with LD providers of registered care and supported living to develop shared learning and promote good practice through a collaborative approach to service improvement.
- There should be an evaluation of the experience of people who have been resettled to understand what has worked well and what needs to change for the better.

9. Safeguarding

In this chapter we will consider the legislation and policy relating to Adult Safeguarding in Northern Ireland, the learning from RQIA inspections, the findings from previous independent investigations of failures in the care provided to vulnerable adults and the views and concerns of family carers and their lived experience relating to safeguarding.

9.1 We have talked in previous chapters about the fact that the confidence of family carers in the HSC system's ability to Safeguard and protect people with a learning disability has been impacted significantly due to findings of abuse at MAH. We gathered evidence through our direct engagement with family carers which included family carers whose loved one has already been resettled and living in the community, as well as MAH family carers. All raised safeguarding as a significant concern with the review team. Family carers provided feedback to the review team about the actions they wish to see addressed in regards to their concerns about adult safeguarding and protection and their views and experiences will be explored later in this chapter.

9.2 It is important to set the concerns and expectations of family carers and the findings of this review in the context of Adult Safeguarding legislation, policy and practice in Northern Ireland.

9.3 A review of Safeguarding policy and practice was not within the scope of this review however, the review team analysed the findings from previous independent investigations of failures in the quality of care provided to vulnerable adults in Northern Ireland to inform our recommendations about individualised care planning and the commissioning and procurement of services to support discharges from Northern Ireland's Learning Disability Hospitals.

9.4 The recommendations arising from the 'Home Truths' report on the Commissioner for Older People's investigation into Dunmurry Manor care home (2018) and the CPEA Independent whole systems review into safeguarding at Dunmurry Care Home (2020) have resulted in a draft 'Adult Protection Bill' (July 2021) which will introduce additional protections to strengthen and underpin the adult protection process; provide a legal definition of an 'adult at risk' and in need of protection and define the duties and powers on all statutory, voluntary and independent sector organisations. An Interim Adult Protection Board (IAPB) was established in February 2021. It is clear to the review team that significant steps have been taken by the Department of Health to update legislation and policy in regards to adult safeguarding.in Northern Ireland in response to the learning from failures in care.

9.5 The Muckamore Departmental Assurance Group (MDAG) was established to monitor the effectiveness of the HSC system's response to the 2018 independent Serious Adverse Incident (SAI) review into safeguarding at MAH following allegations of physical abuse of patients by staff. The action plan monitored by MDAG, includes an action to complete a review of Adult Safeguarding culture and practices at MAH to inform wider consideration of regional safeguarding policy and procedures taking account of lessons also emerging from the Independent Review into Dunmurry Manor. This action is focused on safeguarding culture at MAH however, our engagement with the wider HSC and care providers highlighted variation both in practice and attitudes cross the Trusts. RQIA inspections of other learning disability hospitals in Northern Ireland also highlight ongoing concern about standards of safeguarding practice.

9.6 Current Safeguarding policy and practice is guided by; 'Prevention and Protection in Partnership Policy' (DHSSPS) 2015 and the adult Safeguarding Operational Procedures – 'Adults at Risk of Harm and Adults in Need of Protection' (HSCB) 2016. The policy highlights that adult safeguarding arrangements should prevent harm from happening and protect adults at risk. Safeguarding is a continuum from taking steps to prevent harm through to protection highlighting that safeguarding is everyone's business and not just the business of statutory safeguarding teams. The stories shared by family carers later in this chapter and in chapter 10, put the spotlight on psychological and emotional harm and fact that more could have and should have been done to prevent harm.

9.7 RQIA carried out a review of safeguarding in Mental Health and Learning Disability hospitals (2013) looking specifically at the effectiveness of safeguarding arrangements. A recommendation from the RQIA review was that the DHSSPS should prioritise the publication of the Adult Safeguarding Policy framework. RQIA published a follow up report, Safeguarding of Children and Vulnerable Adults in MH/LD Hospitals in NI (2015) following inspection in the Southern HSC Trust.

9.8 The Bamford Review of Mental Health & Learning Disability recommended a new comprehensive legislative framework for mental capacity legislation and reformed mental health legislation for Northern Ireland. This has been taken forward by the implementation of the Mental Capacity Act (NI) 2016 which has a Rights based approach and brings new safeguards in regards to deprivation of liberty and consent. The Mental Capacity Act (NI) 2016 provides a statutory framework for people who lack capacity to make a decision for themselves and provides a substitute decision making framework. The Act is being implemented in phases. Phase one implemented from December 2019 included provision of Deprivation of Liberty Safeguards (DOLS') and a DOLS Code of Practice. DOH (April 2019) The Mental Capacity Act (NI) 2016 is intended to protect the human rights and interests of the most vulnerable people in society who may be unable to make decisions for themselves and offer enhanced protections to people

lacking capacity. The Act is principles-based and sets out in statute that it must be established that a person lacks capacity before a decision can be taken on their behalf. It emphasises the need to support people to exercise their capacity to make decisions where they can. This legislation will change and shape practice across learning disability services with a focus on Best Interests. Decision making in complex areas such as the use of CCTV will be addressed in more detail later in this chapter.

9.9 Whilst progress has been made in regards to legal safeguards for decision making in respect of individuals who lack capacity and in regards to placing adult safeguarding on a statutory footing, incidents highlighting concerns about safeguarding and restrictive practices remain current in practice.

9.10 This is evidenced in an RQIA inspection report following an unannounced inspection at Lakeview Learning Disability Hospital between August and September 2021 which identified a number of matters of significant concern in relation to adult safeguarding and incident management. A further inspection was completed in February 2022 which found that progress had been made in a number of areas however, there had been limited progress with regards to adult safeguarding and incident management. The RQIA inspection report noted areas for improvement relating to adult safeguarding including a review of the use of CCTV to support adult safeguarding.

9.11 The 'Way to Go' report made a recommendation that In addition to CCTV's safeguarding function as a tool to prevent harm rather than as a means to ensure safe and compassionate care, CCTV should be used proactively to inform training and best practice developments at MAH CCTV needs to be considered This recommendation is included in the MDAG action plan and the BHSCT CCTV policy group continue to engage with stakeholders to reach agreement, on best practice in MAH .The review team were advised that Questionnaires have been issued to family members, carers, patient and staff to seek feedback and engagement around the use of CCTV on site

9.12 CCTV was a central issue of concern for MAH families in the context of discharge planning. Some of the MAH family carers stressed the importance of CCTV in providing them with assurance. Families stressed that CCTV has been central to establishing abuse at MAH and that they hold significant concerns about CCTV not being in place in community settings. The review team were advised about one case where this issue created delay in progressing plans for discharge due to the Trust and the family holding differing views of what could be put in place. During engagement events with families, the review team were advised that some families see the need for CCTV as a consequence of their loved one being the subject of abuse at MAH and that maintaining similar monitoring in the community setting is an important bridge for these families. The debate on the use of CCTV between the family and the Trust in one case could be a barrier to discharge with potential to cause delay. CCTV played an important role in

recording potentially abusive behaviour by staff in Dunmurry Manor Care Home, Winterbourne View as well as MAH. The initial concerns were not initiated by CCTV but rather used to explore concerns raised by family which led to the identification of concerns. Given the importance family carers placed on CCTV, the review team reviewed the actions taken by RQIA to address this issue.

9.13 RQIA issued Guidance on the use of overt closed circuit televisions (CCTV) for the purpose of surveillance in regulated establishments and agencies (May 2016) The guidance was aimed at assisting registered providers in meeting the best interests of service users when considering the use of overt CCTV systems and reminds them of the requirements of the Data Protection Act 1998 and Article 8 of the European Convention on Human Rights-Right to respect for private and family life. The guidance states that CCTV should not be used in rooms where service users normally receive personal care and that a policy must be in place which outlines the provider's position on the use of CCTV. The RQIA also commissioned Queen's University Belfast to carry out a review of the effectiveness of the use of CCTV in care home settings (January 2020) which was commissioned in response to concerns regarding the quality of care and the potential for abuse in care home settings. The research highlighted that this is a complex ethical matter in the context of existing law and guidance. Expectations on the use of CCTV creates tensions between the needs of residents, family members and those providing care. The review completed on behalf of RQIA concluded that there was insufficient research evidence to support the proposed use of CCTV in care home settings.

9.14 Given the importance placed on this issue by some MAH families, the review team recommend further consultation with individuals, family carers and care providers to inform regional policy and practice relating to the use of CCTV in community learning disability accommodation based services.

9.15 The review team considered how the feedback provided by families in regards to their concerns about safeguarding should contribute to the discharge planning process and in supporting an individual through the transition process to a home in the community. Family carers were clear in their feedback to the review team that they have an active role in safeguarding by staying observant and alert to concerns and any change in their loved one's presentation. Families advised that they view flexible visiting and having access to the living environment of their loved one as central to building confidence in safeguarding for the family. MAH family carers expressed concern and frustration due to the visiting restrictions required at MAH in response to the Covid pandemic.

9.16 The following patient story highlights a family's concern about the care arrangements and impact of the living environment on their son. The family highlighted to the review team that the focus at MAH has been on physical abuse of patients by staff but that in their case their concern is about psychological and emotional abuse.

'Family shared the story of their son who returned to MAH following a traumatic breakdown in trial resettlement placement after six months. His parents advised that they have not been advised to date that their son has been the subject of physical abuse, however, they highlighted that their son has suffered emotional and psychological abuse associated with both his in-patient stay in MAH and in regards to a trial resettlement placement. The family expressed concern about the quality of care in both the community placement and in MAH. Their experience of the community placement which had been a new build resettlement scheme was that it operated as a mini institution rather than to the vision of supported living that they had expected. The family were advised after the decision to end the placement was made by the care provider who did not think their son was compatible with other residents. The family experience of discharge planning and trial resettlement has not been positive and they reflected that the discharge planning was not effective and caused harm to their son due to the care provider not being in a position to meet his needs.
The family advised that since his return to MAH their son has regressed. The family expressed further concern about the impact of the Covid restrictions on visiting and in the reduction of the range of activities available which the family believe is detrimental to preparation for their son leaving MAH. The family talked about their experience of MAH being poor and their confidence in the HSC system significantly impacted.'

9.17 This story about the lived experience of a patient, highlights that transitions between services should be handled smoothly and systematically with attention given to ensuring the person's individual needs are well communicated between services. It also highlights that family carers should be seen as important partners in the care planning approach. The chapter on individualised care planning provides further case examples when communication between services was not as effective as it should have been. For individuals with behaviour that may challenge, it is critical that discharge planning is progressed in line with 'Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability services' (2010) with a clear Safety Plan agreed and the family consulted about what is needed to safeguard and protect. The written care plan needs to detail any risks as well as what should happen in a crisis. We give further consideration to good discharge planning in the chapter on individualised care planning, highlighting the need for regional standardisation on the range of assessment and care planning tools used to ensure that individuals are safeguarded. A Person centred safety management plan should be central alongside a functional assessment and essential lifestyle plan and the family fully consulted and engaged in the resettlement planning process. We also highlighted that the risk assessment should be shared with relevant agencies and that the specialist knowledge and communication skills required to care for the individual should be defined and embedded in commissioning specifications and contracts.

9.18 Independent sector providers provided feedback to the review team on their experience of the adult safeguarding policy and procedures in practice which highlighted variation across trust areas. Care providers reflected variation in regards to thresholding of safeguarding referrals and variation in the attitude and support from different safeguarding teams. The review team recommend the review of Adult Safeguarding culture MAH is extended across community settings to address the experiences of key stakeholders including families and care providers.

9.19 Care providers also raised the use of restraint and the need to ensure appropriate focus on management strategies that enable preparation for discharge to the community. There has been growing recognition of the importance of reducing the need for restraint and restrictive intervention. DoH launched a public consultation on a draft regional policy on the use of restrictive practices in HSC settings in July 2021. It is critical that further review and analysis of incidents across all care providers in learning disability services is progressed to ensure learning and to inform the DoH review. The review team did not see evidence of effective sharing of learning from the analysis of incidents and SAI's with independent sector providers.

9.20 Feedback from family carers about safeguarding policy and procedures highlighted concerns that investigations were not progressed in a timely way which causes anxiety for the family. Trusts have highlighted workforce capacity issues. Given the impact of the ongoing PSNI investigation of alleged abuse at MAH and the evidence being provided to the Public Inquiry, more needs to be done to address the impact of delay in safeguarding investigations for families. Engagement with family carers highlighted that their concerns about safeguarding relate to current experience as well as the historic allegations of abuse which are the subject of ongoing police investigation and the focus of the Public Inquiry. It is critical that the experience of individuals and their family carers is heard and addressed.

Recommendations

In summary the conclusions and recommendations from this chapter are

- Further consultation with individuals, family carers and care providers to inform regional policy and practice relating to the use of CCTV in community learning disability accommodation based services.
- Contracts or service specifications for services for people with a learning disability should ensure that safeguarding requirements are adequately highlighted and that arrangements for monitoring are explicit.
- HSC should ensure that capacity in Adult Safeguarding services is maintained to ensure timely investigation and any challenges clearly reported in the Trust Delegated Statutory Function report.

- HSC Trusts should review visiting arrangements for family carers to ensure flexibility and a culture of openness so that families access their loved one's living environment rather that a visiting room.
- HSC Trusts should have arrangements in place to share learning about safeguarding trends and incidents with care providers.

10. Advocacy and Carer Engagement

This section will address the extent to which engagement strategies employed by HSC Trusts and collectively by the HSC system as a whole have been effective in supporting the delivery of the MAH resettlement programme; the extent to which families and patients were engaged in decision- making around resettlement and to what extent Advocacy support was provided.

Sincere thanks are owed to the family carers who engaged with the review team and so generously shared their personal experiences and stories. The families provided the review team with rich information about their lived experience which has shaped the findings for this review.

10.1 Participation and engagement with a wide range of stakeholders was central to the review however, the priority for the review team was to hear the voice of people with a learning disability and their family carers who have lived experience of delayed discharge and the resettlement journey. This was achieved in a number of ways;

- The review team issued a letter to every family with a loved one in MAH extending an invitation to contribute to the review of resettlement. Meetings were held at a neutral venue in the NHSCT, SEHSCT and BHSCT areas to bring families in each HSC Trust area together to hear their individual stories and common experiences.
- Some families did not wish to attend a public meeting but wished to meet with the review team. This was facilitated by home visits and zoom calls.
- The review team met with the 2 family carer representatives on the Muckamore Departmental Assurance group.
- The review team met with families of people who have already been resettled from MAH and whose placements have been successful
- The review team visited individuals with learning disability resettled in their community placement.
- The review team met patients and staff at MAH.
- The review team met with the Patient Client Council in regards to their role in providing Advocacy and supporting families involved in the MAH Public Inquiry.
- Meetings were arranged with Voluntary and Independent Care provider organisations who facilitated meetings with families.
- Engagement with RQIA - to learn about user experience from Inspections

10.2 Engagement strategies employed across the HSC

10.2.1 The Health and Personal Social Services (Quality, Improvement and Regulation) Order 2003 (ctrl click) applied a statutory duty of quality on the HSC Boards and Trusts. The 5 key quality themes which remain relevant to this review are:

- Corporate leadership and accountability of organisations
- Safe and effective care
- Accessible, flexible and responsive services
- Promoting, protecting and improving health and social well being
- Effective communication and information

10.2.2 The quality standards launched in 2006 (ctrl click) includes a standard for effective communication and information. HSC organisations are expected to have active participation of service users and carers and the wider public based on openness and honesty and effective listening.

10.2.3 The Bamford review recommended independent advocacy highlighting the need to support individuals to express and have their views heard. The principle of involving people in decisions about their care has been embedded in policy for many years. In 2012, the Department for Health and Personal Social Services (DHSSPS) launched a 'Guide for Commissioners- Developing Advocacy services' (ctrl click) introducing principles and standards. The DoH 'Co-Production Guide for Northern Ireland (2018) (ctrl click) recognised that co-production takes time and is a developmental process based on building relationships to support effective partnership working with service users and carers.

10.2.4 In the BHSCT's Serious Adverse Incident investigation report, 'A Way to Go', advocacy in MAH was described as '*not as uncomfortably powerful as it should be*' and stated 'it *is possible that the long association that advocacy services have had with the hospital and the impact of protracted delayed discharges have blunted its core purpose*'. The report also acknowledges that 'episodic contact is unhelpful' however, did not address the question of how family members, where they exist, are supported to act as the primary advocate for their loved ones as active partners in their care.

10.2.5 There is significant learning from the Scottish Government's approach to citizenship and involvement. 'A stronger Voice' Independent Advocacy for people with Learning Disability 2018 (Scottish Commission for LD) (ctrl click) states that Independent Advocacy can empower people

- To be listened to
- Understand what is happening and why decisions are made

- Be involved in decision making processes
- Become more confident and able to self-advocate

10.2.6 The review team sought to establish the engagement strategies in place across the HSC system at a population and individual case level. It was evident that all HSC Trusts have a formal infrastructure in place at organisational level to meet their patient and public engagement duty through established committees. This review however, was primarily focused on the experience of individuals and families and the extent to which their voice was heard at individual case level and in influencing the policy and practice in learning disability services.

10.2.7 The Muckamore Abbey Assurance Group (MDAG) has 2 family carers as members representing the views of families with lived experience. At Departmental and HSCB/SPPG level there is limited evidence of engagement and involvement of service users and carers in the development of policy, however, ensuring that this is effective and that the experience of individuals is one of being respected and valued is challenging. The Covid pandemic significantly impacted on business as usual, however, there is limited evidence of meaningful engagement with individuals and carers prior to the pandemic or currently in the range of learning disability work streams led by HSCB/SPPG.

10.2.8 There is variation in the engagement strategies within learning disability services in each of the HSC Trusts however, all HSC Trusts are continuing to review and improve the arrangements in place.

10.2.9 This was evident in BHSCT who have an action plan in place to address the recommendations arising from the 'Review of Leadership and Governance at MAH' (2020) (ctrl click) which includes a 'Communication and Engagement plan' the appointment of an engagement lead for learning disability and a non-Executive Director undertaking a lead for learning disability at Board level and being a visible champion for people with a learning disability and carers. The terms of reference for a range of engagement Forums were shared with the review team. There is a separate forum for MAH families with regular newsletters. The forum for community learning disability has a number of sub-groups to engage carers about transitions and accommodation. The BHSCT was the first Trust to establish a Carers Lead post to represent the views of people with lived experience of learning disability however, this post is now vacant. Whilst this is a positive step, further work and time is required to improve the number of families involved and engaged in the learning disability forums. There are only a small number of the MAH families actively involved in the MAH forum which reflects a significant level of disengagement due to

the breach of trust experienced by families following disclosure of abuse at MAH. The review team completed home visits with MAH families who have lost trust in the BHSCT and whose level of anger, pain and ongoing concerns about Safeguarding and Quality of service at MAH, highlight that a trauma informed and reconciliation approach is needed. The review team observed a number of occasions when engagement about a specific issue may have had a better outcome if the engagement and direct discussion with the family had been escalated to Director Level. Two discharge coordinator posts based at MAH had been funded to coordinate discharges across all patients. One of the discharge coordinator posts is now vacant. The resettlement team at MAH has reduced in size over the past year with an additional post-holder who had completed person-centred planning not filled. The NHSCT and SEHSCT lead the discharge planning for their own patients however, central coordination is required to arrange discharge meetings and to ensure that the range of information required from the MAH teams is available. The review team recommend that BHSCT considers the demand and capacity in the MAH resettlement team.

10.2.10 The NHSCT have also revised their approach to engagement and invited the review team to a public meeting organised by the Trust to engage their MAH families. A key learning point from this engagement event was the recognition that all of the families who attended in person on the evening had a shared experience of being involved in discharge planning for the new Braefields scheme. The families expressed the view that it is their perception that families have deliberately been kept apart and that the principle of stronger together should be embedded so that families can offer each other mutual support and identify common concerns and themes. This raises the need for the HSC system to recognise and value different forms of advocacy and promote voice to include independent advocacy, self-advocacy, and family advocacy.

10.2.11 The NHSCT strengthened their resettlement team recently, appointing a senior manager with oversight responsibility for monitoring progress against resettlement plans. The NHSCT is also in the process of appointing a lead Carers post to work in partnership with the senior management team to influence learning disability policy and service development. The review team met with NHSCT families who had a poor experience of communication however, there was positive feedback from a number of families about the relationship with the Trust's resettlement co-ordinator who has been in post for a lengthy period. The continuity of the relationship was valued by the families and highlights the importance of a key worker role, described to by families as the go to person for families trying to navigate across complex services.

10.2.12 SEHSCT has a long established Carers Forum for Learning disability who engage with the Trust in regards to policy and service development but also provide advocacy and representation of the views of people with learning disability and carers. The SEHSCT's in-patient population has reduced to just six patients whose age and range of needs are very diverse. A young person who transitioned a few years ago from a children's in-patient facility, a patient on detention though a Hospital Order with restrictions and an individual in his late 70's who has lived most of his adult life in MAH. The Trust's engagement with the remaining families is though the key worker, as the discharge solutions needed for the remaining patients are bespoke and highly personalised. The Trust had a dedicated post ensuring Essential Lifestyle discharge planning for all SEHSCT MAH patients transitioning to the community over the past years. This post is now vacant. There is evidence that using the tools of essential lifestyle planning is effective in developing a meaningful person-centred discharge plan. The review team recommend that all HSC Trusts embed essential lifestyle planning in the discharge pathway.

10.2.13 In summary, it is encouraging to see that the engagement strategies in all of the HSC Trusts have developed, but further time and effort is required to address the hurt and harm experienced by MAH families and to build the relationships and bridges needed to facilitate honest and mature dialogue and co-production. Overall across the HSC system, the voice of carers was not sufficiently evident within the leadership processes and there was limited evidence at all levels of effective co-production with carers.

10.3 The Voice of People in MAH - extent to which families and patients were engaged in decision- making around resettlement

10.3.1 Most of the families who attended the engagement meetings had previous experience of a trial resettlement that had broken down and were keen to share their experience of discharge planning and what went wrong.

10.3.2 There was not one voice but there were recurring themes from the review team's engagement with MAH families.

- Lack of trust, anger and families reporting invisibility of LD services
- Significant Safeguarding concerns
- Traumatic impact of abuse disclosures given the blind trust families had over many years seeing MAH as safety net
- not being involved or respected as expert by experience
- not being involved in relevant care planning meetings
- Experience of at least one trial placement breakdown

10.3.3 Some families talked about the culture and attitudes they had experienced over the years with HSC staff trying to 'persuade' them to accept a placement with a number of families referring to passive aggressive through to hostile approaches. Families referred to not being valued or acknowledged as experts by experience.

The following story of a mother's experience highlights the impact of culture and unhelpful communication styles;

10.4 A Mother's Story

10.4.1 Shared the story of a trial placement for her son which broke down within months. The family felt that the environment was appropriate however staff were not adequately trained or competent. Mother did not feel listened to or respected as an expert by experience who knew the triggers and warning signs that staff should have been attentive to. Family expressed the view that MAH did not provide enough information about relevant incidents on the care plan

10.4.2 When asked what needed to improve, the review team were advised by the family that resettlement needed to be accelerated and the following areas addressed;

- Better training for staff and assessment of competencies in key areas.
- An understanding of trauma and recognition of the experience and impact on families as well as their loved ones.
- Family carers valued as experts by experience and fully included in all decisions and meetings
- Better communication – Improvement needed to ensure communication is respectful and effective.
- Possibly some tools like a carers charter; an explicit statement of expectations and principles

10.4.4 The review team were advised that the family have experienced a breach of trust and confidence in the Trust and wider HSC system. The feedback provided to the review team confirmed that further work is required to ensure that all families feel effectively engaged in decision-making around resettlement and the monitoring of trial placements.

10.4.5 A number of families spoke to the review team about the importance of getting the culture, leadership and model of care right. The stories shared by families demonstrate the need for a tiered advocacy framework so that issues of complexity or dissension can be supported and facilitated more effectively

through independent advocacy. Families also told the review team that they have increasingly escalated to legal advocacy through the courts when the issues are systemic about failure to commission a service rather than about individual care planning.

10.5 Patient Story

10.5.1 The family confirmed that significant discharge planning had been progressed prior to the trial resettlement placement and expressed their disappointment and anger that the placement broke down within weeks resulting in their family member being returned to MAH without the family being advised in advance. The family had visited the trial placement daily and witnessed that the care staff were not competent to provide the care required. The family highlighted that the focus should not be on the number of staff required but on the culture, leadership and support the staff receive in addition to training and skills development. The family hold the HSC Trust accountable for commissioning the service and feel that HSC Trusts need to seek assurance that care staff have the appropriate competences.

10.5.2 The family believe that timely resettlement is in the best interests of their loved one and are actively involved in the planning for another trial discharge. The learning from the failed trial resettlement for the family was that they should be seen as a member of the multi-disciplinary team and involved in all meetings and decisions about care.

10.6 The Voice of People who have been successfully resettled

10.6.1 The review team met with a number of families whose family member has been resettled for some time. The narrative and experience of discharge planning and transition arrangements between MAH and the community are in stark contrast to the experiences shared by current families. It is of note that resettlement in the 1990's was strategically led and was progressed at scale with families reporting clarity about the process. This is best summarised through the story of a father who was very resistant to resettlement when the process commenced.

10.7 Lessons from what has gone well- A Father's story

10.7.1 The family of this young man were not keen on resettlement as they believed that their son was settled at MAH and that he was safe and secure. They were fearful of the unknown and had no experience or understanding of supported living services. The family advised that discharge was well planned and that

they had been able to consider a number of options. What has worked is that the care provider is open with the family who are made aware if their son's behaviour is changing. The staff identify the triggers that may result in deterioration and discuss with the family. The family advised the review team that their main concern prior to transition was safeguarding in the community. The family view the ability to visit their son flexibly and unannounced in his own home as providing then with real time assurance about his care rather than the formality of appointments. The family advised that the outcomes that demonstrate that resettlement has improved the quality of life for their son are numerous including the level of engagement he enjoys in activities in his own community, the fact that the parent/ child relationship has changed with their son supported to make adult decisions and personal choices about how he wishes to celebrate birthdays and Christmas. The family compared their son's life now to when he was in MAH and advised that he is living a fulfilling life and is central to his care planning. The family's advice in regards to what can be done to expedite or improve resettlement planning was quite simply 'Get it Done'.

10.8 Story of a young man with very complex behavioural needs living in Supported Living

10.8.1 The review team met with a young man now supported in a specialist supported living placement in the community having previously experienced admissions to MAH and other specialist in-patient facilities. The sustainability of this placement for a young man with very complex needs and challenging behaviour was stated by the care provider to be down to the partnership working between the care provider and the statutory learning disability team. The care provider uses a Positive behaviour approach with staff trained and competent in the methodology. The care provider highlighted that the responsiveness and wraparound support from the statutory team at times of increased challenge, actively reduces the potential for placement breakdown. The review team spoke to the young man and his care staff directly who described the full and active life the young man experiences and the support he receives to make personal choices. Additional positive outcome has been improvement in the young person's physical health with weight loss through a fun focused activity schedule. It was helpful for the review team to see an example of positive behaviour approach in action. The care staff reported that the model provides them with the support they need and they feel part of a wider specialist team.

10.8.2 This young man has needs equivalent too many of the patients in MAH who have been discharge delayed many years and this story is a helpful reminder that supported living models rather than new build bespoke are effective for

individuals whose behaviour can challenge. Voluntary sector care provider organisations stressed to the review team that the primary focus should be on a Positive behaviour approach and a skilled and competent workforce not just on the built environment.

10.9 Extent Advocacy support was provided regarding resettlement

10.9.1 The Review of Leadership and Governance at MAH recommended that the BHSCT should review and develop advocacy arrangements at MAH to ensure they are capable of providing a robust challenge function for all patients and support for their relatives and/or carers.

10.9.2 BHSCT has recently commissioned an independent review of advocacy services which is due to report by September 2022.

10.9.3 There are a number of Advocacy service providers engaging with MAH families. NHSCT commission independent advocacy services from Mencap for their families. SHSCT commission independent advocacy services from Disability Action for their families and Bryson House provides the independent advocacy service for both Belfast and SEHSCT. Families reported confusion about the roles of the various advocates involved, which is heightened when there is more than one advocate involved with the family.

10.9.4 The landscape has become more confusing for families with the Patient Client Council (PCC) providing direct advocacy support to MAH families. The review team met with the PCC Chief Executive and senior management team, who advised that PPC had been asked to provide support during the Leadership and Governance review feedback to families. In addition, the PPC provided a report on the engagement with current and former patients, families and carers regarding the terms of reference of the Public Inquiry. The PCC are now acting as the Independent Advocate for the Public Inquiry into MAH. As a result, the PPC has appointed a dedicated worker to build relationships with MAH families. The review team did not see evidence that the impact of the extended role for PCC on the long-standing commissioned independent advocacy services was considered or discussed between the various advocacy providers. Families reported that current arrangements are confusing and reported a lack of clarity about definition of advocacy, lack of clarity about roles and provided examples when an advocate from PCC and Bryson house were working at cross purposes. The situation was resolved but further review is required. The review of advocacy services commissioned by the BHSCT should bring forward recommendations to address the concerns raised by families.

10.9.5 Some families welcomed the relationship with the advocate involved with the family but struggled to provide examples when the advocate had made a difference in the resettlement outcome. There was confusion between a befriending and advocacy role with families stressing that it was the relationship they appreciated rather than the challenge function.

10.9.6 The following patient and carer story highlight the key issues raised by families in regards to advocacy. The strongest message was that family carers should be the first and primary step in advocating for their loved one.

10.10 Story of Long-Stay patient and experience of Advocacy

10.10.1 A mother met with the review team to share the story of her son who has been in-patient at MAH for some time. The story tells of a family who have maintained close contact with their son. The family have dreams for their son to experience community living with enhanced personal choices and less bound by hospital routines. However, a trial resettlement went badly wrong with the police being called by the care provider and their son being traumatically returned to MAH. The family believe the placement broke down because the care staff did not have the competencies to cope with behaviour that challenges. The family did not feel they were involved in care planning and expressed the view that they were advised by professionals rather than consulted.

10.10.2 The family talked about their experience with advocacy and felt strongly that the family are the strongest advocates in speaking up for their son. The family expressed confusion as there have been 2 advocates involved with the family and they are unclear about their respective roles. Family did not know why advocates became involved and state their view was not sought on the matter. The family advised that their experience of advocacy has not been positive and referred to the fact that the advocates turn up at meetings but the family were not able to identify when the advocate had made a difference. The family expressed the view that advocates had agreed on occasion to do something but did not follow up. The family felt that they are the only ones in their son's life for the long haul and will continue to speak up for their son. The family do not call themselves advocates but felt they provide a strong voice for their son.

10.10.3 The review team have reviewed the Terms of Reference for the comprehensive review of advocacy commissioned by BHSCT. The issues raised by families should be addressed by that review.

10.10.4 Other family carers reflected on current concerns about Safeguarding and the Quality of care in MAH. The families acknowledged that the Covid pandemic impacted on routine business but expressed concern that patient activities

being curtailed directly impacted on quality of life and preparing for transition to the community. Families also reported that the visiting restrictions implemented in response to the Covid pandemic raised anxiety about safeguarding arrangements due to visits being electronic or having to pre-book visiting with no access to their loved ones ward or living environments. Family carers feel they have an active role in Safeguarding by staying observant and alert to concerns and any change in presentation. Families advised that they view flexible visiting and having access to the living environment of their loved one as central to building confidence in safeguarding for the family

10.10.5 Whilst there is relationship complexity across the wide range of stakeholders involved in the resettlement pathway, there is an urgent need to repair relationships and build trust. Families stressed to the review team that professionals talk about services but for the families it is their lives. The change that families want to see in the culture and attitudes across HSC services does not require radical reorganisation. The HSC Collective Leadership strategy (2017) (ctrl click) describes the values needed to promote shared leadership across boundaries and partnership working between those who work in HSC and the people they serve. Families stressed the need for a return to basics to achieve effective person centred planning and involvement of families in all meetings about care and decisions based on openness and respect. A regional one system approach and effective engagement and partnership working with family carers will be required to ensure the effective delivery of the final stage of the MAH resettlement programme

Recommendations

- HSC organisations need to value different forms of advocacy and promote voice to include independent advocacy, self-advocacy, and family advocacy.
- Family members should be listened to and receive a timely response when they advise things are deteriorating
- Advocacy support should be available and strengthened at all stages of care planning-HSC Trusts must ensure that there is a clear pathway and clarification to explain the role of different advocacy services.
- HSC Trusts should utilise the Lived Experience of families who have supported a family member through successful resettlement to offer peer support to current families
- HSC Trusts should arrange group meetings so that families with loved ones being considered for the same placement can support each other and share experiences
- HSC Trusts should improve communication and engagement with families when placements are at risk of breakdown

- Families should be seen as integral to the care planning and review process and invited to all meetings
- A regional policy on the use of CCTV in learning disability community placements should be co-produced with relevant stakeholders.

11. Conclusions

Conclusions

11.1 The review team were determined from the outset of the review to ensure that the experience and voice of those with lived experience and their family carers informed the solutions and actions required to expedite resettlement .The review draws on the experience of people with learning disability who have been successfully resettled and those who have experienced breakdown and returned to MAH. The stories shared with the review team by family carers, brings into stark reality the impact that the allegations of abuse at MAH has had on family carers. In contrast, the stories shared by family members who have experienced successful resettlement, provide evidence of the positive outcomes and improved quality of life their loved ones are now experiencing.

11.2 It is important not to underestimate the challenge of planning for the resettlement of the remaining population whose needs are complex. The review team considered the learning from the policy and practice evidence base in relation to resettlement programmes across the UK and Republic of Ireland and a detailed analysis is contained in Chapter 4. Transforming Care for People with Learning Disabilities - Next Steps" was published in January 2015 The report identified a significant change in direction in the policy and practice in relation to gatekeeping admission to specialist learning disability settings, alongside dedicated strategies for admission avoidance and more effective discharge planning. Actions that should be considered for Northern Ireland include;

- providing enhanced vigilance and service coordination for people displaying behaviours which may result in harm or placement breakdown;
- Establish a Dynamic Support Database to provide focus on individuals at risk of placement breakdown and development of proactive rather than reactive crisis driven response-
- Implementation of a Positive Behaviour Service framework and provider engagement
- Effective Assessment tools/ Discharge planning meetings- Complex care co-ordinators to focus on transition plans
- More detailed tracker tool to support analysis and performance management to create a master database-history of discharges, re-admissions and trends.

11.3 Feedback from a wide range of stakeholders highlighted the need to refresh the strategic policy and service model for Learning Disability in Northern Ireland.

The above actions should be central to policy development but will require system leadership at all levels across the HSC.

11.4 The Learning Disability resettlement programme in the 1990s was successful overall, achieving a significant reduction in the long-stay population. The success factors appear to be that the resettlement programme was strategically and regionally led with ring fenced funding agreed across Department for Communities and the DOH with robust project management monitoring progress against targets. The current resettlement programme would benefit from a similar approach as it is currently a bottom up approach and lacks cohesion and direction. The data provided by the Trusts on progress on resettlement plans was not adequately scrutinised internally in the Trusts or externally by the HSCB/SPPG. The review team advised the HSCB/SPPG officers on actions to establish a more effective tracker tool to improve performance management.

11.5 In general we found that across significant elements of the HSC system there was poor management grip in relation to the learning disability agenda and this resulted in a lack of momentum and a sense of inertia and drift. It is critical that a one system approach is developed in Northern Ireland to address the silo working and duplication that remains across the 5 HSC Trusts involved in supporting individuals who are awaiting discharge from learning disability hospitals. The review team were pleased to see improved collaborative working led by the three directors within the past few months to seek solutions to the delayed discharge challenge and agree mutual aid in response to supporting MAH

11.6 The importance of and necessity to build trusted relationships was evident at strategic and operational leadership levels but more so in relation to building effective partnership working with individuals and families with lived experience of using services. The review team did not see evidence of effective engagement of people who use learning disability services or their family carers influencing the numerous learning disability work streams established by HSCB/SPPG to contribute to and influence the resettlement agenda. Whilst the review team did see evidence of new initiatives in the BHSCT and NHSCT to build an infrastructure to support engagement with family carers, they do not yet reach the MAH families who have disengaged due to the breach of trust they have experienced. People with a learning disability and their family carers should be respected as experts by experience with Trusts building co-production into all levels across the HSC system.

11.7 Family carers raised safeguarding as a significant concern and the review team recommend further engagement with care providers, family carers and Trusts to discuss their expectations and concerns about CCTV.

11.8 The area of strategic commissioning also requires a refreshed approach. Strategic commissioning needs to be underpinned by a strong assessment of needs. It was a recurring finding at strategic and operational levels that needs assessment was not robust. The review team identified models of commissioning which could inform improvements in Northern Ireland. "Integrated Commissioning for Better Outcomes" was published in 2018 to support health and social care economies to transform their services through a person centred approach to commissioning which is focussed on the needs of the local area. In Kent and Medway a new governance framework and an oversight board has been established to ensure that partners were accountable for commitments and performance. Accountability needs to be strengthened across HSC in Northern Ireland in regards to performance management against resettlement.

11.9 Engagement with independent sector care providers and Supporting People leads highlighted to the review team that knowledge and memory has been lost due to the turn-over in senior leaders most especially in BHSCT. Further work is required to build effective working relationships with key strategic partners to address barriers to resettlement.

11.10 The review team sourced data from RQIA and Supporting People in regards to the number of placements and schemes for learning disability and sought additional information from Trusts to form the basis of a supply map as seen in chapter 6. There does not appear to have been any analysis or strategic oversight to inform market shaping and this should be addressed by HSCB/SPPG and Trusts to inform strategic and micro commissioning.

11.11 Further development of social care procurement is urgently required and the review team recommends the development of a commissioning collaborative. Training and skills development on commissioning and procurement is required across the system.

11.12 The review team reviewed the care planning tools used by Trusts to support discharge planning. There is variation across the Trusts and the review team recommends that work is progressed to develop an over-arching resettlement pathway and standardise assessment tools to ensure that the needs of patients are considered as outlined in chapter 7. The learning from placement breakdowns highlights that discharge plans on occasion have not been sufficiently robust.

11.13 The review team scrutinised the current care plans for all the service users in MAH and critically analysed the actions taken by the responsible Trust to identify and commission suitable community placements. The analysis of length

of stay, the location the patient was admitted from and number of previous trial placements is presented in chapter 7.

11.14 The review team have assessed the robustness of discharge plans using the Care Quality Commission definition of a plan .Namely there has to be a named provider, address and confirmed discharge date. If this detail is not available the plan is incomplete. It is critical going forward that there is clarity and consistency in Trusts reporting on progress against discharge plans. The review team recognise that there are plans in development for some patients that show promise but in establishing a trajectory the system should only rely on plans that meet the definition outlined.

11.15 The South Eastern and Northern Trusts had taken steps some years ago to plan capital schemes that have already delivered or due to be operational in the next months. The BHSCT is an outlier in this regard with three capital business cases still in the early stage of development with the earliest date for completion 2025/26. The NHSCT and SEHST had been co-dependent on two of the three BHSCT schemes namely the forensic and on-site for a small number of their patients but are now pursuing other placements options.

11.16 As a result SEHSCT in-patient population at MAH has reduced to 6 patients. Robust plans are in place for 4 patients with no plan yet in place for two forensic patients. Two of the SEHSCT patients will be discharged by end August 2022 and an additional placement by end September 2022.

11.17 NHSCT has made good progress in delivering 2 new build schemes. Mallusk and Braefields which is due to complete end August 2022. NHSCT has taken additional steps to commission a number of individual placements in current schemes and plans to discharge 14 NHSCT patients by March 2023 This includes 12 MAH patients and the two NHSCT in out of area placements in Dorsey and Lakeview hospitals. NHSCT has 2 patients in MAH with plans not yet complete. the NHSCT has made significant progress in developing robust discharge plans with progress hindered by challenge with recruitment to the Mallusk scheme and challenges in the building supply chain that slowed building work moving the handover date of the Braefields scheme from end April to end August 2022.

11.18 BHSCT has been reliant on the 3 capital business cases providing for 10 BHSCT patients. This includes the Minnowburn scheme for 5 BHSCT patients and the Forensic and On-Site schemes. Given the long lead in time BHSCT is

now seeking alternative options to facilitate a more timely discharge. Whilst the BHSCT has adopted a refreshed approach with view to utilising available voids the plans are not yet complete. As a consequence only 2 of the 15 BHSCT patients have robust plans in place and 13 have plans that are not complete.

Reduction in Number of Patients in MAH between June 2021 and July 2022 and trajectory for Robust planned discharge by end March 2023

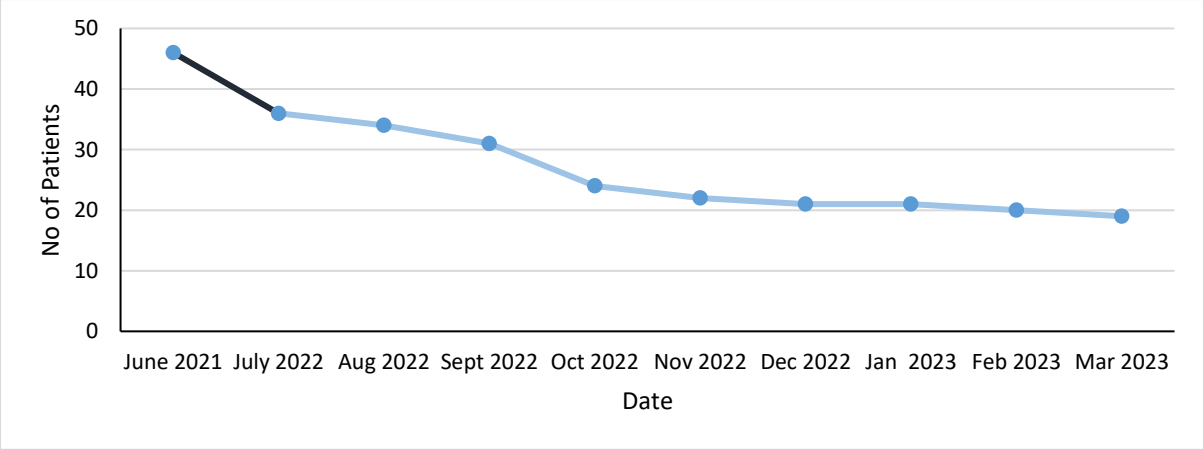


Fig 13

11.19 Fig 13 illustrates the discharge trajectory based on robust plans and robust timeframes. This is a conservative trajectory and the review team have confidence that further individual discharges will be progressed. It is encouraging to note that Trusts have responded to the recent challenge to develop contingency plans and that schemes in planning for some time now have confirmed discharge dates. The MAH population at 11th July 2022 was 36 in-patients, Fig 13 shows that the projected in-patient position by end March 2023 based on completed discharge plans is expected to reduce to 19 patients with potential for further individual discharges. Based on the analysis of the Trusts discharge plans against the Care Quality Commission definition of a discharge plan it is reasonable to assume that a further 17 patients will be discharged by end March 2023.

12. Recommendations

DOH

- The DoH should produce an overarching strategy for the future of services to people with learning disability/ASD and their families, to include a Learning Disability Service Model.

- The Learning Disability sector should be supported to develop a shared workforce strategy, informed by the consultation being undertaken by the DoH as part of the workforce review, to ensure that there is a competent and stable workforce to sustain and grow both the sector in terms of size and quality, so that it is responsive to significantly changing demand.

- People with a learning disability and their family carers should be respected as experts by experience and co-production built into all levels of participation and engagement across the HSC system.
- There should be an evaluation of the experience of people who have been resettled to understand what has worked well and what needs to change for the better and a regional programme to tell the positive stories of those who have moved on, to include audit of proved clinical and quality of life outcomes.

SPPG

- In the context of the overarching strategy the SPPG should develop a commissioning plan for the development of services going forward. This will include the completion of resettlement for the remaining patients awaiting discharge from MAH, and progress the re-shaping of future specialist LD hospital services.
- SPPG should establish a regional Oversight Board to manage the planned and safe resettlement of those patients not currently under active assessment or treatment or deemed multi-disciplinary fit for discharge across all specialist learning disability inpatient settings in Northern Ireland.
- SPPG needs to continue to strengthen performance management across the HSC system to move from performance monitoring to active performance management, and effectively holding HSC Trusts to account.
- SPPG should develop a more detailed tracker tool to create a master database of discharges, readmissions and trends and establish a clear definition of a discharge plan to provide clear projections about the trajectory for discharge and progress over time.

- The Social Care Procurement Board should urgently review the current regional contract for nursing/residential care and develop a separate contract and guidance for specialist learning disability nursing/residential care.
- The SPPG and NIHE/Supporting People should undertake a joint strategic needs assessment for the future accommodation and support needs of people with learning disability/ASD in Northern Ireland.

SPPG and Trusts

- Strategic commissioners within health, care and housing should convene a summit with NIHE, Trusts, Independent Sector representatives, and user/carer representation to review the current resettlement programmes so that there is an agreed refreshed programme and explicit project plan for regional resettlement.
- SPPG and Trusts should develop a database of people displaying behaviours which may result in placement breakdown to provide enhanced vigilance and service coordination ensuring targeted intervention to prevent hospital admission and support regional bed management.

Trusts

- Trust Boards should strengthen oversight and scrutiny of plans relating to resettlement of people with learning disability/ASD in specialist learning disability hospitals.
- A regional positive behaviour support framework should be developed through provider engagement with the standard of training for all staff working in learning disability services made explicit in service specifications and procurement.
- HSC Trusts should collaborate with all stakeholders to urgently agree a regional pathway to support future resettlement/transition planning for individuals with complex needs.
- HSC Trusts should collaborate to standardise their assessment and discharge planning tools to improve the quality and effectiveness of care plans.
- HSC Trusts should ensure that the lived experience of the person and their family is effectively represented in care planning processes and the role of family carers as advocates for their family member is recognised and respected.
- HSC organisations need to value different forms of advocacy and promote voice to include independent advocacy, self-advocacy, and family advocacy at all stages of care planning and develop a clear pathway clarifying the role of different advocacy services.

- HSC Trusts should arrange group meetings so that families with loved ones being considered for the same placement can support each other and share experiences and utilise the Lived Experience of families who have supported a family member through successful resettlement to offer peer support to current families.
- The review team recommends a review of the needs and resettlement plans for all forensic patients delayed in discharge from LD Hospitals.
- HSC Trusts should establish a local forum for engagement with LD providers of registered care and supported living to develop shared learning about safeguarding trends and incidents and promote good practice through a collaborative approach to service improvement.
- Further consultation with individuals, family carers and care providers should be progressed to inform regional policy and practice relating to the use of CCTV in community learning disability accommodation based services.
- HSC Trusts should ensure that capacity in Adult Safeguarding services is maintained to ensure timely investigation and any challenges clearly reported in the Trust Delegated Statutory Function report.
- HSC Trusts should ensure that Contracts or service specifications for services for people with a learning disability have safeguarding requirements adequately highlighted and that arrangements for monitoring are explicit.
- HSC Trusts should review visiting arrangements for family carers to ensure flexibility and a culture of openness so that families access their loved one's living environment rather that a visiting room.

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Appendices

Appendix 1: The Review Team

The HSCB appointed a 2 person review team who were required to possess a strong understanding of health and social care policy and practice in Northern Ireland and Great Britain along with extensive experience in leadership roles directly related to health and social care.

The review team comprised:

Bria Mongan

Ian Sutherland

Appendix 2: Biographies

Bria Mongan and Ian Sutherland

Bria Mongan

Bria has significant Executive level experience within Health and Social Care organisations. Bria completed a Masters in Social Work in 1980 and remains registered as a social worker with the NISCC. Bria retired in May 2020 following a forty year career in Health and Social Care services working across all programmes of care. Prior to retirement, Bria was the Executive Director of Social Work and Director of Children's services in South Eastern HSC Trust. Bria previously was the Director of Adult Services and Prison Healthcare and was accountable for leading mental health and learning disability services including leadership in resettlement programmes. Bria is currently an associate with the HSC Leadership centre.

Ian Sutherland

Ian is an experienced leader in health and social care. He is a psychology graduate, who trained as a social worker in Nottingham in 1986, and completed an MSc in Health and Social Services Management at the University of Ulster in 1994. He has worked as a practitioner and senior leader in both Northern Ireland and England, holding three Director posts. His most recent leadership role was as Director of Adults and Children Services in Medway Local Authority, England. In this role he led partnership commissioning between health and social care in relation to delivery of the Better Care Fund objectives. He has served as a Trustee of the Social Care Institute for Excellence, and is currently an associate with the HSC Leadership Centre in Belfast.

SOUTHERN HEALTH AND SOCIAL SERVICES BOARD

POLICY ON STAFF CONCERNS AND DISCLOSURE

APRIL 2003

MAHI - STM - 097 - 10184

SOUTHERN HEALTH AND SOCIAL SERVICES BOARD

POLICY ON STAFF CONCERNS AND DISCLOSURE

1 INTRODUCTION

All of us at one time or another have concerns about what is happening at work. Usually these are easily resolved. However, when they are about unlawful conduct, clinical malpractice, financial malpractice or could pose a danger to our patients, staff or clients, it can be difficult to know what to do.

You may have been worried about raising issues or may want to keep concerns to yourself, perhaps feeling it's none of your business or that it's only a suspicion. You may feel that raising the matter would be disloyal to colleagues, managers or to the Board. You may decide to say something but find that you have spoken to the wrong person or raised the issue in the wrong way and are not sure what to do next.

The Public Interest Disclosure (N.I.) Order 1998 which came into effect 31 October 1999 provides protection to staff who believe it is necessary to raise issues of public interest either internally or externally. This paper restates the Board's commitment to openness and sets out clearly the process, which can be used by staff who have concerns that anyone in the Board is acting in a manner, which may be contrary to the public interest.

The Board has introduced this procedure to enable you to raise your concerns about such malpractice at an early stage and in the right way. We would rather that you raised the matter when it is just a concern rather than wait for proof.

If something is troubling you which you think we should know about or look into, please use this procedure. If, however, you are aggrieved about your personal position, please use the Grievance procedure – which is contained in your staff handbook or you may obtain a copy from the Human Resources department. This Procedure is primarily for concerns where the interests of others or the organisation itself are at risk.

2 OUR ASSURANCES TO YOU

2.1 YOUR SAFETY

The Board Chief Executive and Senior Management Team are committed to this policy. If you raise a genuine concern under this policy, you will NOT be at risk of losing your job or suffering any form of retribution as a result. Provided you are acting in good faith, it does not matter if you are mistaken. Of course we do not extend this assurance to someone who maliciously raises a matter they know is untrue.

2.2 YOUR CONFIDENCE

We will not tolerate the harassment or victimisation of anyone raising a genuine concern. However, we recognise that you may nonetheless want to raise a concern in confidence under this policy. If you ask us to protect your identity by keeping your confidence, we will not disclose it without your consent. If the situation arises where we are not able to resolve the concern without revealing your identity (for instance because your evidence is needed in court), we will discuss with you whether and how we can proceed.

Remember that if you do not tell us who you are, it will be much more difficult for us to look into the matter or to protect your position or to give you feedback. Accordingly, while we will consider anonymous reports, this policy is not appropriate for concerns raised anonymously.

3 HOW WE WILL HANDLE THE MATTER

Once you have told us of your concern, we will look into it to assess initially what action should be taken. This may involve an internal inquiry or a more formal investigation. We will tell you who is handling the matter, how you can contact him/her and whether your further assistance may be needed. If you request, we will write to you summarising your concern and setting out how we propose to handle it.

When you raise the concern you may be asked how you think the matter may best be resolved. If you do have any personal interest in the matter, we do ask that you tell us at the outset. If your concern falls more properly within the Grievance Procedure we will tell you.

Whilst the purpose of this policy is to enable us to investigate possible malpractice and take appropriate steps to deal with it, we will give you as much feedback as we properly can. We will confirm our response to you in writing. Please note, however, that we may not be able to tell you the precise action we take where this would infringe a duty of confidence owed by us to someone else.

4 HOW TO RAISE A CONCERN INTERNALLY

OPTION 1

If you have a concern about malpractice, we hope you will feel able to raise it first with your line manager. This may be done orally or in writing.

OPTION 2

If you feel unable to raise the matter with your line manager, for whatever reason, please raise the matter with:

Mrs J Johnston – Human Resources Department
Contact details 028 3741 4540

or

NIPSA Officers - Mrs P Quinn –

Contact details 028 3741 0041 Ext 4434

Mr M Lowry –

Contact details 028 3741 0041 Ext 4430

Please say if you want to raise the matter in confidence so that they can make appropriate arrangements.

OPTION 3

If these channels have been followed and you are still concerned, or if you feel that the matter is so serious that you cannot discuss it with any of the above, please contact:

Mr S McKeever – Director of Resources and Contracting

Contact Details 028 3741 0041 Ext 4580

Mr McKeever has responsibility for the operation of this policy within the Board

OPTION 4

In the event that you feel it is inappropriate to discuss your concerns with any of the above you may contact the Chairman of the Board's Audit Committee.

Contact details available from SHSSB reception – Tel No 028 3741 0041.

5 INDEPENDENT ADVICE

Even with the protection afforded by the Order and this procedure it may be that you would wish to seek advice as to whether the concerns you have merit the operation of the procedure. We would urge you that if the concern is one that

you have already discussed with your family or friends then it merits raising in accordance with this procedure. However if you wish to seek independent advice then you can contact any of the following

- Any professional body you belong to
- Your trade union
- An independent charity, Public Concern at Work at 020 7404 6609. Their lawyers can give you free confidential advice at any stage about how to raise a concern about serious malpractice at work.

6 EXTERNAL CONTACTS.

The purpose of this policy is to reassure you that if you have concerns about work then you can raise them and have them addressed without fear of retribution. In most circumstances you will be expected to have raised matters internally before raising matters of concern with external bodies. However, there may be circumstances when you may feel it necessary to raise concerns with the Department of Health, Social Services and Public Safety, the Commissioner for Complaints, the Police or organisations like the Equality Commission. Your trade union or Public Concern at Work will be able to advise you on the circumstances when it would be appropriate to contact an outside body safely.

7 EQUALITY CONSIDERATIONS

This policy has been screened in accordance with the Board's statutory duty and is not considered to require full impact assessment.

8 REVIEW

This policy will be reviewed for effectiveness in 2005.

EASTERN HEALTH AND SOCIAL SERVICES BOARD

SPEAKING UP - RAISING CONCERNS AT WORK

INTRODUCTION

1.1 The Eastern Health and Social Services Board is committed to developing a culture of openness and honesty, between staff at all levels, particularly where this would contribute to improving the service provided by the Board.

1.2 The Public Interest Disclosure (NI) Order 1998 (whistle-blowing) provides protection on qualifying disclosures to staff who believe it is necessary to raise issues of public interest either internally or externally.

1.3 In the legislation a "qualifying disclosure" means any disclosure of information which, in the reasonable belief of the worker making the disclosure, tends to show one or more of the following has been, is being or is likely to occur:

- a criminal offence
- failure to comply with any legal obligation to which he or she is subject
- miscarriage of justice
- the endangerment of the health & safety of any individual
- damage to the environment
- Deliberate concealment of any information relating to any of the above points.

1.4 The term “whistle-blowing” refers to the disclosure by employees or ex-employees, matters of concern, as referred to above, arising in the workplace. To ensure that such matters can be addressed in a consistent and fair manner, this policy has been developed to provide staff with an avenue for raising areas of concern without fear of reprisal.

1.5 From the date of implementation this policy replaces the Confidential Complaints Procedure as introduced August 1998.

1.6 This policy does not affect existing complaints procedures and compliments professional and ethical rules, guidelines and codes of conduct relating to complaints and freedom of speech.

1.7 The **Aim of this policy** therefore, is to promote openness and dialogue, which at the same time upholds the need for confidentiality to be observed, in relation to the work of the Board.

POLICY STATEMENT

2.1 The Board is committed to developing an open and honest culture within which staff have an agreed mechanism for discussing concerns, and accessing the outcome of decisions made without fear of victimisation or reprisal.

2.2 Recognising that the Boards existing policies and procedures which deal with conduct and behaviour at work may not be appropriate to deal with some areas of concern, this policy re-states the Boards commitment to openness and clearly sets out the process, which should be used by staff who have concerns that anyone in the Board is acting in a manner, which may be contrary to the public interest.

2.3 If a member of staff raises a genuine concern under this policy, they will not be at risk of losing their job or suffering any form of retribution as a result, providing they have acted in good faith, even if they are mistaken. This assurance is not extended to someone who maliciously raises a matter they know to be untrue.

2.4 All such concerns should normally be addressed internally in the first instance through the use of the procedure identified in this policy document. In the event that the internal procedures do not reach a satisfactory outcome or when the internal procedure has been exhausted, then matters may be referred to an appropriate body outside of the Board. Failure to use the internal process, when appropriate, may result in disciplinary action.

2.5 This policy may be used to deal with any concern relating to those listed at 1.3 above, whether this arises from an action by a Board officer or within another HPSS organisation, which is witnessed by a Board officer.

2.6 If you are unsure about the appropriateness of using this policy in a particular set of circumstances and need advice you may contact your trade union or professional body who can give you advice on whether to use this procedure. Alternatively, there is an independent charity Public Concern at Work on 020 7404 6609 who can also offer advice on the use of this procedure. If you are in any doubt you should raise the matter with one of the designated officers who will also be able to advise on the appropriateness of this or other Board policies.

2.7 Where it is found that a member of staff has raised a matter which they knew to be untrue this may result in action being taken through the Board's disciplinary procedure.

RESPONSIBILITIES

3.1 The Board

3.1.1 It is the responsibility of the Board to ensure that all issues are taken seriously and are dealt with effectively and efficiently within the procedures set out in this policy document.

3.1.2 The Board will also be responsible for ensuring that employees who raise any concerns will not be penalised for doing so. This assurance will not be extended to those who for example raise an issue concerning another member of staff which they know to be untrue.

3.2 Management

3.2.1 It will be the responsibility of all Managers throughout the Board to take any concerns reported to them seriously. Managers should follow the procedures set out in this policy document, by referring the individuals to one of the Designated Officer's.

3.3 Employees

3.3.1 It is the responsibility of every member of staff to recognise their duty to report any incidents of concern to the Board within the procedures set out in this policy.

DESIGNATED OFFICERS

4.1 The Board has appointed three Designated Officers to be the initial point of contact for concerns to be raised under this procedure. The Designated Officers are:

Mrs Patricia Crossan, Board Secretariat Manager
Mrs Karyn Patterson, Human Resources Manager
Mr Hugh McPoland, Human Resources Adviser

The Designated Officers will have direct access to the Chair/Chief Executive.

PROCEDURE

5.1 In the event that the matter of concern cannot be dealt with informally or under any of the Board's other procedures for dealing with conduct and behaviour at work, such as those previously noted, then the individual should take their concerns to one of the Designated Officers. In the event of the issue involving all of the Designated Officers then the matter should be taken directly to the Chief Executive.

5.2 In some situations a member of staff may have initially discussed the matter with their Line Manager, however, in all circumstances it is important that the matter is immediately brought to the attention of one of the Designated Officers.

5.3 The Designated Officer with whom the matter has been raised will arrange for an initial meeting with the individual raising the concern, to obtain details of the situation, ensure that it is a matter which is appropriate to be dealt with under this policy and provide support and advice to the individual. The initial meeting should normally take place within 3 working days, unless a variation to this is agreed by both parties. At this point meetings will be held in strict confidence and the report of this meeting will be agreed by both parties. The individual will be asked to make a signed written statement outlining their key areas of concern.

5.4 The Designated Officer will report normally report the matter to the Chief Executive. If the complaint is about the Chief Executive the Chair will decide on how the investigation will proceed. This may include an external investigation. In the event that the complaint is about the Chair of the Board, the Chief Executive should refer it, to the Permanent Secretary. If the complaint concerns the improper use of public funds, then the Designated Officer should have access to the Chair of the Board's Audit Committee. The Chief Executive will be responsible for the commission of all other investigations.

5.5 The Board will make every effort to carry out investigations under the terms of strict confidentiality. However, there may come a time where information must be released to another party for example a disciplinary panel, or the police.

5.6 In all circumstances the individual who initially raised the concern should be kept informed of the progress being made under this procedure and/or the need to release any information to another party.

5.7 If it is found that malicious allegations have been made, the Chair/Chief Executive may determine an appropriate course of action including consideration of the need to invoke the disciplinary procedure.

5.8 If an individual is not satisfied with the response to the matters raised then they may consider referring the matter to an appropriate authority outside of the Board such as DHSSPS, the Equality Commission, the Commissioner for Complaints, Trade Union etc.

ANNONYMOUS REPORTS

6.1 If you do not tell us who you are, it will be difficult for the Board to investigate the matter fully, to protect your position or to give you feedback. Accordingly, whilst the Board will give consideration to anonymous reports, it may not be in a position to take specific action.

EQUALITY CONSIDERATIONS

7.1 In developing this policy it has been assessed in accordance with the Boards responsibility under Section 75 and Schedule 9 of the NI Act 1998 and is considered not to require a full impact assessment.

REVIEW OF POLICY

8.1 This policy will be reviewed for effectiveness within 3 years from date of implementation, 31 October 2001.

[redacted]

PROMOTING HEALTH
SECURING CARE

Northern Health and Social Services Board

Memo

Date: 8 October 2002 Ref: 122/21

To: Each Member of SMT

From: Chief Executive

Subject: **POLICY FOR STAFF WHO HAVE CONCERNS ABOUT OUR SERVICES**

Please find attached a copy of the Circular, NB(CE)3/2002, which sets out the rights and responsibilities of staff when raising issues of concern about health and personal social services matters.

I should be grateful if you would draw this to the attention of all staff.

This guidance should be implemented with immediate effect.

Stuart MacDonnell
Chief Executive

Northern Health and Social Services Board

POLICY FOR STAFF WHO HAVE CONCERNS ABOUT OUR SERVICES

September 2002

Policy For Staff Who Have Concerns About Our Services

Introduction

1. In accordance with the provisions of the Public Interest Disclosure (NI) Order 1998, this policy sets out the rights and responsibilities of staff when raising issues of concern about health and personal social services matters. The policy does not affect existing guidance on statutory complaints procedures and it does not change or replace any nationally agreed terms and conditions of employment which give particular groups of employees freedom to speak and write.

2. The policy complements professional or ethical rules, guidelines and codes of conduct on freedom of speech, such as, for example the UKCC Code of Professional Conduct, A Midwife's Code of Practice, and the GMC Guidance on Contractual Arrangements in Health Care. It does not restrict the publication of clinical or scientific research findings.

Purpose

3. This policy aims to make plain that:

- individual members of staff have the right and a duty to raise any matters of concern they may have about health and personal social services issues concerned with the delivery of care of services to a patient or client in the Board's area or the use of public funds.

- every manager has a duty to make sure that staff are easily able to express their concerns and that these are dealt with thoroughly and fairly;

- NHSSB policies and procedures allow these rights and duties to be fully and properly met; and

- individual members of staff have an obligation to safeguard all confidential information to which they have access, particularly information about individual patients or clients which is under all circumstances strictly confidential.

Key Principles - Putting Patients / Clients First

4. The Health and Personal Social Services (HPSS) exists to meet the needs of patients and clients. The key principle of this policy is that their individual interests must be paramount. All HPSS employees have a duty to draw to the attention of their managers any matter they consider to be damaging to the interests of a patient or client and to put forward suggestions which may improve their care.

5. So the normal working culture of the HPSS should foster openness. The Board follows the Health and Personal Social Services Code of Conduct and Code of Practice on Openness. Staff are encouraged to contribute their views freely on all aspects of Health and Personal Social Services activities, especially about delivery of care and services to patients or clients. Free expression of these views can contribute to improving services for patients or clients in the future. Managers are, therefore, expected to make sure that all staff are given every opportunity to make their contribution. Moreover, they must feel that their legitimate views will be welcomed, appreciated and, where appropriate, acted on positively.

6. Under no circumstances will staff who express their views about health and personal social services issues in accordance with this policy be penalised in any way for doing so. Staff who raise concerns responsibly and reasonably will be protected against victimisation and will be supported by the Board. While anonymous concerns, by their nature, create difficulties in investigation, they must not be ignored. The degree, immediacy and particular content of each should be examined to determine how best to investigate the issue raised and if it is possible to gain more and better information on the matter from an alternative source.

7. Management and local staff representatives wish to promote a culture of openness and dialogue which at the same time upholds patient and client confidentiality, does not unreasonably undermine confidence in the service and meets the obligations of staff to the Board.

Confidentiality to Patients and Employer - the Responsibilities of Staff

8. All staff have a duty of confidentiality to patients and clients. Unauthorised disclosure of personal information about any patient or client will be regarded as a most serious matter which may warrant disciplinary action. This applies even where a member of staff believes that they are acting in the best interests of a patient or client by disclosing personal information.

9. Staff also have an implied duty of confidentiality and loyalty to their employer. Breach of this duty may result in disciplinary action, whether or not there is a clause in their contract of employment expressly addressing the question of confidentiality.

10. The duty of confidence to an employer is not absolute. However, in any case involving disclosure of confidential information, it may be claimed that the disclosure was made in the public interest. Such a justification might, in a disputed case, need to be defended and so should be soundly based. As a matter of prudence then, any member of staff who is considering making a disclosure of confidential information because they consider it to be in the public interest, should first seek specialist advice. This could be, for example, from one of the representative or regulatory organisations mentioned in Paragraphs 18-21.

11. The confidentiality provision in an individual staff employment contract does not conflict in any way with the principles and advice set out in this policy.

Informal Procedures

12. The aim should always be for staff concerns about health and personal social services issues to be resolved informally between the individual and their line or professional managers.

    Those managing staff/services should always:

    - take concerns seriously;
    - consider them fully and sympathetically;
    - recognise that raising a concern can be a difficult experience for some staff; and

- seek advice from health and social care professionals where appropriate.

13. Staff who are not in a formal line management relationship should discuss their concerns, if necessary, directly with the Chief Executive.

14. Where a staff concern can be acted upon, action will be taken promptly and the member of staff notified quickly of action taken. Where action is not considered practicable or appropriate, the individual member of staff will be given a prompt and thorough explanation of the reasons for this and will also be told what further action is available under local policies.

Formal Procedures - the Designated Officer

15. Where an informal approach proves ineffective, and matters cannot be resolved by immediate line managers, the member of staff concerned should refer the matter to their Director who may wish to consult with the Chief Executive. However, staff can also approach the Chief Executive directly.

16. In a case where this policy has been followed and the individual member of staff remains dissatisfied, the matter can be referred to the Chairman for action.

17. If an issue raises concerns about the improper use of public funds then the Chairman of the Audit Committee can be consulted.

Reference to Representative and Regulatory Organisations

18. All staff retain the right to consult, seek guidance and support from their professional organisation or trade union, and from statutory bodies such as the United Kingdom Central Council for Nursing, Midwifery and Health Visiting, the General Medical Council, the Northern Ireland Social Care Council, the Boards of the Council for Professions Supplementary to Medicine and the Health and Safety Executive.

19. Managers should encourage staff to consult with representative bodies, particularly if an issue seems likely to remain unresolved, without reference to the Chairman.

The Mental Health Commission for Northern Ireland

20. Where an employee has a concern about the care of a mentally disordered patient or client, regardless of whether or not they are detained under the Mental Health (NI) Order 1986, the matter could be referred to the Mental Health Commission for Northern Ireland if the concern remains unresolved after pursuing it through these procedures.

The NI Parliamentary Commissioner for Administration and the Commissioner for Complaints

21. All staff should be aware that the Ombudsman may look into complaints by staff on behalf of a patient or client, provided that he is satisfied that there is no-one more appropriate, such as an immediate relative, to act on their behalf. Adequate supplies of information leaflets about the Ombudsman's role and the procedures for reference to him are readily available to all staff, as well as to patients and clients.

(Useful contact numbers are attached in Appendix 1)

Reference to Members of Parliament and the Media

22. An employee who has exhausted all the locally established procedures, including reference to the Chairman, and who has taken account of advice which may have been given, might wish to consult his/her Member of Parliament in confidence.

23. As a last resort, staff might contemplate the possibility of disclosing concerns to the media. Such action, if entered into unreasonably, could result in disciplinary action and might undermine public confidence in the service.

24. In view of these considerations, any employee contemplating making a disclosure to the media is advised to first seek further specialist guidance from professional or other representative bodies and to discuss matters further with their colleagues and, where appropriate, line and professional mangers.

However, in the light of the principles set out in this policy, and the fact that local arrangements have been determined in consultation with staff representatives, it is expected that staff concerns can be addressed and dealt with, without telling the media.

APPENDIX 1

USEFUL CONTACT NUMBERS

UK Central Council for Nursing	020 7637 7181
Midwifery & Health Visiting	020 7637 7181
General Medical Council	020 7580 7642
Northern Ireland Social Care Council	028 9041 7600
Council for Professions Supplementary to Medicine	020 7582 0866
Health and Safety Executive	028 9052 4266
The Ombudsman	028 9023 3821

WESTERN
HEALTH AND SOCIAL SERVICES BOARD

STATEMENT ON WHISTLEBLOWING

Introduction

This statement should be read in conjunction with circulars HSS (Gen I) 1/96 "Guidance for Staff on Relations with the Public and the Media" and HSS (Gen 1) 1/2000 "The Public Interest and Disclosure (NI) Order 1998 - Whistleblowing in the HPSS".

The Western Health and Social Services Board seeks to encourage a climate of openness and dialogue which will enable employees to have confidence to raise concerns in the public interest without fear of victimisation.

1. Purpose

The principle emphasis of this statement is to ensure that action is taken to investigate any matters of concern raised by staff and to enable the Board to initiate corrective action where deemed necessary and appropriate. The statement is intended to provide a mechanism to address issues which are not already provided for within existing policies, e.g. Policy on Harassment, Grievance Procedure, Theft, Fraud and Corruption Response Plan, etc. This statement is not intended to substitute for these policies or other normal management reporting mechanisms which are already in place within the Board. It applies to all staff employed by the Western Health and Social Services Board.

2. Concerns

This statement is designed to ensure that concerns within the public interest are brought to the attention of the correct person within the Board and are dealt with through the appropriate procedure. The following are examples of some of the concerns which may be appropriate under this statement if an employee reasonably believes that one of the following either has, is in the process, or is likely to occur:

- A criminal offence
- Failure to comply with a legal obligation
- A miscarriage of justice
- Endangering of an individual's health and safety
- Damage to the environment
- Concealment of any of the above

It is preferable that such concerns are raised at the earliest opportunity in order for the Board to investigate the matter.

3. Raising Concerns

3.1 How to raise concerns

It is expected that employees raise concerns internally at work through their line manager in the first instance. Where this is not appropriate the employee should contact the Head of Consumer Services at Board Headquarters. While employees are entitled to raise concerns externally with relevant Regulatory Bodies, the Board would appreciate the opportunity to first investigate the concern. If your concern relates to the Head of Consumer Services then your initial contact should be with the Chairperson of the Board's Governance and Risk Management Committee. The current Chairperson, Dr Áine Downey, can be reached at aine.downey@ntlworld.com. She will then arrange to meet with you.

3.2 Confidentiality

The Board recognises that an employee may wish to raise a concern in confidence. If the situation arises where a concern cannot be resolved without releasing the identity of the employee, the Board will discuss this with the employee and decide how the issue will be progressed.

3.3 Anonymity

It is extremely difficult for the Board to investigate concerns if they are raised anonymously, for this reason theses concerns are not appropriate to this statement. The Board will determine the most appropriate process to address and investigate such concerns.

3.4 Process for dealing with concerns

3.4.1 When an employee advises the Board of a concern, it will determine what action, if any, is appropriate. The matter may be addressed by another existing procedure as describe in Paragraph 1 or alternatively the Board may instigate a management investigation.

3.4.2 The employee who raised the concern will be informed of the method by which the concern will be progressed and will be advised if their further involvement is required.

3.4.3 If the concern is already or has previously been the subject of an investigation this will not be appropriate for inclusion under the Statement on Whistleblowing.

3.4.4 The Board will ensure that any concern raised by an employee will be dealt with as soon as practicable.

3.4.5 The Board will support employees who raise concerns and will take any steps necessary to protect them against victimisation.

3.5 Outcome of Investigations

3.5.1 On completion of the investigation process, the employee who raised the concern will be informed through appropriate feedback of the outcome of the investigation, including any corrective action.

3.5.2 If, following investigation, an employee's concerns were unfounded, provided the employee acted in good faith, then no further action will be taken. Where it is considered that an employee has made a frivolous or vexatious complaint, the board will take any action considered appropriate including Disciplinary Proceedings.

4.0 Review

This statement will be reviewed at regular intervals.

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

[redacted]

Chief Executive and Director of Finance of each
HSC Body and NIFRS

Your Ref:
Our Ref:
Date: 3 February 2010

Dear Sir/Madam

Re: Whistleblowing Policy

The next meeting of the Departmental Audit & Risk Committee will be in March and, similar to last year, they have requested information on the following:-

- does your organisation have its own whistleblowing policy in place;
- how is your whistleblowing policy communicated;
- does your whistleblowing policy provide initial channels for individuals to raise their concerns internally;
- does your whistleblowing policy provide initial channels for individuals to raise their concerns externally e.g. NIAO, Civil Service Commissioners, Public Concern at Work, etc;
- have you had any cases of whistleblowing of any nature (not just fraud) in your organisation in the financial year 2008/09 and to date;
- details on how these cases of whistleblowing were handled within your organisation.

Please send your response (preferably in electronic format), to Neil Carson – e-mail [redacted] **by close of play on Friday 12 February 2010.**

If you require any clarification on any of these points, please contact Neil Carson on [redacted]

Thank you for your assistance.

Yours sincerely

Neelia Lloyd

Neelia Lloyd
Finance Policy, Accountability & Counter Fraud Unit

Health and Social Care Board

Mr Bernard Mitchell
Programme Director for
Corporate Management
HSCB
12-22 Linenhall Street
Belfast
BT2 8BS

Tel: 02890 553731

Mr Neil Carson
Finance Policy
Accountability & Counter Fraud Unit
DHSSPS
Castle Buildings
Stormont Estate
Belfast
BT4 3SG

Date 10 February 2010

Dear Mr Carson

In response to Ms Lloyd's letter of 3 February 2010, I can advise that to date the Health and Social Care Board is currently working from the Whistleblowing Policies previously approved by each of the legacy HSS Boards. In this context, the attached responses will be in line with the four legacy policies.

I would however like to advise that the development of a new Whistleblowing policy for the HSCB is underway.

Yours faithfully

Mr Bernard Mitchell
Programme Director for Corporate Services

Cc Mr Paul Cummings

Enc

HSCB Responses for Departmental Audit and Risk Committee

1. The HSCB is currently applying Whistleblowing policies previously approved by the four legacy HSS Boards.

2. Policies had previously been circulated to staff and are also available on the legacy HSS Board intranets.

3. All four policies provide initial channels for individuals to raise their concerns internally.

4. All four policies provide initial channels for individuals to raise their concerns externally.

5. There have been no cases of whistleblowing of any nature in the HSCB or former HSS legacy Boards in the financial year 2008/09 and to date.

Health and Social Care Board

WHISTLE BLOWING POLICY

Equality Considerations

This policy has been screened in accordance with the HSCB's statutory duty and is not considered to require a full impact assessment. The screening outcomes will be published on the HSCB website.

Human Rights Act

This policy is compliant with the requirements of the Human Rights Act 1998.

Policy Reference 2011/ Gov/ 01	**Responsible Officer** Head of Corporate Services	**Review Frequency** 2 yearly
Approved by Governance Committee	**Approval Date:** 01 / 09 / 11	**Next review due** SEPT 2013
Superseded documents (if applicable) All legacy HSS Boards' Whistle Blowing Polices		

September 2011

WHISTLEBLOWING ARRANGEMENTS – RAISING CONCERNS AT WORK

1. INTRODUCTION

All of us at one time or another may have concerns about what is happening at work. Usually these concerns are easily resolvable. However, when it is about unlawful conduct, a possible fraud *(including Bribery as defined by the Bribery Act 2011*) or dangers to staff, the public, the environment, or other serious malpractice, it can be difficult to know what to do.

You may be worried about raising such a concern and may think it best to keep it to yourself, perhaps feeling it is none of your business or that it is only a suspicion. You may feel that raising the matter would be disloyal to colleagues, managers or to the Health and Social Care Board (HSCB). You may decide to say something but find that you have spoken to the wrong person or raised the issue in the wrong way and are not sure what to do next.

The HSCB has introduced this Whistle blowing Policy to enable staff[1] to raise concerns about what is happening at work at an early stage and in the right way.

2. PURPOSE AND AIMS

The Health and Social Care Board is committed to developing an environment of openness and honesty which encourages staff to contribute views to all aspects of its activities. The purpose of these arrangements is to reassure you that it is safe and acceptable to speak up. These arrangements will enable you to raise your concern about any malpractice at an early stage and in the right way. Rather than wait for proof, the HSCB would prefer you to raise the matter when it is still a concern.

We have implemented these whistle blowing arrangements for you to raise any concern where the interests of others or the organisation itself are at risk. If something is troubling you of which you think we should know about or look into, please use this procedure to let us know.

If, however, you wish to make a complaint about your employment or how you have been treated, please use the HSCB Grievance Procedure. Staff should be aware that deliberately concealing information which may be of concern to the

[1] The term 'staff' in this policy apply both to those people directly employed by the Health and Social Care Board (HSCB), and those people associated with the HSCB by any other employment contractual arrangement

organisation is a serious matter. Therefore, staff are encouraged to raise issues in line with this policy as soon as they become aware of them. If in doubt, raise it!

If your concern is about possible fraud, you may also wish to refer to our Fraud Response Plan. You can obtain a copy of the plan by contacting the HSCB Head Accountant for Governance and Accountability at our Eastern Office 12-22 Linenhall Street Belfast BT2 8BS Tel 028 9032 1313 Ext 2123 or Direct Dial Line 028 9055 3926.

This policy is intended to provide a mechanism to address issues which are not provided for within existing policies e.g. Disciplinary Procedure, Grievance Procedure. The HSCB also has polices in place for dealing with the reporting of adverse incidents – this policy is not intended to substitute for those policies or for other normal management reporting arrangements within the HSCB.

Whilst this policy provides for raising issues, internally and externally, this does not include the inappropriate release of confidential information, including documents, to the media which is not covered under the Whistleblowing policy and would be dealt with as a disciplinary matter.

3. OUR ASSURANCES TO YOU

- **Your safety**

  The HSCB is committed to making whistle blowing work. If you raise a genuine concern under these arrangements, you will not be at risk of losing your job or suffering any form of retribution as a result. Provided you are acting in good faith, it does not matter if you are mistaken. Of course, this assurance does not extend to someone who maliciously raises a matter they know to be untrue or which is raised in a vexatious or mischievous way.

- **Confidentiality**

  The HSCB will not tolerate the harassment or victimisation of anyone who raises a genuine concern under this policy. However, we recognise that there may be circumstances when you would want to raise a concern in confidence first. If this is the case, please say so at the outset. If you ask us not to disclose your identity, we will not do so without your consent unless required by law. You should understand that there may be times when we are unable to resolve a concern without revealing your identity, for example where your personal evidence is essential. In such cases, we will discuss with you whether and how the matter can best proceed.

- **Anonymity**

  Remember that if you do not tell us who you are, it will be much more difficult for us to look into the matter, to protect your position, or to give you feedback. Accordingly, while we will consider anonymous reports, these arrangements are not well suited to deal with concerns raised anonymously.

  If you are unsure about raising a concern you can get independent advice from Public Concern as Work (see contact details under Independent Advice).

4. HOW TO RAISE A CONCERN INTERNALLY

Please remember that you do not need to have firm evidence of malpractice before raising a concern. However we do ask that you explain as fully as you can the information or circumstances that gave rise to your concern.

Step One

If you have a concern about malpractice, we hope you will feel able to raise it first with your line manager. To make it as easy as possible to raise a concern, this can be done orally or in writing (by letter or email). You should specify from the outset if you wish the matter to be dealt with in confidence. The line manager should raise the concern with their Director, who will notify the Head of Corporate Services (Senior Designated Officer) of the matter.

Step Two

If, for whatever reason, you feel that raising it with your line manager is not appropriate or it has not worked, please raise the matter with their immediate manager or Director or with one of the following senior management team members:

[redacted]

Step Three

If these channels have been followed and you believe there is an ongoing risk or you feel the matter is so serious that you cannot discuss it with any of the above, you can raise your concern directly with:

[redacted]

5. HOW WE WILL HANDLE THE MATTER

Once you have told us of your concern, we will look into it to assess initially what action should be taken. This may involve an informal review, an internal inquiry or a more formal investigation. Where it is decided that a formal investigation is necessary the overall responsibility for the investigation will lie with a nominated "investigation officer."

In any event, we will tell you

- who is dealing with the matter,
- how you can contact him or her, and
- whether your further assistance may be needed.

If you request, we will write to you summarising your concern and setting out how we propose to handle it.

When you raise the concern you may be asked how you think the matter might best be resolved. If you do have any personal interest in the matter, we do ask that you tell us at the outset. If your concern falls more properly within the Grievance Procedure we will tell you.

We will give you as much feedback as we properly can, and if requested, we will confirm it in writing. However, we may not be able to tell you the precise action we take where this would infringe a duty of confidence owed by us to someone else.

A summary of concerns raised under this policy will be reported on an annual basis to the Governance Committee by the Head of Corporate Services who will give an indication of the status of each investigation whilst respecting the confidentiality of the Whistleblower.

6. INDEPENDENT ADVICE

If you are unsure whether or how to raise a concern or you want confidential advice at any stage, you may contact your trade union or your professional body. You may also contact the independent charity Public Concern at Work on 020 7404 6609 or by email at helpline@pcaw.co.uk. Their lawyers can talk you through your options and help you raise a concern about malpractice at work. For more information, you can visit their website at www.pcaw.co.uk.

7. EXTERNAL DISCLOSURES

It is important to note that the HSCB encourages staff to raise matters internally first, before any external organisation is involved and while we hope we have given you the reassurance you need to raise your concern, internally with us, we recognise that there may be circumstances where you can properly report a concern to an outside body. In fact, we would rather you raise a matter with the appropriate regulator – such as the Northern Ireland Audit Office, the Health and Safety Executive of Northern Ireland or the Equality Commission - than not at all. Public Concern at Work (or your union or your professional body) will be able to advise you on such an option and on the circumstances in which you may be able to contact an outside body safely.

A list of external contact details are provided in Appendix 1 – this list is not intended to be exhaustive.

8. CONCLUSION

While we cannot guarantee that we will respond to all matters in the way that you might wish, we will strive to handle the matter fairly and properly. By using these whistle blowing arrangements you will help us to achieve this.

Please note, this procedure has been developed to meet best practice and comply with the Public Interest Disclosure (NI) Order 1998 (PIDO) which provides employment protection for whistle blowing. Please refer to Appendix 2 for details of Protection under the order. For more information on the law, see (web link to the law) http://www.legislation.gov.uk/nisi/1998/1763/contents.

9. ALTERNATIVE FORMAT

Every effort will be made to provide information in an alternative format if written format is not accessible to a member of staff.

APPENDIX 1

The Ombudsman
Progressive House
33 Wellington Place
Belfast
BT1 6HN

0800 34 34 24
www.ni-ombudsman.org.uk

Equality Commission
Equality House
7-9 Shaftesbury Square
Belfast
BT2 7DP

028 9050 0600
www.equalityni.org

N.I. Audit Office
106 University Street
Belfast
BT7 1EU

028 9025 1000
whistleblowing@niauditoffice.gov.uk

Information Commissioner for Northern Ireland
51 Adelaide Street
Belfast
BT2 8FE

028 9026 9380
www.ico.gov.uk/about_us/our_organisation/northern_ireland+

Health & Safety Executive for Northern Ireland
83 Ladas Drive
BELFAST
BT6 9FR

028 9024 3249 (Free phone 0800 0320 121)
www.hseni.gov.uk

Regulation and Quality Improvement Authority
9th Floor Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

028 9051 7500
www.rqia.org.uk

Northern Ireland Social Care Council
7th Floor Millennium House
Great Victoria Street
BELFAST
BT2 7AQ

028 9041 7600
www.niscc.info

Nursing & Midwifery Council
23 Portland Place
LONDON
W1B 1PZ

020 7637 7181
www.nmc-uk.org/Nurses-and-midwives/safeguarding/Northern-Ireland

General Medical Council
20 Adelaide Street
BELFAST
BT2 8GD
028 9051 7022
www.gmc-uk.org/about/northernireland

Health Professions Council
184 Kennington Park Road
LONDON
SE11 4BU

020 7840 9814
www.hpc-uk.org

Department of Health, Social Services & Public Safety
Castle Buildings
Stormont
BELFAST
BT4 3SJ

028 9052 0500
www.dhsspsni.gov.uk

DHSSPS Fraud Hotline - Tel 08000 963396

This list is not intended to be exhaustive.

APPENDIX 2

PROTECTION FOR QUALIFYING DISCLOSURES

1.1 A qualifying disclosure will be protected under the Order if it is made:

- In good faith to the HSCB (either directly or through internal procedures authorised by the HSCB), or to another person whom the discloser reasonably believes is solely or mainly responsible for the failure in question.

- To a legal adviser in the course of obtaining legal advice.

- In good faith to a Government Minister by an employee in a Government appointed organisation such as a Non-Departmental Public Body; or

- To a person or body prescribed in Statutory Rule 1999 No. 401 ("a prescribed person"), for example, the Health and Safety Executive for Northern Ireland, the Comptroller and Auditor General for Northern Ireland.

1.2 In the last case the employee must make the disclosure in good faith, reasonably believe that the information and the allegation in it are substantially true, and reasonably believe that the matter falls within the description of matters for which the person has been prescribed.

1.3 Qualifying disclosures will also be protected if they are made other than in the previous paragraph, provided that the person makes the disclosure in good faith, reasonably believes that the information and the allegation contained in it are substantially true, and does not act for personal gain. One or more of the following conditions must apply:

- The discloser reasonably believed that they would be victimised if they had made the disclosure to the employer or a prescribed person;

- There was no prescribed person and the discloser reasonably believed that disclosure to the employer would result in the destruction or concealment of evidence; or

- The discloser had already disclosed substantially the same information to the employer or a prescribed person.

1.4 It must also be reasonable for the discloser to make the disclosure. In deciding the reasonableness of the disclosure, an industrial tribunal will consider the circumstances. This will include:

- The identity of the person to whom the disclosure was made;

- The seriousness of the concern;

- Whether the failure is continuing or likely to recur;

- Whether the disclosure breached the duty of confidentiality which the employer owed to a third party;

- What action has been taken or might reasonably be expected to have been taken if the disclosure was previously made to the employer or a prescribed person; and

- Whether the discloser complied with any approved internal procedures if the disclosure was already made to the employer.

1.5 A disclosure made about an "**exceptionally serious**" failure, other than described above, will be protected if the discloser makes the disclosure in good faith, reasonably believes that the information disclosed and any allegations contained in it are substantially true and does not act for personal gain, provided that it is reasonable for that person to make the disclosure, having regard, in particular, to the identity of the person to whom the disclosure is made. It will be for the Industrial Tribunal to consider and decide whether any particular failure is "exceptionally serious". This will be a question of fact, not of an individual's personal belief.

Health and Social Care Board

WHISTLE BLOWING POLICY

Produced by the Corporate Services Directorate
Health and Social Care Board
12-22 Linenhall Street, Belfast, BT2 8BS

March 2018

Title:	**HSCB Whistleblowing Policy v2.0**		
Author(s):	Jacqui Burns – This policy is based on regional HSC Whistleblowing Policy developed by all HSC Organisations 2017		
Ownership:	Head of Corporate Services		
Approval By:	Governance Committee	Approval Date:	29 March 2018
Operational Date:	April 2018	Next Review:	March 2019
Version No.	2.0	Supersedes:	HSCB Whistleblowing Policy Sept 2011
Responsible Officer:		Head of Corporate Services	
Directorate:		Corporate Services	
Links to other Policies:			
HSCB Information Governance Policies and guidance			
Grievance Policy			
Disciplinary Policy			
HSCB Procedure for the reporting and follow up of SAIs			
Incident and Near Miss Policy			
Fraud Policy and Response Plan			
Complaints Policy			
Code of Conduct for HSC Employees			

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1. INTRODUCTION

All of us, at one time or another, may have concerns about what is happening at work. The HSCB wants you to feel able to raise your concerns about any issue troubling you with your managers, at any time. It expects its managers to listen to those concerns, take them seriously and take action to resolve the concern, either through providing information which gives assurance or taking action to resolve the concern. However, when the concern feels serious because it is about a possible danger, professional misconduct or financial malpractice that might affect patients, colleagues, or the HSCB itself, it can be difficult to know what to do.

The HSCB recognises that many issues are raised by staff and addressed immediately by line managers - this is very much encouraged. This policy and procedure is aimed at those issues and concerns which are **not resolved, require help to get resolved or are about serious underlying concerns.**

Whistleblowing refers to staff reporting suspected wrongdoing at work, for example, concerns about patient safety, health and safety at work, environmental damage or a criminal offence, such as, fraud.

You may be worried about raising such issues and may think it best to keep it to yourself, perhaps feeling it is none of your business or that it is only a suspicion. You may also feel that raising the matter would be disloyal to colleagues, to managers or to the organisation. It may also be the case, that you have said something but found that you have spoken to the wrong person or raised the issue in the wrong way and are not sure what to do next.

Remember that if you are a healthcare professional you may have a professional duty to report a concern. **If in doubt, please raise it.**

Rather than wait for proof; raise the matter when it is still a concern. If something is troubling you of which you think we should know about or look into, please let us know. The HSCB has implemented these whistleblowing arrangements for you to raise any concern where the interests of others or the organisation itself are at risk.

2. AIMS AND OBJECTIVES

The HSCB is committed to running the organisation in the best way possible. The aim of the policy is to promote a culture of openness, transparency and dialogue which at the same time:

- reassures you that it is safe and acceptable to speak up;
- upholds patient confidentiality;
- contributes towards improving services provided by the HSCB
- assists in the prevention of fraud and mismanagement;
- demonstrates to all staff and the public that the HSCB is ensuring its affairs are carried out ethically, honestly and to high standards;

- provides an effective and confidential process by which you can raise genuine concerns so that patients, clients and the public can be safeguarded.

The HSCB roles and responsibilities in the implementation of this policy are set out at **Appendix A.**

3. SCOPE

The HSCB recognises that existing policies and procedures, which deal with conduct and behaviour at work (Disciplinary, Grievance, Working Well Together, Harassment and Bullying, the Complaints Procedure and the Accident/Incident Reporting Procedure) may not always be appropriate to extremely sensitive issues which may need to be handled in a different way.

This policy provides a procedure for all staff of the HSCB, including permanent, temporary and bank staff, staff in training working within the HSCB, independent contractors engaged to provide services, volunteers and agency staff who have concerns where the interests of others or of the organisation itself are at risk. **If in doubt - raise it!**

Examples may include:

- malpractice or ill treatment of a patient or client by a member of staff;
- where a potential criminal offence has been committed, is being committed or is likely to be committed;
- suspected fraud;
- breach of Standing Financial Instructions;
- disregard for legislation, particularly in relation to Health and Safety at Work;
- the environment has been, or is likely to be, damaged;
- a miscarriage of justice has occurred, is occurring, or is likely to occur;
- showing undue favour over a contractual matter or to a job applicant;
- research misconduct; or
- information on any of the above has been, is being, or is likely to be concealed.

This list is not intended to be exhaustive or restrictive

If you feel that something is of concern, and that it is something which you think the HSCB should know about or look into, you should use this procedure. If, however, you wish to make a complaint about your employment or how you have been treated, you should follow the HSCB's local grievance procedure or policy for making a complaint about Bullying and/or Harassment which can be obtained from your manager.

This policy complements professional and ethical rules, guidelines and codes of conduct and freedom of speech. It is not intended to replace professional codes and mechanisms which allow questions about professional competence to be raised. (However such issues can be raised under this process if no other more appropriate avenue is apparent).

4. SUSPECTED FRAUD

If your concern is about possible fraud or bribery the HSCB has a number of avenues available to report your concern. These are included in more detail in the HSCB's Fraud Policy, Fraud Response Plan and Bribery Policy and are summarised below.

Suspicions of fraud or bribery should initially be raised with the appropriate line manager but where you do not feel this is not appropriate the following officers may be contacted:

- Fraud Liaison Officer (FLO) - HSCB Head Accountant

Employees can also contact the regional HSC fraud reporting hotline on **0800 096 33 96** or report their suspicions online to www.repporthealthfraud.hscni.net These avenues are managed by Counter fraud and Probity Services (CFPS) on behalf of the HSC and reports can be made on a confidential basis.

The HSCB's Fraud Response Plan will be instigated immediately on receipt of any reports of a suspicion of fraud or bribery.

The prevention, detection and reporting of fraud and bribery and other forms of corruption are the responsibility of all those working for the HSCB or under its control. The HSCB expects all staff and third parties to perform their duties impartially, honestly, and with the highest integrity.

5. HSCB'S COMMITMENT TO YOU

5.1 Your safety

The HSCB, the Chief Executive, managers and the trade unions/professional organisations are committed to this policy. If you raise a genuine concern under this policy, you will not be at risk of losing your job or suffering any detriment (such as a reprisal or victimisation). The HSCB will not tolerate the harassment or victimisation of anyone who raises a genuine concern.

The HSCB expects you to raise concerns about malpractices. If any action is taken that deters anyone from raising a genuine concern or victimises them, this will be viewed as a disciplinary matter.

It does not matter if you are mistaken or if there is an innocent explanation for your concerns, you will be protected under the law. However, it is not uncommon for some staff to maliciously raise a matter they know to be untrue. In cases where staff maliciously raise a matter they know to be untrue, protection under the law cannot be guaranteed and the HSCB reserves the right to take disciplinary action if appropriate.

5.2 Confidentiality

With these assurances, the HSCB hopes that you will raise concerns openly. However, we recognise that there may be circumstances when you would prefer to speak to someone in confidence first. If this is the case, you should say so at the outset to Designated Advisors/ Advocates: HSCB Governance Manager or Assistant Governance Manager (*refer to HSCB Whistleblowing Contacts)*
.

The HSCB is committed to maintaining confidentiality for everyone involved in a concern. This includes the person raising the concern and the person(s) whom the concern is about. Confidentiality will be maintained throughout the process and after the issue has been resolved.

If you ask for your identity not to be disclosed, we will not do so without your consent unless required by law. You should however understand that there may be times when we will be unable to resolve a concern without revealing your identity, for example, where personal evidence is essential. In such cases, we will discuss with you whether and how the matter can best proceed.

5.3 Anonymity

Remember that if you do not disclose your identity, it will be much more difficult for us to look into the matter. It will also not be possible to protect your position or give you feedback. So, while we will consider anonymous reports in the exact same manner as those which are not anonymised, these arrangements are not best suited to deal with concerns raised anonymously.

If you are unsure about raising a concern you can get independent advice from Public Concern at Work (see contact details under Independent Advice).

6. RAISING A CONCERN

If you are unsure about raising a concern, you can get independent advice at any stage from your trade union/professional organisation, or from one of the organisations listed in Section 7. You should also remember that you do not need to have firm evidence before raising a concern. However, you should explain as fully as possible the information or circumstances that gave rise to the concern.

6.1 Who should I raise a concern with?

In many circumstances the easiest way to get your concern resolved will be to raise it with your line manager. But where you do not think it is appropriate to do this, you can use any of the options set out below.

If raising it with your line manager does not resolve matters, or you do not feel able to raise it with them, you can contact one of the following:

- the Designated Advisor/ Advocate - HSCB Governance Manager

If you still remain concerned after this, you can contact:

- the HSCB Head of Corporate Services, who has overall responsibility for Whistleblowing or
- Non- Executive Director who has responsibility for oversight of the culture for raising concerns (Whistleblowing) within the HSCB - *refer to HSCB Whistleblowing Contacts*

All these people have been trained in receiving concerns and will give you information about where you can go for more support. If for any reason you do not feel comfortable raising your concern internally, you can raise concerns with external bodies (refer to section 7 below).

If exceptionally, the concern is about the Chief Executive, then it should be made (in the first instance) to the HSCB Chair, who will decide on how the investigation will proceed.

6.2 Independent advice

If you are unsure whether to use this policy, or if you require confidential advice at any stage, you may contact your trade union/professional organisation.

Advice is also available through the independent charity Public Concern at Work (PCaW) on 020 7404 6609.

6.3 How should I raise my concern?

You can raise your concerns with any of the people listed above, in person, by phone or in writing (including email).

Whichever route you choose, please be ready to explain as fully as you can the information and circumstances that gave rise to your concerns.

7. RAISING A CONCERN EXTERNALLY

The HSCB hopes this policy reassures you of its commitment to have concerns raised under it taken seriously and fully investigated, and to protect an individual who brings such concerns to light.

Whilst there may be occasions where individuals will wish to report their concerns to external agencies or the PSNI, the HSCB would hope that the robust implementation of this policy will reassure staff that they can raise such concerns internally in the first instance.

However, the HSCB recognises that there may be circumstances where you can raise a concern with an outside body including those listed below:

- Department of Health;
- A prescribed person, such as:
  - General Chiropractic Council, General Dental Council, General Medical Council, General Osteopathic Council, Health & Care Professional Council, Northern Ireland Social Care Council, Nursing and Midwifery Council, Pharmaceutical Society Northern Ireland, General Optical Council
- The Regulation and Quality Improvement Authority;
- The Health and Safety Executive;
- Serious Fraud Office,
- Her Majesty's Revenue and Customs,
- Comptroller and Auditor General;
- Information Commissioner,
- Northern Ireland Commissioner for Children and Young People,
- Northern Ireland Human Rights Commission

Disclosure to these organisations/persons will be protected provided you honestly and reasonably believe the information and associated allegations are substantially true.

We would wish you to raise a matter with the external agencies listed above than not at all. Public Concern at Work (or your union) will be able to advise you on such an option and on the circumstances in which you may be able to contact an outside body safely.

8. THE MEDIA

You may consider going to the media in respect of their concerns if you feel the HSCB has not properly addressed them. You should carefully consider any information you choose to put into the public domain to ensure that patient/client confidentiality is maintained at all times. The HSCB reserves the right to take disciplinary action if patient/client confidentiality is breached.

Communications with the media are coordinated by the HSCB Corporate Services Communications Team on behalf of the HSCB. Staff approached by the media should direct the media to this department in the first instance.

9. CONCLUSION

While we cannot guarantee that we will respond to all matters in the way that you might wish, we will strive to handle the matter fairly, impartially and properly. By using these whistleblowing arrangements you will help us to achieve this.

Please note, this document has been developed to meet best practice and comply with the Public Interest Disclosure (NI) Order 1998 (the Order) which provides employment protection for whistleblowing.

The Order gives significant statutory protection to staff who disclose information reasonably in the public interest. To be protected under the law an employee must act with an honest and reasonable belief that a malpractice has occurred, is occurring or is likely to occur. Disclosures may be made to certain prescribed persons or bodies external to the HSCB listed in the Order. The Order does not normally protect employees making rash disclosures for example to the media, when the subject could have been raised internally.

10. APPENDICES

Appendix A - Roles and Responsibilities
Appendix B - Procedure
Appendix C - Advice for Managers

11. EQUALITY, HUMAN RIGHTS & DDA

This policy has been drawn up and reviewed in the light of Section 75 of the Northern Ireland Act (1998) which requires the HSCB to have due regard to the need to promote equality of opportunity. It has been screened to identify any adverse impact on the nine equality categories.

The policy has been screened without mitigation.

12. PERSONAL & PUBLIC INVOLVEMENT (PPI) /CONSULTATION PROCESS

This policy has been adopted by the HSCB in line with regional guidance. Appropriate consultation has been carried out with colleagues across all relevant HSC bodies.

13. ALTERNATIVE FORMATS

This document can be made available on request in larger font, Braille, audiocassette and in other minority languages to meet the needs of those who are not fluent in English.

14. SOURCES OF ADVICE IN RELATION TO THIS DOCUMENT

The Policy Author, responsible Director as detailed on the policy title page should be contacted with regard to any queries on the content of this policy.

APPENDIX A

ROLES AND RESPONSIBILITIES

The HSCB

- To listen to our staff, learn lessons and strive to improve patient care;
- To ensure that this policy enables genuine issues that are raised to be dealt with effectively;
- To promote a culture of openness and honesty and ensure that issues are dealt with responsibly and taken seriously;
- To ensure that employees who raise any issues are not penalised for doing so unless other circumstances come to light which require this, e.g. where a member of staff knowingly raises an issue regarding another member of staff which they know to be untrue;
- To share learning, as appropriate, via organisations shared learning procedures.

The Non- Executive Director (NED)

- To have responsibility for oversight of the culture of raising concerns within their organisation.

Senior Manager

- To take responsibility for ensuring the implementation of the whistleblowing arrangements.

Managers

- To take any concerns reported to them seriously and consider them fully and fairly;
- To recognise that raising a concern can be a difficult experience for some staff and to treat the matter in a sensitive manner if required;
- To seek advice from other professionals within the HSCB where appropriate;
- To invoke the formal procedure and ensure the Designated Advisors/ Advocates: HSCB Governance Manager is informed, if the issue is appropriate;
- To ensure feedback/ learning at individual, team and organisational level on concerns and how they were resolved.

Whistleblowing adviser/ advocate

- To ensure that any safety issue about which a concern has been raised is dealt with properly and promptly and escalated appropriately through all management levels;

- To intervene if there are any indications that the person who raised a concern is suffering any recriminations;
- To work with managers and HR to address the culture in an organisation and tackle the obstacles to raising concerns.

This list is not intended to be exhaustive or restrictive

All Members of Staff

- To recognise that it is your duty to draw to the HSCB's attention any matter of concern;
- To adhere to the procedures set out in this policy;
- To maintain the duty of confidentiality to patients and the HSCB and consequently, where any disclosure of confidential information is to be justified, you should first, where appropriate, seek specialist advice for example from a representative of a regulating organisation such as the Nursing & Midwifery Council or the General Medical /Dental Council.

ROLE OF TRADE UNIONS AND OTHER ORGANISATIONS

All staff have the right to consult and seek guidance and support from their Professional Organisations, Trade Union or from statutory bodies such as the Nursing & Midwifery Council, the General Medical Council, Health Professional Council and the Social Care Council for Northern Ireland.

APPENDIX B

EXAMPLE PROCEDURE FOR RAISING A CONCERN

STEP ONE (Informal)

If you have a genuine concern about what you believe might be malpractice and have an honest and reasonable suspicion that the malpractice has occurred, is occurring, or is likely to occur, then the matter should be raised in the first instance with your Line Manager. This may be done verbally or in writing.

You are entitled to representation from a trade union/ fellow worker or companion to assist you in raising your concern.

STEP TWO (informal)

If you feel unable to raise the matter with your Line Manager, for whatever reason, please raise the matter with our designated Advisors/ Advocates: HSCB Governance Manager or Assistant Governance Manager email: hscbwhistleblowing@hscni.net

This person/s has been given special responsibility and training in dealing with whistleblowing concerns. They will:

- treat your concern confidentially unless otherwise agreed;
- ensure you receive timely support to progress your concerns;
- escalate to the board any indications that you are being subjected to detriment for raising your concern;
- remind the organisation of the need to give you timely feedback on how your concern is being dealt with;
- ensure you have access to personal support since raising your concern may be stressful.

If you want the matter dealt with in confidence, please say so at the outset so that appropriate arrangements can be made.

STEP THREE (formal)

If these channels have been followed and you still have concerns, or if you feel that the matter is so serious that you cannot discuss it with any of the above, please contact:

- the HSCB Head of Corporate Services,
- Non- Executive Director who has responsibility for oversight of the culture for raising concerns (Whistleblowing) within the HSCB - *refer to HSCB Whistleblowing Contacts*

These people have been trained in receiving concerns and will give you information about where you can go for more support. If for any reason you do not feel comfortable raising your concern internally, you can raise concerns with external bodies (refer to section 7 below).

If exceptionally, the concern is about the Chief Executive, then it should be made (in the first instance) to the HSCB Chair, who will decide on how the investigation will proceed. *(Refer to HSCB Whistleblowing Contacts)*

STEP FOUR (formal)

You can raise your concerns formally with the external bodies listed at Section 7:

WHAT WILL WE DO?

We are committed to listening to our staff, learning lessons and improving patient care. On receipt, the concern will be recorded and, where possible, you will receive an acknowledgement within three working days.

A central register will record the date the concern was received, whether you have requested confidentiality, a summary of the concerns and dates when we have given you updates or feedback. While your identity may be included within the allegation or report, the register will not include any information which may identify you, nor should it include any information which may identify an individual or individuals against whom an allegation is made.

INVESTIGATION

Where you have been unable to resolve the matter quickly (usually within a few days) with your Line Manager, we will carry out a proportionate investigation – using someone suitably independent (usually from a different part of the organisation) and properly trained – and we will reach a conclusion within a reasonable timescale (which we will notify you of).

Wherever possible we will carry out a single investigation (so, for example, where a concern is raised about a patient safety incident, we will usually undertake a single investigation that looks at your concern and the wider circumstances of the incident). The investigation will be objective and evidence-based, and will produce a report that focuses on identifying and rectifying any issues, and learning lessons to prevent problems recurring.

We may decide that your concern would be better looked at under another process: for example, our process for dealing with bullying and harassment. If so, we will discuss that with you. We will advise you, where possible, and those identified as the subject of a concern, 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

Any employment issues (that affect only you and not others) identified during the investigation will be considered separately. Where an Agency worker raises a concern then it is the responsibility of the HSCB to take forward the investigation in conjunction with the Agency if appropriate

For the purposes of recording, if the concern is already, or has previously been, the subject of an investigation under another procedure e.g. grievance procedure it will not be appropriate to categorise it under the HSCB Whistleblowing Policy.

COMMUNICATING WITH YOU

We welcome your concerns and will treat you with respect at all times. We will discuss your concerns with you to ensure we understand exactly what you are worried about. We will endeavour to provide a response within 12 weeks of the concern being received. We will provide an update on progress by week 6 and again by week 10 of the investigation. We will share the outcome of the investigation report with you (while respecting the confidentiality of others).

HOW WE WILL LEARN FROM YOUR CONCERNS

The focus of the investigation will be on improving our services. Where it identifies improvements that can be made, we will track them to ensure necessary changes are made and are working effectively. The final outcome and 'lessons learned' will be documented and approved as final by the responsible Director. In addition the Chief Executive will independently assess the findings and recommendations for assurance that the matter has been robustly considered and appropriately addressed.

BOARD OVERSIGHT

The HSCB board and the Department of Health will be given high level information about all concerns raised by our staff through this policy and what we are doing to address any problems. We will include similar high level information in our annual report. The board supports staff raising concerns and want you to feel free to speak up. The Chair has nominated a non-executive director with responsibility for the oversight of the organisation's culture of raising concerns.

REVIEW & REPORTING

We will review the effectiveness of this policy and local processes at least annually, with the outcome published and changes made as appropriate. We will provide an annual report to the HSCB senior management team and to our Governance Committee on our whistleblowing caseload and an annual return to the Department of Health setting out the actions and outcomes.

APPENDIX C

ADVICE FOR MANAGERS RESPONDING TO A CONCERN

1. Thank the staff member for raising the concern, even if they may appear to be mistaken;

2. Respect and heed legitimate staff concerns about their own position or career;

3. Manage expectations and respect promises of confidentiality;

4. Discuss reasonable timeframes for feedback with the member of staff;

5. Remember there are different perspectives to every story;

6. Determine whether there are grounds for concern and investigate if necessary as soon as possible. Where appropriate alert those identified as the subject of the concern. If the concern is potentially very serious or wide-reaching, consider who should handle the investigation and know when to ask for help. If asked, managers should put their response in writing;

7. Managers should ensure that the investigator is not connected to the concern raised and determine if there is any actual, potential or perceived conflict of interest which exists prior to disclosing full details of the concern. Should a conflict of interest arise during the investigation the investigator must alert the manager. (Note: Any such conflict must be considered, and acted on, by the manager);

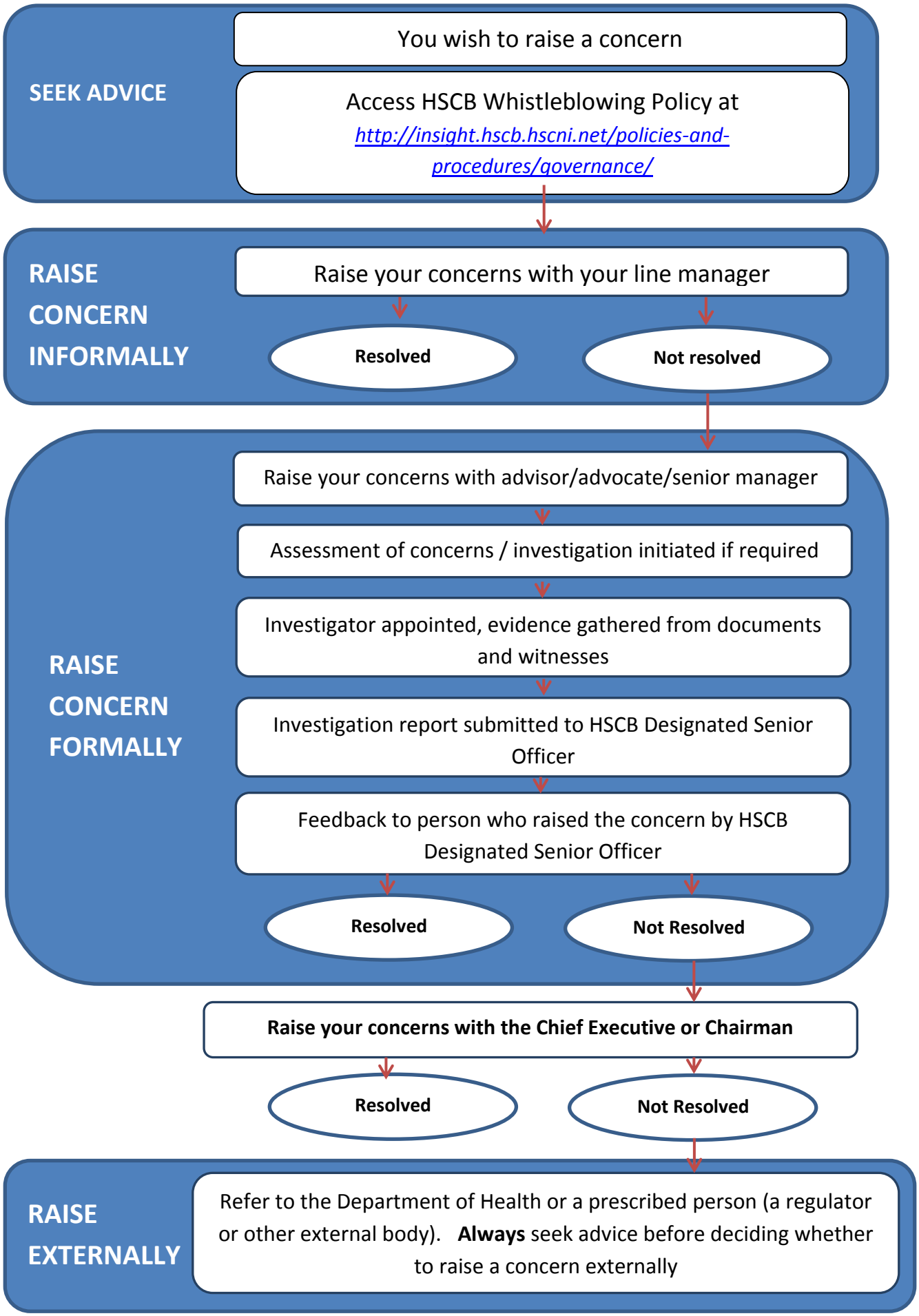
8. Managers should bear in mind that they may have to explain how they have handled the concern;

9. Feed back to the whistleblower and those identified as the subject of a concern (where appropriate) any outcome and/or proposed remedial action, but be careful if this could infringe any rights or duties which may be owed to other parties;

10. Consider reporting to the board and/or an appropriate regulator the outcome of any genuine concern where malpractice or a serious safety risk was identified and addressed; and

11. Record-keeping - it is prudent to keep a record of any serious concern raised with those designated under the policy, and these records should be anonymous where necessary. Please ensure the Designated Advisor/ Advocate: HSCB Governance Manager is informed of any concern raised under this policy.

ANNEX B - RAISING CONCERNS AND WHISTLEBLOWING PROCESS



The Regulation and Quality Improvement Authority

Review of the Operation of Health and Social Care Whistleblowing Arrangements

September 2016

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland. RQIA's reviews aim to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest. Our reviews are carried out by teams of independent assessors, who are either experienced practitioners or experts by experience. Our reports are submitted to the Minister for Health, Social Services and Public Safety, and are available on our website at www.rqia.org.uk.

RQIA is committed to conducting inspections and reviews and reporting against four key stakeholder outcomes:

- Is care safe?
- Is care effective?
- Is care compassionate?
- Is the service well-led?

These stakeholder outcomes are aligned with Quality 2020[1], and define how RQIA intends to demonstrate its effectiveness and impact as a regulator.

Public Concern at Work

Public Concern at Work (PCaW)[2] is an independent charity and legal advice centre. The cornerstone of the charity's work is a confidential advice line for workers who have witnessed wrongdoing, risk or malpractice in the workplace but are unsure whether or how to raise their concern. The advice line has advised over 20,000 whistleblowers to date; this unique insight into the experience of whistleblowers informs their approach to organisational policy development and campaigns for legal reform.

In February 2013, PCaW established the Whistleblowing Commission to examine the effectiveness of whistleblowing in the United Kingdom and to make recommendations for change. The Whistleblowing Commission published its report in November 2013.[3] The key recommendation of the Commission was the creation of a statutory Code of Practice, which sets out the principles for effective whistleblowing, which can be taken into account by courts and tribunals considering whistleblowing claims.

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[1] Quality 2020 - A 10-Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland - http://www.dhsspsni.gov.uk/quality2020.pdf
[2] Public Concern at Work - http://www.pcaw.org.uk/
[3] The Whistleblowing Commission report, November 2013 - http://www.pcaw.org.uk/files/WBC%20Report%20Final.pdf

Membership of the Review Team

Gary Walker	Former National Health Services Trust Chief Executive; self-employed interim and turnaround specialist
Patricia Snell	Deputy Director Quality Improvement and Patient Safety, Guy's & St Thomas National Health Services Foundation Trust
Mark Hudson	Associate Director of Workforce, Guy' & St Thomas National Health Services Foundation Trust
Cathy James	Chief Executive, Public Concern at Work
Bob Matheson	Adviser, Public Concern at Work
Hall Graham	Head of Programme for Reviews - RQIA

Janine Campbell	Project Administrator - RQIA
Jim McIlroy	Project Manager - RQIA

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Executive Summary

Encouraging staff to raise concerns openly as part of day to day practice, is an important part of improving quality of service and providing assurance of patient safety. When concerns are raised and dealt with appropriately, at an early stage, corrective action can be put in place to ensure the continued delivery of high quality and compassionate care.

This however, has not always been the case in the health service. The public inquiry into poor standards of care at the Mid Staffordshire National Health Service (NHS) Foundation Trust found that staff voices had been consistently ignored by the Trust Board. Freedom to Speak Up, the report of a review led by Sir Robert Francis was published in February 2015 and concluded that although many cases are handled well, too many are not. If this leads to others being deterred from speaking up in the belief that nothing will be done, patients may be put at risk.

Employers, if they truly want to know about malpractice, risk, abuse or wrongdoing in their organisation must take steps to encourage workers to raise concerns. Effective arrangements for raising those concerns should be a part of every healthy organisations culture.

It is essential that all organisations work towards developing an open and honest reporting culture. Staff must have the confidence to bring forward any concerns they may have, without fear and with the knowledge that any genuine concern will be treated seriously and investigated appropriately.

The findings from this review demonstrate that whistleblowing is mostly seen as a very negative term, which has not been helped by media portrayal. Focus groups highlighted that the only stories published seemed to be those where the whistleblower had suffered personally, creating an image that all whistleblowing ended negatively. There is also confusion as to what the term ‘whistleblowing’ actually referred to. Some staff considered that it was only whistleblowing if the issue being raised was very serious or was being raised outside the organisation.

The review team considers that the first step in encouraging the normalisation of raising concerns is the development of a model policy for health and social care in Northern Ireland that reflects current thinking. This should be supported by increasing the awareness for all staff about the needs and benefits of raising concerns.

A positive step in encouraging the raising of concerns would be the development of an independent helpline to provide advice and support for health and social care staff in Northern Ireland. It is recommended that this should be run as a pilot, with a subsequent evaluation to decide on whether or not to continue it.

Extremely positive steps have been taken in the area of visible leadership, but further development in this area is necessary. The review team considers that it is important to assess the effectiveness of any developments in this area.

For a system of raising concerns to work effectively, training needs to be available for staff who receive the concerns. They must be appropriately skilled in relation to managing and investigating concerns. Organisations must also assess how recording and reporting concerns fits in the overall governance process, including incident reporting and complaints

The Freedom to Speak Up report considered that feedback was an important part of the process. The review team was told that organisations generally provided feedback on action that was taken as a result of raising a concern. They considered that any method of feedback is to be supported, but feedback to individuals is essential.

Evidence from this review suggests that while many staff do raise concerns, a significant minority do not, for a variety of reasons, including feeling that nothing will be done and fear of reprisal. Most organisations had not effectively promoted raising concerns or looked for evidence of the effectiveness of their strategies.

It is not acceptable for organisations to assume a low level of raising concerns is positive; they must each ‘test the silence’ to gain assurance that the process of raising concerns is working well in their organisation.

This report makes 11 recommendations to improve whistleblowing arrangements within HSC organisations in Northern Ireland.

Section 1 - Introduction

1.1 Introduction

Health and social care services have been developed to promote the health, wellbeing and dignity of patients and service users. The people who deliver these services generally want to do the best they can for those they serve. However, for a variety of reasons, there will be occasions when things go wrong in the workplace. Encouraging staff to raise concerns openly as part of day to day practice is an important part of improving quality of service and providing assurance of patient safety.

When concerns are raised and dealt with appropriately, at an early stage, corrective action can be put in place to ensure the continued delivery of high quality and compassionate care. It is essential that all organisations should work towards development of an honest and open reporting culture, where staff have the confidence to bring forward any concerns they may have, without fear and with the knowledge that any genuine concern will be treated seriously and investigated appropriately and properly.

The term whistleblowing has no legal definition and is not enshrined in any legislation. Originally, the term developed from British police officers (bobbies) blowing their whistles to alert the public to criminals, while later, private business owners would use their own whistles to alert the police to the fact that a crime was being committed. US civic activist Ralph Nader is said to have coined the phrase in the early 1970s to avoid the negative connotations associated with other words such as informers and snitches. However, more recent media coverage, emphasising negative outcomes for whistleblowers, has led to whistleblowing being seen as a generally negative term, which could have a detrimental effect on the way staff approach raising concerns within their organisations.

The whistleblowing charity, PCaW defines whistleblowing as “A worker raising a concern about wrongdoing, risk or malpractice with someone in authority either internally and/or externally (i.e. regulators, media, MPs).”

Whistleblowing, or raising a concern, should be welcomed by public bodies as an important source of information that may highlight serious risks, potential fraud or corruption. Workers are often best placed to identify deficiencies and problems before any damage is done, so the importance of their role as the eyes and ears of organisations cannot be overstated.

Whistleblowing best practice and legislation[4] to protect workers raising concerns developed following a number of disasters and public scandals in the late 1980s and the early 1990s:

- capsizing of the passenger ferry the Herald of Free Enterprise (1987)
- the explosion on the Piper Alpha oil platform (1988)
- the train collision at Clapham Junction London (1988)
- the Bristol Royal Infirmary (1991-1995)

In each of these cases, workers had been aware of dangers but did not know what to do or who to approach, were too frightened to speak out due to fear of losing their jobs or being victimised, or spoke out but weren't listened to. Raising concerns or whistleblowing is therefore essential to:

- safeguard the integrity of an organisation
- safeguard employees
- safeguard the wider public
- prevent damage

Employers, if they truly want to know about malpractice, risk, abuse or wrongdoing in their organisation, must take steps to encourage workers to raise concerns. Effective arrangements for raising those concerns should be a part of every healthy organisation's culture. Workers who are prepared to speak up about wrongdoing should be recognised as one of the most important sources of information for any organisation seeking to enhance its reputation, by identifying and addressing problems that disadvantage or endanger other people.

The benefits of encouraging staff to report concerns include:

- identifying wrongdoing as early as possible
- exposing weak or flawed processes and procedures which make an organisation vulnerable to loss, criticism or legal action
- ensuring critical information gets to the right people who can deal with concerns
- avoiding financial loss and inefficiency
- maintaining a positive corporate reputation
- reducing the risks to the environment or the health and safety of employees or the wider community
- improving accountability
- deterring workers from engaging in improper conduct

The public inquiry into poor standards of care at the Mid Staffordshire NHS Foundation Trust[5] found that staff voices had been ignored by the Trust Board.

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[4] Public Interest Disclosure (Northern Ireland) Order 1998 - http://www.legislation.gov.uk/nisi/1998/1763/contents

[5] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry - 6 February 2013 - https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

Robert Francis QC concluded that:

"The board did not listen sufficiently to its patients and staff, or ensure the correction of deficiencies brought to the trust's attention.
Above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities."

In his report he went on to recommend that the:

"Reporting of incidents of concern relative to patient safety, compliance with the law and other fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon. Staff are entitled to receive feedback in relation to any report they make, including information about any action taken or reasons for not acting."

Dame Janet Smith in the inquiry[6] which followed the conviction of Harold Shipman, a GP who had killed at least 215 patients over a period of 24 years, commented in her report:

"To modern eyes, it seems obvious that a culture in all healthcare organisations that encourages the reporting of concerns would carry great benefits. The readiness of staff to draw attention to errors or near misses by doctors and nurses and the facility for them to do so, could have a major impact upon patient safety and upon the quality of care."

Subsequently in her report she stated:

"I believe the willingness of one healthcare professional to take responsibility for raising concerns about the conduct, performance, or health of another could make a greater contribution to patient safety than any other single factor."

A whistleblowing commission was established in February 2013 by PCaW to examine the effectiveness of existing arrangements for workplace whistleblowing in the United Kingdom and to make recommendations for change.

The commission made 25 recommendations,[7] including a recommendation that a code of practice drafted by the commission be adopted.

[6] The Shipman Inquiry - 27 January 2005 http://webarchive.nationalarchives.gov.uk/20090808154959/http://www.the-shipman-inquiry.org.uk/reports.asp

[7] Report on the effectiveness of existing arrangements for workplace whistleblowing in the UK - November 2013 http://www.pcaw.org.uk/files/WBC%20Report%20Final.pdf

The code of practice sets out standards to assist with development of effective arrangements for raising concerns and provides advice for organisations in relation to:

- written procedures
- training, review and oversight of arrangements for raising concerns
- dealing with anonymity and confidentiality
- legislation related to raising concerns

In November 2014, Whistleblowing in the Public Sector – a good practice guide for workers and employees[8], developed in conjunction with PCaW, was published by the four United Kingdom audit offices. It was designed to provide information for public sector workers on how to raise concerns and what they should expect in turn from their employers. It also provided guidance for public sector employers on the benefits of having a robust system for raising concerns and on how to encourage workers to raise concerns and deal effectively with those concerns.

Freedom to Speak Up[9], the report of a review led by Sir Robert Francis was published in February 2015. The review was set up in response to continuing disquiet about the way NHS organisations deal with concerns raised by staff and the treatment of some of those who have spoken up.

The review concluded that although many cases are handled well, too many are not. If this leads to others being deterred from speaking up in the belief that nothing will be done, patients may be put at risk. It also emphasised the importance of all who raise concerns, and those who respond to them, the need for behaving with empathy and understanding towards others, focusing together on patient safety and the public interest.

Organisations should have an ethos where genuine concerns are investigated objectively and learning shared, while supporting those who have raised the concerns. Genuine issues about an individual's performance or conduct should be dealt with separately and fairly.

The report set out a number of principles and actions under the following headings:

- culture change
- better handling of cases
- measures to support good practice
- particular measures for vulnerable groups
- enhancing the legal protection

[8] Whistleblowing in the Public Sector - A good practice guide for workers and employers – November 2014 - http://www.niauditoffice.gov.uk/wb_good_practice_guide.pdf
[9] Freedom to Speak Up - An Independent Review into Creating an Open and Honest Reporting Culture in the NHS – February 2015 - http://webarchive.nationalarchives.gov.uk/20150218150343/https://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf

The report emphasised the need for a change in culture, with boards devoting both time and effort to achieve this change. As part of the culture change, raising concerns should be part of the routine business of any organisation and speaking up should become part of what everyone does and is encouraged to do. The report considered that policies and procedures should not distinguish between reporting incidents and making protected disclosures and that visible leadership at all levels of the organisation was essential in supporting the culture of raising concerns.

All organisations should have systems in place to support the raising of concerns both formally and informally and organisations should have a range of staff available to whom concerns may be reported. All staff should receive training in their organisation's approach to raising concerns and there should be transparency about incidents and concerns and how an organisation has responded to them.

The report also recommended that there should be an external review of systems for raising concerns, in the form of an Independent National Officer. The Care Quality Commission (CQC) was also encouraged to take account in the well-led domain of its hospital inspections, of how organisations handle concerns that are raised.

In its response to the Freedom to Speak Up review, the Scottish Government decided that:

- non-executive whistleblowing champions would be introduced in each NHS Scotland Board
- further national whistleblowing events would be provided to designated policy contacts within boards, with a view to roll out locally
- the Cabinet Secretary would write to all NHS Scotland Boards to draw attention to relevant local actions identified within the review report and ask that Health Board Chairs and Chief Executives consider how these recommendations can be implemented locally
- the Cabinet Secretary would write to Healthcare Improvement Scotland as the relevant scrutiny body in NHS Scotland, to ask it to consider and feedback on how the report's recommendation on scrutiny may be implemented

Additionally, the Scottish Government committed to: "The development and establishment of an Independent National (Whistleblowing) Officer (INO), to provide an independent and external review on the handling of whistleblowing cases".

In November 2015, a consultation paper regarding the establishment of an INO was produced by the Scottish Government[10].

[10] Consultation on proposals for the introduction of the role of an Independent National (Whistleblowing) Officer for NHSScotland Staff - http://www.gov.scot/Publications/2015/11/5123

Regarding professional regulation, in his report, The Handling by the General Medical Council of Cases Involving Whistleblowers[11], the Right Honourable Sir Anthony Hooper noted that it is sometimes said that a whistleblower is a person who raises concerns externally, that is with persons other than his or her employer. In his opinion that was not correct. He went on to say that many people who raise concerns, do not, at the time of raising concerns see themselves as whistleblowers. They may be ignorant of the protections afforded to those who raise such concerns. They are more likely to come to regard themselves as whistleblowers if they suffer detriment as a result of raising concerns or if no action is taken in response to their concerns. The report made a number of recommendations regarding the position of raising concerns in relation to professional regulation.

1.2 Context for the Review

The Public Interest Disclosure (Northern Ireland) Order 1998[12] sets out the legislative basis for those workers who raise concerns about wrongdoing and makes provision about the kinds of disclosures that may be protected; the circumstances in which such disclosures are protected and the persons who may be protected. The Order also lists the organisations to which disclosures of information may be made under the Order.

On 17 February 2009, Circular HSS (F) 07/2009[13] provided whistleblowing guidance for HSC organisations, setting out their responsibilities and providing a model policy template for all organisations to adapt to their own circumstances. The circular stated that organisations should have clear arrangements in place to assist staff with reporting concerns. If these were not in place, organisations were to take steps to devise and implement them in line with the model policy template.

In March 2012, the then Minister for Health, Mr Edwin Poots, wrote to Chief Executives of all HSC bodies, asking them to bring the contents of his letter to the attention of all employees and make it available alongside each organisational whistleblowing policy. The letter set out a number of principles that every employee should expect in relation to raising concerns within their own organisation, which included:

- The right to whistleblow - every member of staff should be confident that managers at all levels would respond positively to expressions of concern and should it be necessary they would be protected from victimisation.

[11] The handling by the General Medical Council of cases involving whistleblowers – 19 March 2015 - www.gmc-uk.org/Hooper_review_final_60267393.pdf

[12] The Public Interest Disclosure (Northern Ireland) Order 1998 - https://www.dhsspsni.gov.uk/articles/public-interest-disclosure-northern-ireland-order-1998

[13] Circular Reference: HSS (F) 07/2009 - 17 February 2009 - https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/hssf-2009-07.pdf

- The right to be heard by management and a responsibility to speak up – staff should feel empowered to speak up if they see, or become aware of practice which is unsafe, or creates unacceptable risks to patients or clients. Managers and leaders at all levels would then be responsible for creating and maintaining an atmosphere of mutual support and mutual learning.

The letter concluded with encouragement for staff to raise genuine concerns where appropriate and emphasised that this was a vital element of good public service based on the values and principles that are at the heart of Health and Social Care.

In December 2014, the then Department of Health, Social Services and Public Safety (DHSSPS) commissioned Sir Liam Donaldson to carry out a review of the arrangements for assuring and improving the quality and safety of care in Northern Ireland. His report, The Right Time the Right Place[14], made a number of recommendations including that "the Regulation and Quality Improvement Authority should review the current policy on whistleblowing and provide advice to the minister".

In August 2015, Dr Paddy Woods, Deputy Chief Medical Officer, commissioned RQIA to undertake a review of the operation of HSC whistleblowing arrangements.

This review forms part of the Department of Health's (DoH) overall review of HSC whistleblowing arrangements.

The report makes 11 recommendations in order to continue the journey towards normalisation of raising of concerns within HSC organisations in Northern Ireland.

1.3 Terms of Reference

The terms of reference for this review were:

1. The review will consider the:
    a. existence (current, consistent, robust)
    b. operation (understanding, training, learning)
    c. accessibility, availability, support
    d. governance

    of Arm's Length Bodies' whistleblowing arrangements.

2. In light of the findings of the review RQIA will identify any recommendations for improvement to the arrangements.

[14] The Right Time the Right Place - An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland – December 2014 - https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/donaldsonreport270115_0.pdf

1.4 Exclusions

The review has excluded the whistleblowing arrangements within the Northern Ireland Fire and Rescue Service and RQIA.
The Northern Ireland Guardian Ad Litem Agency has also been excluded from the review. These organisations will be assessed by the DoH[15] at a later stage.

Circulars, guidance, standards, reviews and reports which arise during the course of this review will not be assessed as part of this review and will be highlighted for consideration in the future.

1.5 Review Methodology and Scope

The scope of the review included the following organisations:

DoH – Arm's Length Bodies *	
Belfast Health and Social Care Trust	Patient and Client Council
South Eastern Health and Social Care Trust	Business Services Organisation
Northern Health and Social Care Trust	Northern Ireland Blood Transfusion Service
Southern Health and Social Care Trust	Public Health Agency
Western Health and Social Care Trust	Northern Ireland Medical and Dental Training Agency
Northern Ireland Ambulance Service Health and Social Care Trust	Northern Ireland Practice & Education Council for Nursing and Midwifery
Health and Social Care Board	Norther Ireland Social Care Council

PCaW, a whistleblowing charity, is accepted as a leading authority in this field. They:

- advise individuals with whistleblowing dilemmas at work
- support organisations with their whistleblowing arrangements
- inform public policy and seek legislative change

[15] On 9 May 2016, as part of the restructuring of the Northern Ireland government departments, Department of Health, Social Services and Public Safety has been renamed the Department of Health.

RQIA engaged PCaW to assist with a number of pieces of work to inform the review.
The review included the following stages, designed to gather information about the presence and operation of HSC whistleblowing arrangements:

- A review of relevant literature set out the context for the review and identified appropriate lines of enquiry.

- Meetings with professional regulatory and representative organisations to obtain their views about whistleblowing arrangements, to help inform the review.

- A review of each organisation's whistleblowing policy and procedures against best practice guidance.

- Staff engagement and obtaining their views was a key element of this review. A staff questionnaire was developed and distributed to staff in the organisations subject to the review. Secondly, RQIA worked in partnership with PCaW to hold focus groups with a range of staff groups in each of the organisations.

- Information was obtained from the HSC staff survey which included a number of questions about whistleblowing arrangements.

- Validation visits to each of the organisations were undertaken, to meet with staff who have responsibility for the operation of whistleblowing arrangements and other senior staff including board members.

- A stakeholder event to present the initial findings from the review to representatives from each of the organisations. The majority of organisations involved in the review were represented, with 40 delegates attending the event. The findings from the review were discussed, and delegates made suggestions for enhancing and taking forward the recommendations from the review.

Findings from questionnaires, meetings with organisations and feedback from the stakeholder event were collated, and the information used to inform this report. The report is an overview report and provides a regional view of arrangements for raising concerns and provides general recommendations to improve the process for raising concerns in Northern Ireland. No organisation is reported individually.

Section 2 - Findings from the Review

2.1 Engagement with Interested Stakeholders

During the planning stages of the review, RQIA met with several professional regulatory and representative organisations, including the General Medical Council[16], the Pharmaceutical Society of Northern Ireland[17], the Royal College of Nursing[18], the Chair of the Trade Union Forum, UNITE[19], and UNISON[20]. The meetings were designed to obtain their views about current whistleblowing arrangements within health and social care, with the intention of using the information to inform the review.

Professional Regulatory Organisations

The General Medical Council and the Pharmaceutical Society of Northern Ireland are the professional regulatory organisation for doctors and pharmacists respectively. They have legal powers to set guidance, and have done so in relation to the raising of patient safety concerns and in the professional duty of candour.

Both organisations have guidance[21,22] in relation to raising concerns, which places a duty on the professionals they regulate to raise concerns where they believe that patient safety has been compromised. They also state that professionals must be open and honest with their regulators, and with each other to ensure that concerns are raised where appropriate.

Both regulators provided advice and support to members who were considering raising a concern or had already done so. They generally did not raise a concern on behalf of a member, but supported them to raise their concern through the mechanisms within their own organisation.

Unions

Not all Unions representing workers in health and social care engaged with RQIA during the review. The Royal College of Nursing, UNITE and UNISON did take the time to engage.

The Unions represent the professional interests of staff working in a range of health and social care specialties and settings.

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[16] General Medical Council - http://www.gmc-uk.org/
[17] Pharmaceutical Society of Northern Ireland - http://www.psni.org.uk/
[18] Royal College of Nursing - https://www.rcn.org.uk/
[19] UNITE - http://www.unitetheunion.org/
[20] UNISON - https://www.unison.org.uk/
[21] General Medial Council guidance on whistleblowing - http://www.gmc-uk.org/DC5900_Whistleblowing_guidance.pdf_57107304.pdf
[22] Pharmaceutical Society of Northern Ireland guidance on whistleblowing - http://www.psni.org.uk/wp-content/uploads/2012/09/Guidance-on-Raising-Concerns.pdf

They provide advice and support to members who were considering raising a concern or had already done so, but generally did not raise a concern on their behalf. They encourage their members to raise concerns through mechanisms already in place within their own organisation.

All Unions provide guidance[23,24,25] on whistleblowing for their members. During discussions, Unions were able to cite many examples where staff were afraid or unwilling to raise concerns.

Outcome of the Discussions

The outcome of these discussions was consistent with the themes that were uncovered during the review. In summary all organisations considered:

- the term whistleblowing as being negative and not conducive to encouraging staff to raise concerns
- the current arrangements were not suitable and many cases were not managed appropriately
- there was a lack of awareness and training in relation to whistleblowing

All organisations welcomed any improvements to the arrangements for raising concerns. They expressed a willingness to be involved in the development of new arrangements, as well as becoming a more integrated part of these new arrangements.

2.2 Review of Whistleblowing Policies

In the initial stage of the review, all HSC organisations were asked to submit their whistleblowing policies. In order to review these documents, PCaW adopted the methodology used by the United Kingdom National Audit Office (NAO), following their review of a number of United Kingdom government departmental and Arm's Length Bodies' whistleblowing policies in 2014. This methodology was devised following wide consultation by the NAO, and closely follows the requirements on best practice for whistleblowing arrangements, encapsulated in the Whistleblowing Commission's Code of Practice[26] and the British Standards Institution's whistleblowing guidance.[27]

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[23] Royal College of Nursing guidance on whistleblowing - https://www.rcn.org.uk/employment-and-pay/raising-concerns/guidance-for-rcn-members

[24] UNITE guidance on whistleblowing - http://wbhelpline.org.uk/resources/raising-concerns-at-work/?doing_wp_cron=1395055349.5939080715179443359375

[25] UNISON guidance on whistleblowing - https://www.unison.org.uk/get-help/knowledge/disputes-grievances/whistleblowing/

[26] The Whistleblowing Commission was established by PCaW in early 2013. The Independent Commissioners took evidence from stakeholders in whistleblowing and published a report in November 2013 that included a proposed Code of Practice, which forms the basis of PCaW's best practice guidelines. Copies of the full Commission report, including the Code of Practice are available on http://www.pcaw.co.uk/

[27] BSI publicly available specification 1998:2008 http://shop.bsigroup.com/forms/PASs/PAS-1998/

Each organisation's whistleblowing policy was assessed against eight criteria, which are based on good practice and current whistleblowing legislation. The NAO review criteria[28] are summarised below. While each policy has been reviewed against the detailed criteria, this report contains general trend analysis and a summary of main findings. The categories for review adopted by the NAO and used to assess the policies reviewed for this report are:

Setting a Positive Environment for a Whistleblowing Policy

a. **Commitment, clarity and tone from the top**
This involves making it clear to staff that any concern will be welcomed; it should reassure the reader, who may be thinking of raising a concern that the organisation's leadership will take it seriously and will not punish the employee if the concern turns out to be untrue, as long as the employee had reasonable suspicion of wrongdoing.

b. **Structure**
It is also important that guidance is easy to use so that readers are clear how they should raise a concern. The policy should include information relating to all areas of whistleblowing and provide comprehensive guidance for employees. It should be clear, concise and avoid including irrelevant detail that might confuse readers.

c. **Offering an alternative to line management**
Concerns may relate to behaviour of line managers or an employee may be unwilling or unable to discuss concerns with immediate management. Thus, alternative channels inside the organisation should be offered. Staff may be unwilling to approach extremely senior people with a concern, so the alternatives offered should be suitable.

d. **Reassuring potential whistleblowers**
Guidance should make clear that it is serious misconduct to victimise employees who are preparing to raise a concern, or have already done so. Similarly, it should make clear that employees who knowingly disclose false information will be subject to disciplinary action.

e. **Addressing concerns and providing feedback**
Whistleblowing policies should set out procedures for handling concerns. This will reassure readers that their concern will be taken seriously and also that wrongdoing can be identified and dealt with appropriately. The organisation should be clear about the actions it will take to investigate the concern and the feedback it will be able to provide to whistleblowers. Best practice will also give a general indication of the timescales involved in handling concerns, e.g. how long it will take to arrange an initial meeting, provide feedback etc.

[28] National Audit Office – Assessment criteria for whistleblowing policies – January 2014 - https://www.nao.org.uk/wp-content/uploads/2014/01/Assessment-criteria-for-whistleblowing-policies.pdf

Supporting Whistleblowers

a. **Openness, confidentiality and anonymity**
Guidance should make sensible and realistic statements about respecting whistleblowers' confidentiality. It should also outline the potential issues that could arise from employees reporting a concern anonymously.

b. **Access to independent advice**
Employees may need advice where they feel unsure or unaware of how to raise a concern. Guidance should address the point and identify how to contact potential advisers.

c. **Options for whistleblowing to external bodies (prescribed persons)**
Guidance should make employees aware of how they can raise a concern outside the organisation, e.g. to an external auditor or regulator. This may be a legal obligation in certain circumstances, for example where there is evidence of a criminal act. Guidance that follows best practice should encourage internal reporting, as this is where the concern can be addressed most effectively and where employees will receive the greatest protection. However, guidance should also identify the procedure for external reporting as well as outline potential bodies that employees can raise a concern with.

Assessment of Whistleblowing Policies

With these criteria in mind, an overall assessment is now provided of the organisations' policies as a whole against each of the above criteria, commenting on common trends and gaps in the policy wording overall.

a. Commitment, clarity and tone from the top
In order to achieve an excellent rating: there should be a stated commitment to maintaining high ethical standards and taking concerns seriously; the language should be inviting and reassuring; and there should be a clear distinction between whistleblowing and other concerns or grievances. Only a small number of the policies (two out of 14) scored an excellent rating in this category.

As a general rule, there was a lack of evidence of senior leadership contained in the policies reviewed. While many of the policies referred to a commitment on the part of the organisation to ensure that the policy and accompanying processes work in practice, rarely did this specifically refer to the leadership of the organisation. This is essential if the policy aims to instil trust and confidence in the process for all staff.

While in many of the policies reviewed, there was language stating that the organisation was committed to operating at very high standards, rarely was a specific body (such as the organisational board or equivalent) referred to.

Many of the policies referred to the Public Interest Disclosure Order as the starting point for the introduction to the policy or as the reason for having the policy. If the aim of the policy is to encourage staff to speak up and to ensure that it is safe and acceptable to do so, then this will not set the right tone from the start. In this category, two policies were rated as excellent, eight as satisfactory and four as poor.

b. **Structure**

An excellent rating in this category required the policy to be concise and well-presented, provide clear guidance that is both factual and informative, and guide the reader through the process in easy to follow language (flowcharts are recommended).

A third of the policies reviewed achieved an excellent rating in this category. One of the problems with many of the policies reviewed was a legalistic approach to the policy wording (i.e. leading with the Public Interest Disclosure Order as the introductory wording). Using the language of complaints and grievances and or/mixing management guidance for handling a concern were also issues with a number of the policies scrutinised.

An impersonal approach with a focus on an individual's responsibilities as opposed to focusing on the organisation's commitment to protect those raising a concern or disclosing information, would also have resulted in a low score for this category. Of the 14 policies, four were rated excellent, six satisfactory and four poor in this category.

c. Alternative to line management

Suggesting that workers consider raising a concern with their manager, but at the same time offering alternatives to the line management are both essential for any whistleblowing policy to be effective. It is clearly important that the line management process is included in the 'how to' section of any whistleblowing policy, as this will often be the starting point for raising a concern for most workers. However, it is also vital that any policy includes an alternative to line management, as the concern may relate to the behaviour of the line manager or it may be that line management is involved in the wrongdoing.

To gain an excellent rating, the policy should consider inclusion of appropriate contacts for the types of concerns being raised, have a flexible approach to when a concern might be raised outside of the management line and provide name and contact details for those designated to receive concerns. A number of the policies required individuals to raise the issue with their line manager first; this would have resulted in a low score because although it is proper to go through line management it should never be an absolute requirement. Six policies scored highly in this category, five were satisfactory and three were rated as poor.

d. **Reassuring potential whistleblowers**
An excellent policy will include language to assure the individual that they will not face sanctions for honestly raising a genuine concern, irrespective of whether they later turn out to be wrong. It will confirm that there are sanctions for victimising those who raise a concern or for preventing a concern being raised, and will also confirm that it is an abuse of the policy, and therefore a disciplinary offence, to knowingly raise a false concern.

Only one policy scored an excellent rating in this category. The main reason why many policies received a low score was the fact that disciplinary sanction was applied to frivolous/malicious/vexatious concerns. In order to strike the right balance, policy wording should only apply sanctions to the knowingly false concern. Extending sanctions more broadly, risks adding to the already numerous hurdles that whistleblower's experience, without necessarily reducing the number of concerns raised which lack merit.

e. **Addressing concerns and providing feedback**
In order to score highly, the policy wording should reassure readers that their concern will be taken seriously and also that wrongdoing will be identified and dealt with appropriately. It should include a summary of the procedures for handling concerns, an indication of how long before feedback is provided (noting that this will depend on the nature of the concern), an outline of the type of feedback whistleblowers can expect (while respecting the confidentiality of those being investigated), and clear guidance to managers on how to handle concerns (which may be published as a separate document[29]).

In this category, five policies scored highly, six satisfactory and three were rated as poor. Examples of difficulties in the policies reviewed include a lack of clarity around timescales (or no mention of this at all), using the language of a grievance process, requiring written statements from those using the policy, and long detailed manager's guidance which could confuse the concerned member of staff wishing to use the policy.

f. Openness, confidentiality and anonymity
An excellent rating clearly explains the difference between anonymity and confidentiality, and outlines where confidentiality cannot be maintained (e.g. where legal obligations mean that the identity of the person providing the information will have to be disclosed). It will encourage open disclosure and outline the difficulties with raising a concern anonymously (namely difficulties investigating, providing feedback, and protecting an individual's identity). The NAO review also requires a statement that anonymous disclosures are preferable to silence about wrongdoing.

[29] Public Concern at Work would suggest that this should be published as a separate document in order to keep the messaging in the policy itself as clearly aimed at those considering raising a concern.

It might also be sensible to say that anonymous concerns will be investigated in any event, but that there may be limitations on the protection available if the identity of the person raising the concern is unknown.

Difficulties with the wording of policies reviewed, included reference to the duty of confidentiality being more important than anything else, in terms of how the individual approached the raising of concerns and/or limited assurances around the protection of the individual's identity. In the latter case, the most common problem identified was that the policy stated that the organisation will use 'all reasonable steps' (or similar wording) to protect identity rather than confirming that if asked, the individual's identity will not be disclosed unless required by law. Other common issues with this category included use of confusing language about data protection, and patient confidentiality being referred to, at the same time as explaining the key policy assurance around the worker's identity. Four of the policies scored highly in this category, nine had a satisfactory rating and one had a poor rating.

g. Access to independent advice

To score highly here, a policy will address how an individual can obtain independent advice, and list relevant bodies, such as, PCaW, trade unions and professional associations, along with their contact details. The majority of the policies reviewed contained information about advice services including PCaW. In this category, 12 policies scored an excellent rating, and three satisfactory. The latter rating was applicable where only one source of external advice is referred to.

h. Options for whistleblowing to external bodies (prescribed persons)

An excellent rating will be achieved by policies which include external sources for raising a concern, including a comprehensive list of regulatory and oversight bodies relevant to the organisations and discussion on wider disclosures and the risks involved. The majority of the policies reviewed included reference to external bodies, but surprisingly many did not refer to the relevant healthcare regulators for Northern Ireland, RQIA and the Northern Ireland Social Care Council (NISCC), as organisations prescribed in the Public Interest Disclosure Order to which a protected disclosure may be made. Eleven policies scored an excellent rating in this category and four were satisfactory (usually because key regulators were not mentioned).

2.3 Staff Surveys

During the planning stage of the review, trust representatives reported that a staff survey specifically in relation to whistleblowing arrangements had been carried out in the Southern Health and Social Care Trust (Southern Trust). A decision was taken to carry out a similar survey in the other Arm's Length Bodies, as part of the RQIA review.

Subsequently, a questionnaire was issued to all staff from Arm's Length Bodies, via Survey Monkey, based on the Southern Trust questionnaire. The process was not repeated in the Southern Trust, as they had agreed to allow their results to be included in the final report. The regional HSC survey, which contained a number of questions related to whistleblowing, had just been conducted prior to the RQIA review.

3085 staff completed the RQIA questionnaire and a breakdown of numbers per organisation[30] is shown in the Table 1 below.

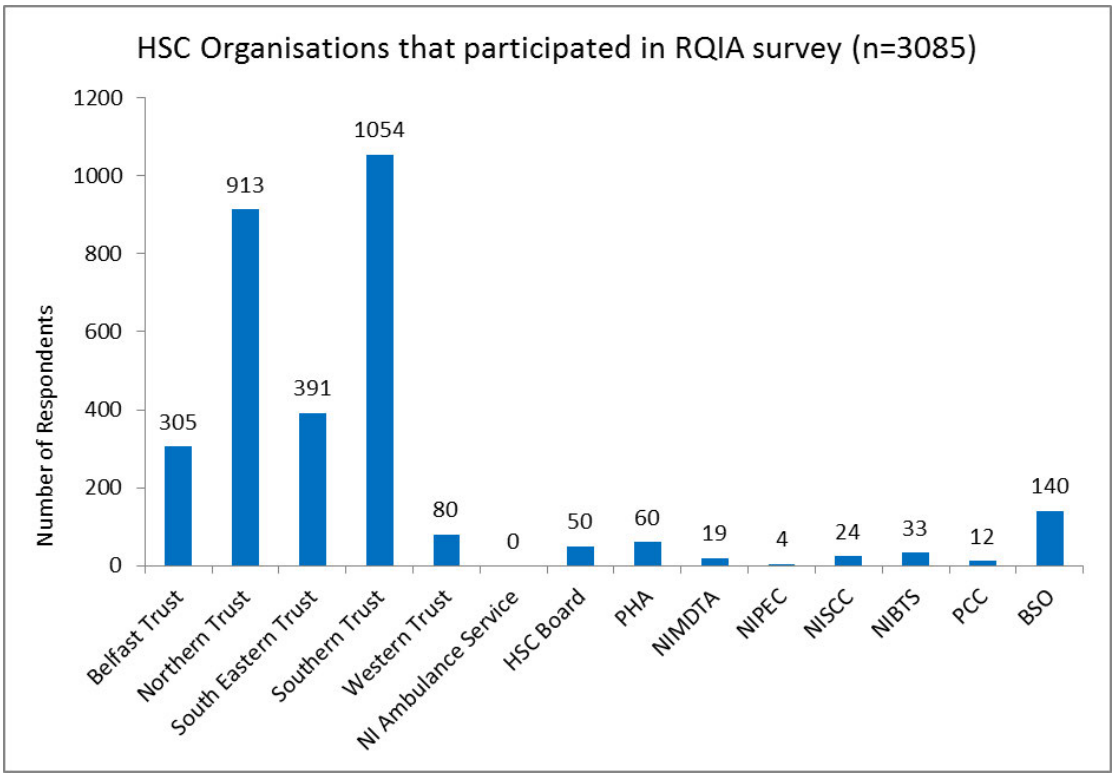

Table 1 – Number of responses per organisation

The RQIA questionnaire asked a number of questions that were similar to those asked by the regional HSC survey; however, the RQIA questionnaire allowed staff to enter freetext in order to explain the reasons, if any, as to why they had given a particular answer.

2559 (82.9%) respondents were aware that their organisation had a whistleblowing policy in place that provided guidance on how to raise a concern. However, only 1709 (55.4%) had confidence that their organisation would carry out a robust investigation of any concern they might raise.

Staff were asked if they would feel comfortable raising a concern with a senior manager/director in their organisation.

[30] It was reported by the Northern Ireland Ambulance Service that due to an administrative oversight, the survey was not distributed to their staff.

1632 (52.5%) answered yes to this question. A number of reasons were given as to why those who answered no would not feel comfortable. A summary of these responses included:

- afraid of the consequences
- afraid of repercussions
- afraid to be seen/labelled as a trouble maker
- afraid of harassment, victimisation and bullying
- fear of intimidation
- fear of reprisal
- fear of being isolated
- fear of losing job
- impact on career development and promotion
- lack of support and protection
- lack of confidentiality
- concerns were ignored
- raised concern before and it was ignored
- seen how cases were handled in the past
- don't have confidence in the process or management to deal with the concern appropriately

1553 (50.34%) respondents felt they would be more likely to raise a concern using a web based system that guaranteed anonymity.

841 (27.3%) respondents had experience of raising a concern within their organisation. The majority of those (681) had raised the concern with their line manager. 572 (68%) had not referred to the organisation's whistleblowing policy and the majority 745 (88.6%) had not raised the concern anonymously.

477 (56.7%) of those who had raised a concern felt that the concern had not been dealt with appropriately. The reasons given by respondents as to why they felt their concern had not been dealt with appropriately were:

- concern was ignored or not investigated
- poor investigation
- the concern was covered up
- the issue was put on hold, but never revisited
- got punished for raising the concern
- nothing happened/changed, and the issue persists
- issues still ongoing
- never got any feedback
- don't know the outcome

Of the 841 staff who had raised a concern, 372 (44.2%) considered that they had suffered detriment as a result of raising that concern. The key areas where staff believe they suffered detriment as a result of raising a concern:

- no action was taken and the person continues to do what they were doing
- person got moved or was transferred after raising concern

- disciplined for raising concern
- career has suffered - got overlooked for jobs and promotion
- financially worse off - fighting the case, impact on salary and pension
- damage to reputation
- was isolated/ignored by colleagues
- got bullied at work
- suffered from stress
- victimised after raising concern
- health has suffered - emotionally and physically

However, the majority – 627 (74.6%) reported that they would be very likely or likely to again raise a concern if they suspected wrondoing which is a positive result, showing that staff understand the importance of raising concerns.

Staff were also asked a number of questions specifically regarding fraud. The vast majority were aware that fraud falls within the scope of whistleblowing, were aware of a fraud policy within their organisation and would feel comfortable raising a concern regarding fraud with a senior manager/director within their organisation**.**

Finally staff were asked what would have improved the experience for them. The key points staff rasied were:

- a dedicated liaison person as a contact
- support from management
- counselling and support
- being listened to
- professional respect
- confidentiality
- the concerns being taken seriously
- formal process
- assurance that something will get done/ investigated
- having the whole process completed quicker
- a robust investigation
- a more open and transparent process
- appropriate action
- honesty from people involved
- feedback on the outcome
- a fair outcome

A regional staff survey was conducted in all HSC organisations in Northern Ireland from October to December 2015. This was conducted prior to the RQIA review and its questionnaire contained a number of questions regarding whistleblowing/raising concerns. The relevant questions were as follows:

- Are you aware of your organisation's policy and process for raising concerns about negligence or wrongdoing?
- Would you have the confidence to speak up within your organisation and raise concerns if you had cause to do so?

- Do you have confidence that your organisation would appropriately handle the investigation of any concerns raised?
- Are you aware of your organisation's whistleblowing process?
- Do you understand your responsibility under your organisation's whistleblowing process?

All organisations surveyed a full census of staff, with sample sizes ranging from 19 to 22,567. The overall number of staff surveyed was 70,213. 17,798 completed questionnaires were returned from this sample, which is a response rate of 26%. The key results from the regional survey were:

- 88% of staff reported that they are aware of their organisation's policy and process for raising concerns about negligence or wrongdoing
- 80% of staff reported that they would be confident to speak up and raise concerns if they had cause to
- 65% of staff reported that their organisation would appropriately handle the investigation that resulted
- 81% of staff reported that they are aware of their organisation's whistleblowing process
- 79% of staff reported that they understood their responsibility under their organisation's whistleblowing policy

Although the results from the HSC survey presented a positive reflection of whistleblowing, the review team was concerned that 35% of staff who responded were not confident that their organisation would appropriately handle the investigation of any concerns raised.

2.4 Focus Groups

As part of the review, staff were engaged in a series of focus groups and one-to-one appointments across all of the organisations involved in the review. The aim of these sessions was to determine staff perception and knowledge of, as well as trust and confidence in, their respective organisation's whistleblowing arrangements.

PCaW was commissioned to undertake this part of the review, in conjunction with RQIA staff. It was considered that as an organisation, they brought the necessary expertise, as their advice line has advised over 20,000 whistleblowers to date. This gives them a unique insight into the problems workers regularly face, when trying to raise a whistleblowing concern and when seeking action in relation to the issue raised. It was also considered that staff might raise a concern with them more readily than they would with RQIA alone.

Methodology

Over a four week period, 13 organisations were involved in the focus groups, with 368 individuals from a cross section of different staff groups participating in sessions.

This is a small number compared to the total number of staff working in health and social care. However, the review teams consider that the feedback provided a fair representation of staff understanding of the existence, operation and accessibility of whistleblowing arrangements across the sector.

Due to the size of the task (60,000 staff across the 14 organisations), it was not practical for PCaW to meet with every organisation. For several of the smaller Arm's Length Bodies, focus groups were undertaken solely by representatives from RQIA. For the larger Arm's Length Bodies, such as the trusts, PCaW facilitated the focus groups with RQIA in attendance. Within the trusts, focus group sessions were held at several locations. Following a low turn-out at one of the health trusts visited, repeat sessions were again undertaken solely by RQIA staff.

All focus group sessions were structured around a series of basic questions, intended to elicit discussion and thought on the broad themes of the engagement, i.e. perception, understanding, trust and confidence. However, these questions were only the starting point for an informal group discussion, and in most instances the conversation took unique, interesting and sometimes disparate turns. Nevertheless, across sessions, several consistent and strong themes emerged and these are detailed in the body of this report.

In addition to the focus groups, at each site an opportunity was provided for those with experience of whistleblowing to speak to PCaW staff. These experiences have been referenced where appropriate in the main body of this report, but also form the content of Appendix 3, where a number of anonymised case studies focusing on the experience of those involved have been included. A number of case studies were excluded, as individuals were seeking ongoing advice about their particular circumstances and the sensitive nature of such cases prevents inclusion of even an anonymised version of events. The inclusion of the case studies in Appendix 3 were discussed with those involved, and their permission was granted for inclusion in this report.

During the focus group sessions, all staff who attended were asked to write down suggestions on how whistleblowing arrangements could be improved. These suggestions have been collated and are set out in Appendix 2.

Themes and Perceptions

The almost universal perception was that the term whistleblowing was viewed as being a negative label for the process of raising a concern.

The terms 'touting', 'squealing' and 'telling tales' were regularly cited as being linked to the term 'whistleblowing' and for many, these appeared to be inextricably linked to the history of the Troubles in Northern Ireland. Indeed, this theme, while not always explicitly expressed, seemed to touch upon various aspects of the general discussion around whistleblowing. From an outside perspective, this period in Northern Ireland's history seemed to permeate a culture of silence from community level through to the workplace with respect to questioning wrongdoing.

It should be noted, that in no sessions did the question of religious or political affiliation get raised; the relevant issue appeared to be how you were seen to interact with authority in a generalised sense.

It was notable that there was a clear trend with younger workers, who may have been less influenced by this political history, to have slightly more positive views surrounding the issue. Several of this group made comments to the effect that they believed their peers saw whistleblowing/raising concerns for what it was; a necessary ingredient in carrying out your job. Clinicians (especially representatives from nursing and pharmacy) were on the whole, more positive in relation to raising concerns, and a large part of this seemed to be from recent pushes towards a more 'open and honest culture' within their teams. This also appeared to be closely linked to the incident reporting and quality improvement agenda in several of the organisations involved. It was identified that in the medical records and pharmacy departments, which were often held accountable for issues, such as, missing charts or wrong prescriptions, staff had a clearer understanding of the need and process for raising concerns.

There was, however, an interesting nuance to these views. While there was almost universal agreement that whistleblowing was seen negatively, only a small proportion of participants were prepared to ascribe those views to themselves. In other words, they saw whistleblowing as 'doing the right thing', but believed others would see it in a negative light and too often the individual will be seen to be part of the problem. Perhaps this is in part because individuals may have felt uncomfortable expressing a view they felt would paint them in a negative light (i.e. not doing anything about a serious issue they had witnessed). It was also possible that those who attended sessions may not have been a fully representative subset of the work force. Nevertheless, it seemed that there was a clear disjoint between how whistleblowers were actually seen and how they were perceived to be seen.

There was a strong view that the act of whistleblowing resulted in negative consequences for the whistleblower.

The most prevalent negative outcome discussed was that of blacklisting, or general stalling of career prospects. Many participants seemed resigned to the fact that this was in many ways a natural and expected outcome of becoming known as a whistleblower. Equally, however, there was also a fear of retribution, although in many instances it was assumed that this would come from colleagues more than management. In one group, a threat to physical safety to both the individual and their family was discussed; however, this was very much a fringe view.

In several sessions, it was commented on how this fearful view was to a large degree driven by the media's portrayal of whistleblowers' fortunes. Participants referenced how the only stories published were those where the whistleblower had suffered personally and that this in turn built an image that all whistleblowing ended negatively.

In fact, as most participants had no personal or direct experience of whistleblowing, it may well be that the only factor currently driving such a perception of negative outcomes is the media. Where individuals had been involved in whistleblowing (see Appendix 3), the overriding experience was negative, whether as the individual who had reported an issue, or as an accused. There were, however, a small number of participants who had been involved in the investigation or oversight of the whistleblowing process and these individuals had more positive views and better overall understanding of the process.

Understanding of the term 'whistleblowing' was inconsistent, confused and in many cases, wrong.

One of the strongest themes to emerge from the sessions was the almost universal confusion as to what the term 'whistleblowing' referred to. Almost all participants understood it to be some form of raising concerns but the 'how/where/what' varied hugely. There were almost as many variations and combinations as there were groups; however, certain common factors were consistently mentioned during the discussions.

Many participants considered that whistleblowing was only used if the issue being raised was very serious. Others considered that it was when the concern was being raised outside of the organisation (perhaps to the media), and some believed it was when the concern was raised anonymously. A less widespread but still prevalent understanding was that whistleblowing referred to those incidents of reporting which were likely to result in a specific individual being put under scrutiny. Additionally, another common view was that whistleblowing was an option of last resort; a means of raising concerns when all other routes had been tried. Many staff thought that the starting point for whistleblowing would be with a line manager. When asked, very few individuals knew what was in their organisation's policy itself and only one participant had received specific training.

This lack of conviction in what whistleblowing might refer to manifested itself sharply in participants' conception of how whistleblowing fitted in with existing reporting procedures, which is to say what circumstances required whistleblowing as opposed to recording on Datix[31] or serious adverse incident reports[32]. This was of particular interest given that, while most individuals had difficulty differentiating between reporting streams, whistleblowing was seen negatively whereas everything else was just part of the job. This felt like a very significant area of confusion for the participants. Most staff were unable to conceptualise when or how a whistleblowing policy might be invoked.

[31] Datix is the leading supplier of patient safety software for healthcare risk management, incident and adverse event reporting. The software is widely used within both public and private healthcare organisations around the world. - http://www.datix.co.uk/

[32] This sort of confusion was less prevalent in those participants based in non-clinical environments given that they very rarely used the clinical reporting lines. That being said, generally understanding of whistleblowing was actually better in clinical groups as opposed to non-clinical.

Another common, although less pervasive area of confusion, was the difference between grievances and whistleblowing. Even those participants, who claimed to have a better understanding of the distinction, on further discussion, rarely had any confidence in their assertions.

Although there is no specific and universal definition of the term whistleblowing, especially in a complex medical environment where it must interact with multiple other reporting streams, what is important is a degree of consistency in understanding across the workforce. When this misunderstanding of the term is combined with the background of historic influences and the sense of potential negative outcomes, it seems that for the most part, staff would not consider using a whistleblowing process.

It was the view of many of the staff groups that whistleblowing was often seen as a process intended as a safety net for when the usual reporting systems do not work. Without more effort in the communication process, it would seem that there is a dangerous tendency towards a culture of silence. This was despite the view that to report risk or wrongdoing was the right thing to do. This may present a risk that where existing reporting structures do not capture a concern, it may be lost and harm to patients may potentially ensue.

Throughout the sessions, a popular suggestion was to do away with the term ‘whistleblowing’ given both the confusion and negativity that surrounds it. Unfortunately language does not work like this, and removing a word from internal publications will not stop the public and the media continuing to use it. The risk here is that you entrench negative views towards some of the rarer, but often entirely appropriate, ways of raising concerns. Some participants saw the value in incorporating whistleblowing into the wider family of raising concerns rather than not using it at all.

Some of the group discussions centred on the perception that one of the barriers to raising concerns might be that the issue raised would not be addressed. This results in a sense of futility, therefore discouraging the individual from raising a concern in the first place. There were mixed views expressed around this theme. In many of the discussions about raising an issue with an immediate line manager, there was a sense that the issue would be addressed; however, it was less clear that raising the issue further up the line management chain would be as easy. In a minority of the discussions, the difficulties and problems surrounding other reporting mechanisms, such as Datix, and confusion where raising concerns fits within the system, were mentioned as a more fundamental problem with safety reporting mechanisms in the health service generally.

Knowledge

Although rarely explicitly stated, it was clear that whistleblowing policies were misunderstood and a lack of knowledge about the content of such polices was almost universal.

Almost all participants knew that their trust had a whistleblowing policy and the vast majority could find it if needed. However, very few participants had actually ever read it, knew the content of it, or understood it.

This appeared to be part of a wider trend with respect to policies. A consistent message was that the overbearing number of policies made it impractical to read them all and so policies were only accessed when they were needed. For the majority of participants, this was a satisfactory state of events; however, several groups recognised that this approach presented a problem if the policy was intended to convey messages relevant at a point before things had gone wrong.

Of those that had read the policy, all but a negligibly small number belonged to the following groups:

- their job role meant they had frequent contact with policies
- they had been in a situation in which they believed the policy applied
- they had read it in preparation for the focus group

Of those that had not seen the policy, there was usually little idea of what it might contain. Commonly, it was suggested that the policy allowed a worker to contact someone higher in the line management chain where their concerns had not been dealt with by direct management. Some participants suggested that the policy might contain a list of individuals who could be approached with concerns, although there was generally little idea how this might extend outside of the line management chain.

Where a policy only fulfils its function when actively sought out by workers, it naturally follows that it does not serve that function if individuals are unaware of when it might be relevant to their situation. This is obviously the case with respect to the widespread confusion as to what whistleblowing refers to (see above) but also relevant where there is little conception of what the policy might contain. Most of the organisations' policies contain commitments about protection of whistleblowers, options for raising concerns outside of line management and assurances that their concerns will be properly investigated. These messages will be of no use to staff who make their decisions not to access the policy because they are: scared of the consequences; do not consider their line manager an appropriate contact; and do not believe their views will be valued.

It is of note that only one individual advised of receiving any training on the issue of whistleblowing. This was provided by the Royal College of Nursing as part of an external training resource, as opposed to being part of any in-house training module.

Outside of the line management chain, where experiences were generally positive, knowledge of other forums for raising concerns was sparse.

Most participants mentioned their line manager as the natural starting point for raising a concern they may have. Several groups touched upon the challenge involved in escalating an issue to the line manager's line manager. This was seen to be problematic as the senior manager may well have a personal relationship with the line manager. Indeed, multiple participants told us of circumstances where an issue that had been escalated had been passed straight back down to the line manager, rendering the escalation beyond the line manager not only pointless, but also problematic and potentially confrontational. When asked, several line managers involved in the focus groups had negative attitudes toward the concept of being circumvented by those staff members they manage. Lack of knowledge of the routes open to staff through whistleblowing arrangements was as prevalent among managers as it was with those with no management responsibilities.

Most commonly, staff referred to Human Resources (HR) as an alternative to the management line. A point of contact in Risk and Governance was also suggested, and when put forward as an alternative; some participants saw value in this idea. Likewise a role with independence was often suggested by participants, such as a Board member or a Non-Executive Director, but only with some prompting beforehand.

Many participants mentioned their union as a possible alternative for raising concerns, although in discussion it was recognised that unions may not be able to deal with the issue themselves. In the course of a couple of sessions, union representatives commented on how the unions were perhaps poorly placed to deal with concerns raised with them. There may be a conflict of interest relating to those accused in some matters, as well as the fact that they would be looking to protect the worker, not deal with the concern raised.

It was particularly surprising how little the regulators within the sector, RQIA and NISCC, were proposed during discussions as a forum for concerns. Even where they were cited as a body that could be approached in the organisation's whistleblowing policy, there was generally confusion as to how this might be achieved. This seemed to be a distinct gap in reporting structures.

There was a strong and consistent message from participants that the media had little role to play in getting concerns dealt with effectively. A number of media shows and personalities were the subject of particular comment and criticism. Several participants commented on how the media's agenda of entertainment rarely aligned with the whistleblower's aim to get problems solved, and that this often resulted in a lack of responsibility and proportionality when handling the issue.

Although the topic was only covered in a small number of sessions, it appeared as if there was a complete lack of knowledge that there was legislation protecting whistleblowers from detriment, or any legal element to the protection of those who raise concerns within the workplace. Hence there was a very low awareness of the Public Interest Disclosure Order 1998.

Trust and Confidence

The only consistent message from the groups on how whistleblowers could be protected from negative consequences was by the protection of their identity.

Generally, the only way that participants felt they could be protected, was by their identity not being associated with the concern. There was confusion around the difference between a concern being raised anonymously (where no-one knows who it is that has provided the information) and confidentially (where one or more individuals know the identity of the whistleblower but protects that identity during the course of the investigation).

Views were mixed on whether confidentiality would be respected by those handling the concern. One prominent view was that confidentiality in the Northern Ireland's health service didn't really exist; communities were too closed and interlinked. Several participants commented on how multiple members of a family might commonly work in the same unit or the same trust, and so the likelihood of the 'rumour mill' operating to uncover the identity of the person who raised the concern, was considered to be very high.

For many, the option of confidentiality was seen to be a desirable element of protection for staff that raised a concern; they commented on how they had no reason to believe that managers wouldn't protect their confidence in these situations.

It was stated consistently from those tasked with handling investigations, that in most instances, it was almost impossible to investigate anonymous concerns. Additionally, those involved in a number of investigations advised that anonymous concerns can be extremely damaging to team morale.

From this perspective, it appeared that raising concerns anonymously was appealing from a protection point of view, but it was not generally an effective way of getting problems dealt with. Furthermore, one individual who contacted PCaW talked passionately about the effect that anonymous concerns can have on the wider workforce and the potential for them to be used vexatiously. This participant described how a series of anonymous disclosures had bred a culture of paranoia and had eroded staff confidence.

In response to how whistleblowers can be protected, participants rarely suggested that managers have a role to play.

Very few participants put forward the idea that the actions of management played a role in protecting whistleblowers from victimisation. That said, once the idea was put to groups, individuals generally agreed that managers could directly support the whistleblower. Generally, it was suggested that the best way this could be achieved was by being seen to take firm action against those who victimised whistleblowers, rather than actually being able to stop the victimisation in the first place.

Many participants commented on how this no tolerance approach needed to extend to management, especially in cases where no action had been taken by them after a concern had been raised.

While staff having confidence that their concerns will be dealt with is an important piece of the puzzle, several groups commented on how it was also important to have confidence that the receiver of concerns would not overreact. This formed the basis of some discussion in several of the groups interviewed, particularly in relation to minor issues raised anonymously. It was felt that there could sometimes be a lack of proportionality when the whistleblowing policy had been invoked, and those accused in these circumstances were subsequently not sufficiently supported. This was a theme that was raised at several of the groups and at different organisations. There is clearly a need for proportionality and fairness for those accused of wrongdoing, as well as for the individual raising the concern.

Participants regularly commented on how the most common aim of the whistleblower was to have the concern addressed and not for there to be serious repercussions for staff or the unit. A fear of unnecessary repercussions was highlighted as a factor which may prevent people from highlighting concerns.

Generally participants were confident that if they raised serious issues with their managers then they would be dealt with.

In some groups, however, there was an understanding that this might not be so true of concerns that were linked to funding, such as understaffing.

Several non-senior auxiliary staff that attended the focus groups, expressed doubts as to whether they would be listened to if they raised concerns. This could be a missed opportunity, given that these staff are very much the eyes and the ears of the organisations, and will often be the first to observe any problems.

Conclusions

From the outcomes highlighted in this section of the report: the combination of a lack of understanding around what is contained within whistleblowing policies; a fear of negative repercussions; and a sense that raising a concern may be futile; do not facilitate effective whistleblowing arrangements.

The review team considers that as a minimum, training or awareness raising sessions should be developed to improve staff awareness and understanding of the whistleblowing process, together with communication focusing on how the whistleblowing policy is more than a safety net for other every day reporting mechanisms. Furthermore, it should be considered whether work can be done at an organisational level, to make potential whistleblowers feel supported and protected, reducing the reliance on anonymity for safety.

It is to be hoped that such work may go some way to normalising the whistleblowing process and overcoming the existing staff perceptions and misunderstanding of whistleblowing.

2.5 Meetings with Senior Teams

As part of the review, the review team met with senior managers from each of the organisations, who had responsibility for oversight of whistleblowing arrangements. The discussions focused on the operation of their respective whistleblowing arrangements and what could improve whistleblowing across health and social care. The discussions were very constructive and form the basis of the conclusion section of this report.

2.6 Stakeholder Event

In April 2016, as part of the review methodology, RQIA hosted a stakeholder event which was themed 'Raising Concern, Raising Standards'. It provided an opportunity for a range of staff working across different HSC organisations to discuss the initial findings from the review, identify arrangements for whistleblowing in other jurisdictions and discuss potential next steps that may be included in the final report.

During the event, one reviewer shared their own personal experience of being involved in a whistleblowing case; a representative from the Scottish Government outlined the development and current arrangements for raising concerns in Scotland; PCaW presented the initial findings in relation to the assessment of the whistleblowing policies and the staff engagement; finally, the review team presented the initial findings from the review.

Participants discussed the findings with members of the review team and were also involved in group discussions regarding next steps, in relation to:

- changing culture within organisations
- arrangements for recording and reporting concerns
- future oversight arrangements

Changing Culture within Organisations

Participants accepted there was a need to change the culture within organisations in relation to raising concerns. As the organisations were fundamentally different, a single solution would not fit. Some participants proposed that the equality and diversity agenda may be a suitable mechanism to facilitate this.

It was acknowledged that further clarity on raising concerns needs to be provided for staff. This could be achieved through improved communication about raising concerns and training for all staff within the organisations.

Participants suggested that more advertising and promotion of raising concerns was needed, such as, posters or campaigns to increase awareness. Encouragement and praise would also be required to demonstrate the positive outcomes of raising concerns. This should be supported by a more visible demonstration of management's commitment to raising concerns.

Participants all understood that changing organisational culture was a huge task, and would not be achieved immediately. However, implementing some of the areas they proposed would be an initial step in the right direction.

Arrangements for Recording and Reporting Concerns

Participants felt this was an area that could not be solved in a single workshop, due to its complexity. However, they proposed many very sensible and useful suggestions.

Putting in place appropriate mechanisms for recording and reporting was acknowledged as a task which would require input from all stakeholders. Given the size and complexity of the different organisations, it was recognised that the mechanism may be different for each organisation.

In relation to what, when and how often things should be recorded and reported, participants considered that individual organisations and stakeholders would have to determine how this was taken forward. Key areas for further discussion and development were proposed, such as:

- formal or informal reporting and the exceptions
- differentiating between concerns and other issues, such as, grievances or complaints
- methods of raising concerns and how these are captured
- internal or external reporting and the mechanisms to achieve this
- lessons that could be learned from the concerns raised and how this could be shared

Participants highlighted that there are many existing mechanisms for recording and reporting activities throughout all organisations. Rather than invent something new, existing mechanisms should be considered as possible ways to support recording and reporting of concerns. Learning arising from appropriate recording and reporting of concerns should be shared throughout the organisations.

Future Oversight Arrangements

During the stakeholder event, presenters outlined the details of the oversight arrangements for raising concerns in England and Scotland. Participants then discussed the merits of the different arrangements within the context of Northern Ireland.

In conclusion, it was acknowledged that oversight arrangements for whistleblowing already exist in Northern Ireland, through DoH. Participants considered that some clarity on any proposed oversight arrangements was required, to determine what they were designed to achieve. It was proposed that rather than setting up new bodies or developing new arrangements, existing arrangements should be revised to ensure they provide appropriate outcomes in relation to raising concerns.

Participants acknowledged that much work was required in relation to setting up appropriate arrangements and mechanisms for raising concerns, which would require input from all stakeholders.

Section 3 – Conclusions and Recommendations

3.1 Overall Conclusions

Policy Development

Throughout the review, a recurring theme was the use of the term whistleblowing. Whistleblowing was universally seen as a very negative term, which was not helped by the media's portrayal of cases of whistleblowers. Focus groups highlighted that the only stories published seemed to be those where the whistleblower had suffered personally, creating an image that all whistleblowing ended negatively. There was also confusion as to what the term actually referred to; some staff considered that it was only whistleblowing if the issue being raised was very serious or was being raised outside the organisation. Other staff considered that whistleblowing was about something that involved criminal wrongdoing such as fraud, rather than being about a patient safety concern. There was also confusion as to where whistleblowing fitted into existing reporting procedures such as incident reporting. Focus group participants saw incident reporting as just part of their job but were not really aware as to when their organisation's whistleblowing policy might be used.

In his review of whistleblowing in the NHS, Freedom to Speak Up, Sir Robert Francis gave consideration to recommending that the term whistleblower should be dropped. Even though there were reservations about its continuing use, he had been persuaded that the term was now so widely used that removing it would not succeed. PCaW considered that removing a word from internal publications would not stop the public and the media from using it. There is a danger that the word may shift its meaning to denote only those rarer forms of raising concerns, which may only further entrench the stigma towards whistleblowing.

The review team is aware that removing a single word from the vocabulary of HSC policy will not automatically lead to an improved culture of raising concerns. However, they consider that in light of the overwhelming negative view of the term whistleblowing and the fact that it might be actively preventing proper reporting of the full range of concerns, it should not be the main title of any policy in relation to raising concerns, as this immediately takes the reader to the end point of what should be a spectrum of raising concerns.

All organisations subject to the review had a whistleblowing policy in place. Although a number had been updated, it seemed that most policies were based on guidance provided by DHSSPS in February 2009. In its review of existing HSC policies, PCaW considered that a number were overly legalistic and tended to use language associated with handling of complaints or grievances, which is not conducive to encouraging staff to use the policy.

The review team considers that whistleblowing is only one step along a continuum or spectrum of raising concerns and may be seen as the end point of raising a concern. Concerns are raised and dealt with daily and most may be resolved quickly and informally. However, for more serious concerns, there needs to be a more formal process. The process needs to provide clarity to the person raising the concern as to what will actually happen next, to how they will be kept informed of progress, and eventually how they will be informed of the outcome as a result of their raising a concern. Any policy should reflect the reporting of both formal and informal concerns and should culminate in providing advice about other organisations a member of staff may go to when they feel it is appropriate. The policy should also easily distinguish between raising concerns and incident reporting and act as a signpost as to where concerns would be best addressed.

The review team considers that the first step in encouraging the normalisation of raising concerns is the development of a model policy for Northern Ireland that reflects current thinking. The policy should consider the negative connotations associated with the term whistleblowing and take account of the whistleblowing code of practice and recent policies such as the Department of Finance and Personnel Whistleblowing Policy[33] and the new policy – Freedom to Speak Up: raising concerns (whistleblowing) policy for the NHS, which was developed following the Robert Francis Review[34].

The review team considered feedback that indicated that a one size does not fit all and one policy would therefore not be the best way forward; however, this approach has already been taken in both England and Scotland and the review team considered this would be the best approach for Northern Ireland. It should be emphasised that all organisations could individualise the policy to take account of their particular situation.

The review team has made recommendations for improvement to the arrangements to whistleblowing across health and social care. The recommendations have been prioritised in relation to the timescales in which they should be implemented, following the publication of the report:

- Priority 1 - completed within 6 months of publication of report
- Priority 2 - completed within 12 months of publication of report
- Priority 3 - completed within 18 months of publication of report

Recommendation 1	**Priority 1**
The Department of Health should produce a model policy for raising concerns in HSC bodies in Northern Ireland. The process should take account of recent policy development elsewhere and seek expert advice where necessary.	

[33] Department of Finance and Personnel – April 2011 - https://www.dfpni.gov.uk/publications/dfp-whistleblowing-policy
[34] Freedom to speak up: raising concerns (whistleblowing) policy for the NHS - April 2016 - https://improvement.nhs.uk/uploads/documents/whistleblowing_policy_30march.pdf

Effective Leadership

All organisations provided evidence of having extensive governance arrangements in place, with some demonstrating good integration with quality improvement and organisational learning programmes.

There was an awareness of the need to create an open and honest culture, and many organisations demonstrated their understanding of the need for visible leadership. A number of methods were used to achieve this, with senior management and board member walk rounds being the most popular. Other methods included staff open forums where senior staff were available to listen to staff concerns. In one organisation these concerns were logged in order to try to facilitate feedback. This was considered to be a very positive development which also led to better feedback to those who raised a concern.

A learning and development steering group has been developed in an organisation, chaired by a non-executive board member, which discusses concerns and uses scenarios to elicit learning which is then passed through the organisation.

The review team considered that these were extremely positive steps but that further development in this area was necessary. The review team also considered that it was important to assess the effectiveness of any developments in this area.

Recommendation 2	**Priority 1**
All organisations should develop or continue to develop and support behaviours which promote and encourage staff to speak out, such as open forums, access to senior staff and board members where appropriate.	

Reporting to organisational boards is also an important step in assuring that raising concerns is seen as an integral piece of organisational governance. It was unclear to the review team that this was happening to any great extent and it seemed to be very much left to individual judgement as to what was or was not reported.

The very extreme examples of what would ordinarily be termed whistleblowing would be brought to boards, but the review team considered that the principle of normalising raising of concerns had not yet become part of day to day practice.

Concerns that had not reached a particular threshold were not being recorded or passed up the chain to organisational boards. However, there were areas of good practice where service users and employees were offered the opportunity to attend board meetings to report on their experiences.

To ensure further development in this area, the review team considered that a non-executive board member should be appointed to have responsibility for overseeing the culture of raising concerns within each organisation.

Recommendation 3	**Priority 1**
Each HSC organisation should appoint a non-executive board member to have responsibility for oversight of the culture of raising concerns within their organisation.	

Staff Training and Awareness

Policy development and leadership are important steps in development of a culture that openly normalises the raising of concerns, making it part of day to day business. Staff awareness and ability to understand and be comfortable with the process of raising a concern are also vital components of any system.

On the positive side, both the HSC and RQIA surveys indicated that a large percentage of staff knew their organisation had a whistleblowing policy in place. The HSC survey also reported that the majority of staff (80%) would be confident to speak up and raise a concern. The majority of staff responding to the RQIA survey would feel comfortable in approaching their line manager to raise a concern (80.9%).

However, a lesser percentage (65%) of respondents to the HSC survey indicated that they felt their organisation would handle their concern appropriately. 55.4% of staff who responded to the RQIA survey had confidence that their organisation would carry out a robust investigation of any concern they might raise and only 52.5% would feel comfortable reporting a concern to a senior member of their organisation. This identifies that approximately one third of staff responding to the HSC survey feel their organisation would not handle their concern appropriately.

841 members of staff who had raised a concern within their organisation responded to the RQIA survey. 477 (56%) of these respondents considered that their concern had not been dealt with appropriately and 572 (68%) had not referred to the organisation's whistleblowing policy. 372 (44.2%) considered that they had suffered detriment as a result of raising that concern.

While the survey numbers are small, the results indicate that although staff are aware of whistleblowing policy and procedure, a number are not confident that if they raised a concern it would be dealt with appropriately. Of those who had raised a concern, over half felt their concern had not been dealt with appropriately.

The majority of staff attending focus groups were also aware of the existence of a whistleblowing policy but few were aware of what it contained. However, once again staff felt confident about approaching their line manager.

It was noted that several non-senior auxiliary staff expressed doubt as to whether they would be listened to if they raised concerns.

It was identified that many staff had a limited understanding of whistleblowing and the associated process for raising a concern. If advice and support was readily available to them, this may have increased the number of concerns raised.

A whistleblowing helpline has been established by the Department of Health in England. The helpline is provided free of charge, staffed by specially trained advisors and provides advice to individuals at all stages of the spectrum of raising concerns, from those thinking about speaking up to those who have suffered as a result.

On 2 April 2013, The Scottish Government, in its response to the Francis Report, launched The National Confidential Alert Line for NHS Scotland. This helpline was managed by PCaW, and was designed to provide a safe space where staff could raise concerns about patient safety and malpractice. Staff could also obtain advice and support if they felt they had been victimised as a result of whistleblowing. Following what was considered to be a successful pilot, the Confidential Alert Line was continued after receiving further funding.

To demonstrate a commitment in relation to raising concerns within Northern Ireland, the review team considered that DoH should establish a pilot confidential helpline. The helpline should provide independent advice and support in relation to raising concerns, for HSC staff in Northern Ireland.

In line with the Scottish approach, the helpline could be run as a pilot for a period of at least one year, with an evaluation prior to the pilot finishing to decide whether or not to continue with it. Data from the calls should be used in the evaluation and also to support learning.

Recommendation 4	**Priority 1**
The Department of Health should establish a pilot confidential helpline to provide independent advice and support in relation to raising concerns, for HSC staff in Northern Ireland. The pilot should run for a period of at least one year, with an evaluation to be carried out prior to the pilot finishing.	

All senior staff reported that the whistleblowing policy formed part of a staff induction process. The policy was then made available on organisational intranets. Other methods of raising staff awareness included a Raising Concerns Booklet, staff notice boards, posters and screensavers on employee computers.

One organisation is currently developing an e-learning package for staff, and another had developed a training package to be delivered across middle management which will place an emphasis on “ringing bells” rather than “blowing whistles”, in order to decrease the negativity around being seen as a whistleblower. These were seen by the review team as positive developments.

However, beyond this no further training or awareness sessions were carried out and no organisation tested staff awareness on an ongoing basis. It was also unclear as to the level of training provided for line managers and all other managers with responsibilities outlined in whistleblowing policies.

The review team considered that for a system of raising concerns to work effectively, awareness training needed to be available for staff in how to raise concerns but also in relation as to how raising a concern fits in the overall governance process, including incident reporting complaints etc. For operational staff, this could indeed be part of induction but needed to go further than just being made aware of the existence of a policy. Managers need to be provided with the competence and confidence to enable them to respond to and address concerns raised with them.

Specific training also needs to be available for all staff involved, including managers, in the operation of the process for raising concerns. The review team considered that following development of any new policy, awareness training and bespoke training in relation to raising concerns should be developed for staff. This work may involve utilising existing training resources or the development of new e-learning packages.

Recommendation 5	**Priority 2**
Following development of a regional policy for raising concerns, awareness training in relation to raising concerns should be made available for all staff who might wish to raise a concern. This could take the form of a regional e-learning package.	

Recommendation 6	**Priority 2**
All managers should receive bespoke training in the operation of their policy for raising concerns.	

As well as the provision of training, assessing the effectiveness of any training provided is also important. One method of assessing staff awareness of raising concerns and the effectiveness of any training provided is through staff appraisal. Appraisal also provides an opportunity to emphasise to staff, the importance to the organisation of raising concerns. The review team discussed appraisal rates during meetings with senior teams.

Appraisal rates in the small organisations were mainly good; however, appraisal rates in the larger organisations varied between 42% and 80%. It is not uncommon for smaller organisations to have a higher appraisal rate than in the larger organisations; however, the review team considered that appraisal rates in some organisations were very low and efforts should be made to increase the uptake of staff appraisal.

Recommendation 7	**Priority 1**
All organisations, particularly where appraisal rates are low, should work towards raising the uptake of staff appraisal.	

Organisational Oversight

One of the recommendations of the Freedom to Speak Up review was in relation to where responsibility for the daily oversight of the process for raising concerns should be situated. In the majority of organisations in the United Kingdom, responsibility lies with the HR department. However, the Francis review questioned as to whether this was appropriate. HR may be seen as threatening, as it is the department that will take the lead in grievance processes and processes to deal with poor performance. The Francis report made the recommendation that:

“To reinforce the concept of raising concerns as a safety issue, responsibility for policy and practice should rest with the executive board member who has responsibility for safety and quality, rather than human resources”.

A number of organisations reported that having whistleblowing under the responsibility of HR worked well for them, and saw no reason to change. Some of the smaller organisations may also see any change being difficult as a result of their size. There is logic, however, that if the raising and reporting of concerns becomes part of everyday culture, responsibility may best sit elsewhere within governance reporting structures. This would then allow HR departments to become more independent when it comes to any concern that required further investigation.

The review team does not feel that it can be prescriptive as to where responsibility is best placed, but would recommend that when a new policy is developed, consideration should be given as to where best responsibility for oversight sits.

Recommendation 8	**Priority 1**
All organisations should consider, where in their governance structures, responsibility for operating processes for raising concerns is best placed.	

Effective Feedback

One of the principles contained in the Whistleblowing Code of Practice is that a member of staff who has raised a concern should be told, where appropriate, the outcome of any investigation. The Freedom to Speak Up report also considered that feedback was an important part of the process.

The review team considered that any change in practice/procedure should take place at both an operational and an organisational level. The review team was told that organisations mostly did not record concerns and also did not feedback what action was taken as a result of raising a concern. That is not to say that there was no feedback at all, and several organisations described multiple feedback methods including newsletters, staff briefings and learning reports. One organisation, perhaps as a result of previous incidents, had a more developed culture of raising concerns, was reflecting these on risk registers and when resolved, feeding back to those involved in raising the concern.

Any method of feedback is to be supported, but feedback to individuals is essential. Using the mediums described did not emphasise that learning and any change in practice, was as a result of reporting a concern. The review team also considered this would be an important step towards normalising the raising of concerns.

Recommendation 9	**Priority 1**
All organisations should routinely feedback at individual, team and organisational levels on concerns raised and how they were resolved.	

Local Advocates

The Freedom to Speak Up report suggested that organisations develop local champions in relation to raising concerns. The functions of a local champion included:

- ensure that any safety issue about which a concern has been raised is dealt with properly and promptly and escalated appropriately through all management levels
- intervene if there are any indications that the person who raised a concern is suffering any recriminations
- work with HR to address the culture in an organisation and tackle the obstacles to raising concerns

An example of the development of local champions is the appointment of advocates in relation to raising concerns in Guys & St Thomas' NHS Foundation Trust.

The role of an advocate in the trust is one of support for members of staff who wish to raise concerns and to help them to determine the most appropriate way for their concern to be dealt with. In their role profile, advocates "provide immediate support and signposting for staff members raising concerns, determining the best course of action and advising the staff member of their options. It is not envisaged that the Advocate would take on the concern but rather support the staff member to effectively raise their concern, where appropriate, or seek an alternative course of action."

The review team considered that the development of advocates at a number of levels, especially in larger organisations, may contribute to development of a more open culture in relation to raising concerns.

Recommendation 10	**Priority 2**
All organisations should consider appointing an appropriate number of advisers/advocates to signpost and provide support to those wishing to raise a concern.	

Independent Oversight

The Freedom to Speak Up review recommended that an Independent National Officer be appointed, with functions that include:

- reviewing the handling of concerns raised by NHS workers where there is cause for concern in order to identify failures to follow good practice
- advising the relevant NHS organisation, where any failure to follow good practice has been found, to take appropriate and proportionate action, or to recommend to the relevant systems regulator or oversight body that it makes a direction requiring such action
- acting as a support for Freedom to Speak Up Guardians
- offering good practice advice about handling concerns
- publishing reports on the activities of the office

The Scottish government has also committed to the development and establishment of an Independent National (Whistleblowing) Officer, to provide an independent and external review on the handling of whistleblowing cases.

The topic of whether or not Northern Ireland should have such an oversight body was discussed during a number of organisational meetings and also at the stakeholder event. The consensus of opinion seemed to be that due to the scale of the system in Northern Ireland, there was no need for such an appointment and the review team agreed with this point of view. However, the review team considered that there should be some ongoing oversight at an operational level as to whether processes for raising concerns were effective.

RQIA carries out reviews and inspections in acute hospitals, assessing them against the domains of safe, effective, compassionate care and well-led. The review team considered that progress in relation to normalisation of raising concerns may be included as part of the well-led domain of the RQIA regulatory process. This would provide assurance in the larger trusts, and DoH should consider how this could be taken forward in the smaller Arm's Length Bodies.

Recommendation 11	**Priority 1**
RQIA should include progress in relation to normalisation of raising concerns in the well-led domain of its regulatory programme.	

All organisations recognise that raising concerns is one essential element of an open and transparent culture. All organisations felt that they had an open and transparent culture but were unclear as to what evidence could be produced to substantiate this claim. All organisations quoted the results of the HSC survey and a number quoted having gained Investors in People as measures that all was well with the culture in their organisation. These are positive developments and not to be underestimated, but are quite high level measurements.

Evidence from this review suggests that while many staff do raise concerns, a significant minority do not, for a variety of reasons, including feeling that nothing will be done and fear of reprisal. The review team considered that most organisations had not effectively promoted raising concerns or looked for evidence of the effectiveness of their strategies.

Northern Ireland has a very low level of whistleblowing, and again, organisations used this as another measure of demonstrating that all is well. The lack of whistleblowing cases may indeed reflect that systems are working effectively; however, it may also be evidence that the system is not working at all. The reason for a very small number of cases may be that staff do not have confidence that there will be positive outcomes for them or their organisation, as a result of raising a concern.

What should be reported and recorded in terms of raising concerns was also the subject for much discussion during organisational visits and also during the stakeholder event. It is accepted that not every conversation that takes place between a line manager and a member of staff needs to be recorded; however, there must be a threshold beyond which a concern should at least be recorded in the system.

Identifying a threshold for recording concerns will enable better monitoring of trends and will help to normalise the raising of concerns, which could contribute to a more open and honest culture.

It would also:

- facilitate the process of feedback to staff who have raised a concern
- enable outcomes, in terms of change in practice, to be demonstrated

Such feedback has the added advantage of making staff feel valued and helps them to understand what they do actually matters. It again has to be emphasised that it is not the intention of this review to create yet another industry around reporting and recording of concerns.

Organisations already have strong governance processes in place and raising concerns should become part of normal day to day governance. Awareness raising for all staff and training for managers should provide them with the skills to assist with the process.

Due to the diverse nature of the organisations, it is very difficult to make specific recommendations aimed at developing an open and honest culture. This is something that organisations must develop themselves. Organisations must also identify ways of demonstrating that they are working towards developing such a culture that fits their particular circumstance. All organisations must also decide what level of recording and reporting they feel is appropriate for them. The review team considers that it is not acceptable for organisations to assume that a low level of raising concerns is positive. They must each 'test the silence' using a range of metrics and indicators to build a picture of the 'health' of individual directorates/divisions/departments. This will provide assurance as to whether the process of raising concerns is working well in their organisation.

The review team understands the difficulty in prioritising raising a concern/ whistleblowing when it is competing against a wide range of other priorities. It may be that there are low levels of concerns in Northern Ireland. However, if these small numbers are not treated appropriately, then many more staff will learn from this negative experience that it is better not to speak up.

Culture change will not occur overnight and striving for a true open and honest culture is an ongoing and perhaps never ending process. Normalising the reporting of concerns is only one building block of an open and honest culture; however, it can be an important issue in terms of patient safety.

This report and the recommendations contained within it are designed to create a framework where all staff understand the need to report appropriate concerns and feel totally comfortable raising those concerns.

RQIA wishes to thank the management and staff from the HSC organisations for their cooperation in taking forward this review, and the contributions from the other stakeholders for their input.

3.2 Summary of Recommendations

The recommendations identified during the review have been prioritised in relation to the timescales in which they should be implemented.

Priority 1 - completed within 6 months of publication of report
Priority 2 - completed within 12 months of publication of report
Priority 3 - completed within 18 months of publication of report

Implementation of the recommendations will improve the arrangements for raising concerns.

Number	Recommendation	Priority
1	The Department of Health should produce a model policy for raising concerns in HSC bodies in Northern Ireland. The process should take account of recent policy development elsewhere and seek expert advice where necessary.	Priority 1
2	All organisations should develop or continue to develop and support behaviours which promote and encourage staff to speak out, such as open forums, access to senior staff and board members where appropriate.	Priority 1
3	Each HSC organisation should appoint a non-executive board member to have responsibility for oversight of the culture of raising concerns within their organisation.	Priority 1
4	The Department of Health should establish a pilot confidential helpline to provide independent advice and support in relation to raising concerns, for HSC staff in Northern Ireland. The pilot should run for a period of at least one year, with an evaluation to be carried out prior to the pilot finishing.	Priority 1
5	Following development of a regional policy for raising concerns, awareness training in relation to raising concerns should be made available for all staff who might wish to raise a concern. This could take the form of a regional e-learning package.	Priority 2
6	All managers should receive bespoke training in the operation of their policy for raising concerns.	Priority 2
7	All organisations, particularly where appraisal rates are low, should work towards raising the uptake of staff appraisal.	Priority 1
8	All organisations should consider, where in their governance structures, responsibility for operating processes for raising concerns is best placed.	Priority 1

9	All organisations should routinely feedback at individual, team and organisational levels on concerns raised and how they were resolved.	Priority 1
10	All organisations should consider appointing an appropriate number of advisers/advocates to signpost and provide support to those wishing to raise a concern.	Priority 2
11	RQIA should include progress in relation to normalisation of raising concerns in the well-led domain of its regulatory programme.	Priority 1

Appendix 1 - Abbreviations

CQC	- Care Quality Commission
DHSSPS	- Department of Health, Social Services and Public Safety
DoH	- Department of Health
HR	- Human Resources
HSC	- Health and Social Care
INO	- Independent National (Whistleblowing) Officer
NAO	- National Audit Office
NHS	- National Health Service
NISCC	- Northern Ireland Social Care Council
PCaW	- Public Concern at Work
RQIA	- Regulation and Quality Improvement Authority
Southern Trust	- Southern Health and Social Care Trust

Appendix 2 – Staff Suggestions from Focus Groups

At the end of each focus group, participants were asked to propose some suggestions as to how their organisation could improve its whistleblowing arrangements. Those suggestions that were in effect a differently worded version of the same idea were grouped under a common heading. Furthermore, in processing the data captured, suggestions were grouped together in certain themes.

What follows is a summary of the findings.

Top Suggestions	
Training (no further specification)	33
Training for management	12
Mandatory training	11
Awareness, improvement through posters etc.	11
Assurances for confidentiality	9
Use different term	7
E-learning	6
Interactive awareness/workshop sessions	6
Independent whistleblowing contact in the trust	5
Talk about whistleblowing in team meetings	5
Flowchart/poster to show channels in raising concerns	4
Publication of positive outcome whistleblowing/reporting of number of cases	4
Feedback for whistleblower	4
Better support for whistleblower	4
Shortening investigations/clear-cut timeframes	4
Increase awareness of policy	4

Over 40% of all suggestions related to the need for training around whistleblowing.

While this was a huge finding, when considered alongside the findings of the main staff engagement report, it is perhaps not that surprising. It was clear that throughout the sector there was a lack of knowledge and understanding around the core principles of whistleblowing, right down to what the term even refers to. As a means of educating staff, training is the obvious solution to this problem.

Of those suggestions captured under the theme of training, there were some consistent more specific suggestions. The most common of the specific ideas (29%), was that there should be specific training for management around whistleblowing. This suggestion seemed largely borne out of the gross negative effect that management can have on the system if they don't handle instances appropriately. Many participants suggested that training should be mandatory, although many people felt that this would be unworkable, given the already large amount of training that needed to be undertaken.

One proposal that made up 15% of the training suggestions was to have compulsory e-learning. Several participants spoke of how this was a manageable and often quite effective way of conducting training.

The second most common grouping of suggestions related to ways in which management communicated to the staff body – i.e. management messaging.

Interestingly, similar to training detailed above, these sorts of suggestions also related to the way in which staff could be educated about whistleblowing. The most common suggestion (42%) in this category was a poster campaign designed to improve awareness around whistleblowing. Another popular idea as to how information on whistleblowing could be communicated was via a regular slot in team meetings. Many participants felt that this may normalise the process.

Another idea that was repeated on several occasions was to have flowcharts posted in wards detailing options for raising concerns, and in what order they should be attempted. Not all suggestions in this grouping related to informing staff of the arrangements for whistleblowing. It was also considered by some participants that management messaging could be used as a way to improve trust and confidence in the organisations whistleblowing arrangements. The most popular of these suggestions was for the organisation to publicise successful instances of whistleblowing where the problem was solved and the whistleblower unaffected. Many participants questioned the feasibility of this given various duties of confidentiality; however, the benefits of countering the media's overwhelming negative portrayal were seen to be a very worthwhile goal.

How concerns are handled (15%), points of contact for raising concerns (8%) and the term *whistleblowing* itself (6%), were all also popular topics.

Approaches to improving handling were mainly directed at improving things for the whistleblower. This made up 88% of the suggestions in this group, and this aim was evenly split between better protection of the whistleblower's identity (to avoid victimisation) and better support for the whistleblower. In the former category the prevalent view was for greater assurances around confidentiality, whereas in the latter sub-group, views were spread across better support, feedback for the whistleblower and shorter, or better time framed, investigations. Generally, this was slightly out of step with the views expressed in the sessions themselves, where protection of identity was often seen as the only way of making things better for whistleblowers. This might reflect the fact that participants had just not thought of other ways the organisation could improve measures, and that once this was put to them they saw the value in it.

Very often in the focus groups, there were discussions about what, if anything, to do with the term whistleblowing, given the negativity that surrounded it.

This unsurprisingly manifested itself in a significant proportion of participants putting forward suggestions related to this. The vast majority of suggestions were to change the name as means of escaping the stigma, although some participants suggested that a better route was to try and normalise it.

The majority of suggestions (71%) related to points of contact were for more internal options. The most common of these was for an independent whistleblowing contact within the organisation who sat outside of the line management chain.

Although a much smaller share of the total suggestions, many participants also put forward suggestions relating to the organisation's policy (5%) and the advice available to whistleblowers (3%).

Training		Points of contact		Messaging		Handling		The term		Advice		Policy		Other		
Mandatory training	11	Independent whistleblowing contact in the trust	5	Awareness improvement through posters etc	11	Joined up policy for incident reporting	1	Use different term	7	Independent source of advice	3	More accesible policy	3	Online system for raising concerns	2	
E-learning	6	Independent reporting contact outside of the trust	2	Flowchart/poster to show channels in raising concerns	4	Gateway teams' for handling whistleblowing concerns	1	Increase use of the term to familiarise/normalise it	3	Better awareness of advice available	1	Forced reading of policy	1	Cross-trust investigations	1	
Training for management	12	Senior management more visible / drop-in	2	Encourage staff to raise concerns	2	Improving audit of existing reporting arrangements	1	Better understanding	1	For managers	1	Simplified policy	1	"Have no fear of repurcussions for whistleblowing"	1	
Interactive awareness/worksh op sessions	6	Make reporting to senior management more straight forward	3	Talk about whistleblowing in team meetings	5	Assurances of confidentiality	10			On site advice	1	Increase awareness for policy	4	Responsibility for whistleblowing devolved to invidividual departments	1	
Training on policy	2	Independent external body that can mediate	1	Publicisation of positive outcome whistleblowing / reporting of number of cases	4	Feedback for whistleblower	4							Independent panel within trust to investigate whistleblowing concerns	2	
Training to complete at home	1	Making contacting RQIA easier	1			Better support for whistleblower	4							Code of practice for management in dealing with concerns	1	
Training on distinguishing from other reporting lines	1					Shortening investigations / clear-cut time frames	4							Discipline managers who breach confidence	2	
Training for investigators	1					Guaranteed anonymous way of raising concerns	2							Improve confidence in reporting	1	
Induction training	1															
Training (no further specification)	33															
	74		14		26		27		11		6		9		11	178
	41.57%		7.87%		14.61%		15.17%		6.18%		3.37%		5.06%		6.18%	100.00%

Appendix 3 – Case Studies

During each day of focus groups, an opportunity was provided for those with first-hand involvement of whistleblowing to talk with PCaW directly, so that their experiences could be included within the report.

There were several stories which PCaW felt, given the sensitivity of the case, would not be appropriate to include. This was due to a risk that the individual would be identified by the nature of the facts and their situation could potentially be made worse.

Of those stories that PCaW felt could be anonymised, a selection of these case studies have been detailed below. In addition to telling the individual's unique story, while still retaining the spirit of the experience, the case studies demonstrate some of the more general challenges faced in getting whistleblowing arrangements right.

Potential Consequences

Several participants spoke about the potentially damaging, and unnecessary effects that whistleblowing can have on their own personal circumstances. One of these stories highlighted the stark contrast between the positive change that the person was trying to make and the eventual personal cost that they had to endure.

An individual advised of raising serious concerns about another colleague, who apparently in a fit of temper, had shouted, man-handled and took away the belongings of a patient who had severe pre-existing anxiety issues. The whistleblower took the concerns to their manager, but fearing a reaction from the staff member implicated, had requested that their identity be kept confidential.

Confidentiality was not maintained and the disclosure eventually made its way back to the guilty party, who apparently then proceeded to manipulate the team against the individual who raised the concern. The individual advised that trusted colleagues turned against them, resulting in the individual suffering stress and distress, and subsequently having to take time off work. The individual described in vivid terms how their health, both physical and mental, deteriorated as they tried to cope with the circumstances.

Although the individual was back in employment and generally recovered, they described the intense anger they had towards the way that their manager had handled the incident. The lack of confidentiality resulted in challenging times for the whistleblower, and a presumed knock-on effect of fear, for anyone who might think of raising a concern in the future.

Anonymous Concerns

During a one-to-one session, a participant described their experiences of the effects that anonymous concerns can have on staff, and the delivery of service. The individual worked in a clinical environment which had, over the course of a short period of time, been the subject of several anonymous letters written to senior management. The participant explained that the consequent long investigation times and lack of knowledge surrounding the issues permeated a culture of fear, distrust and uncertainty throughout the team. They advised that there was a clear loss of morale and suggested that the service provided was less effective, as staff no longer trusted their instincts and were constantly checking every decision with management.

Of the concerns where investigations had concluded, the participant advised that no action had been taken. The participant acknowledged the need for workers to be able to raise their concerns in any way possible, but stated that these incidents had come at a high cost for their team. They advised that the team was also no clearer as to the specific circumstances surrounding the concerns, and rumours had spread that the concerns raised were vexatious. The participant questioned what action their team or the trust could do to protect themselves in this instance.

Challenges for Trade Unions

On many different occasions there were discussions about the role that the trade unions played with respect to whistleblowing. Many participants advised that if they were unsure how to raise concerns, or needed support in doing so, they would approach their trade union.

A core function of the Union is their duty towards their members. This however, became a particular challenge in cases where they had to support staff on both sides of a concern.

Handling of Concerns by Management

During the course of the staff engagement exercise, PCaW met with a clinician in one of the trusts, who described how multiple members of the staff had separately raised concerns about a particular site. The individual explained how staff not only had identified problems, but also suggested practical and attainable solutions.

The clinician advised that staff felt they were unable to escalate their concerns beyond a particular level of management, the positions became entrenched, relationships broke down, and ultimately the concerns remained. The situation has since improved; however, according to the individual, many of those involved in raising the concerns left the organisation, as a result of how this was handled.

Lack of Feedback – a Missed Opportunity for a more Positive Outcome

For many whistleblowers, the potential victimisation from colleagues can be a major concern. This was a particular concern for one individual who spoke with PCaW.

An individual advised of being concerned about the level of professionalism by some managers within the team, and the knock-on effect that this was having on the service users.

They advised of following the whistleblowing policy, and stated that initially it worked well for them, as it provided an avenue for the concerns to be raised outside of line management. However, once the concerns had been detailed to senior management, the individual stated that they were considered no longer involved in the process. They stated that HR sometimes contacted them, but not with any updates in relation to the concerns.

Due to the lack of feedback, the individual stated that they could only speculate on what was happening. They did not know, and were concerned about, whether others knew that they raised the concern. The individual advised of becoming somewhat paranoid about any potential consequences. As a result, they advised of becoming stressed, which was starting to impact on their health. They found it hard to cope and subsequently had to take time off work. After an extended period of absence, they advised that they are only now starting to get back to normal.

The participant described how whistleblowing, even when they are not directly involved, can be an extremely stressful experience, and especially when there is no support during the process.

RQIA Published Reviews

Review	Published
Review of the Lessons Arising from the Death of Mrs Janine Murtagh	October 2005
RQIA Governance Review of the Northern Ireland Breast Screening Programme	March 2006
Cherry Lodge Children's Home: Independent Review into Safe and Effective Respite Care for Children and Young People with Disabilities	September 2007
Review of Clinical and Social Care Governance Arrangements in Health and Personal Social Services Organisations in Northern Ireland	February 2008
Review of Assessment and Management of Risk in Adult Mental Health Services in Health and Social Care Trusts in Northern Ireland	March 2008
Reducing the Risk of Hyponatraemia When Administering Intravenous Infusions to Children	April 2008
Clostridium Difficile – RQIA Independent Review, Protecting Patients – Reducing Risks	June 2008
Review of the Outbreak of Clostridium Difficile in the Northern Health and Social Care Trust	August 2008
Review of General Practitioner Appraisal Arrangements in Northern Ireland	September 2008
Review of Consultant Medical Appraisal Across Health and Social Care Trusts	September 2008
Review of Actions Taken on Recommendations From a Critical Incident Review Within Maternity Services, Altnagelvin Hospital, Western Health and Social Care Trust	October 2008
Review of Intravenous Sedation in General Dental Practice	May 2009
Blood Safety Review	February 2010
Review of Intrapartum Care	May 2010
Follow-Up Review: Reducing the Risk of Hyponatraemia When Administering Intravenous Infusions to Children	July 2010
Review of General Practitioner Out-of-Hours Services	September 2010
RQIA Independent Review of the McDermott Brothers' Case	November 2010
Review of Health and Social Care Trust Readiness for Medical Revalidation	December 2010
Follow-Up Review of Intravenous Sedation in General Dental Practice	December 2010
Clinical and Social Care Governance Review of the Northern Ireland Ambulance Service Trust	February 2011
RQIA Independent Review of Child and Adolescent Mental Health Services (CAMHS) in Northern Ireland	February 2011
Review of General Practitioner Out-of-Hours Services	September 2010

Review	Published
RQIA Independent Review of the McDermott Brothers' Case	November 2010
Review of Health and Social Care Trust Readiness for Medical Revalidation	December 2010
RQIA's Overview Inspection Report on Young People Placed in Leaving Care Projects and Health and Social Care Trusts' 16 Plus Transition Teams	August 2011
Review of Sensory Support Services	September 2011
Care Management in respect of Implementation of the Northern Ireland Single Assessment Tool (NISAT)	October 2011
Revalidation in Primary Care Services	December 2011
Review of the Implementation of the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults	February 2012
RQIA Independent Review of Pseudomonas - Interim Report	March 2012
RQIA Independent Review of Pseudomonas - Final Report	May 2012
Mixed Gender Accommodation in Hospitals	August 2012
Independent Review of the Western Health and Social Care Trust Safeguarding Arrangements for Ralphs Close Residential Care Home	October 2012
Review of the Implementation of Promoting Quality Care (PQC) Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services	October 2012
Review of the Northern Ireland Single Assessment Tool - Stage Two	November 2012
Review of the Implementation of the Cardiovascular Disease Service Framework	November 2012
RQIA Baseline Assessment of the Care of Children Under 18 Admitted to Adult Wards In Northern Ireland	December 2012
Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland, Overview Report	February 2013
Independent Review of the Governance Arrangements of the Northern Ireland Guardian Ad Litem Agency	March 2013
Independent Review of the Management of Controlled Drug Use in Trust Hospitals	June 2013
Review of Acute Hospitals at Night and Weekends	July 2013
National Institute for Health and Care Excellence Guidance: Baseline Review of the Implementation Process in Health and Social Care Organisations	July 2013
A Baseline Assessment and Review of Community Services for Adults with a Learning Disability	August 2013

Review	Published
Review of Specialist Sexual Health Services in Northern Ireland	October 2013
Review of Statutory Fostering Services	December 2013
Respiratory Service Framework	March 2014
Review of the Implementation of NICE Clinical Guideline 42: Dementia	June 2014
Overview of Service Users' Finances in Residential Settings	June 2014
Review of Effective Management of Practice in Theatre Settings across Northern Ireland	June 2014
Independent Review of Arrangements for Management and Coordination of Unscheduled Care in the Belfast Health and Social Care Trust and Related Regional Considerations	July 2014
Review of the Actions Taken in Relation to Concerns Raised about the Care Delivered at Cherry Tree House	July 2014
Review of Actions Taken in Response to the Health and Social Care Board Report Respite Support (December 2010) and of the Development of Future Respite Care/Short Break Provision in Northern Ireland	August 2014
Child Sexual Exploitation in Northern Ireland - Report of the Independent Inquiry	November 2014
Discharge Arrangements from Acute Hospital	November 2014
Review of the Implementation of the Dental Hospital Inquiry Action Plan 2011	December 2014
Review of Stroke Services in Northern Ireland	December 2014
Review of the Implementation of GAIN Guidelines on Caring for People with a Learning Disability in General Hospital Settings	December 2014
Baseline Assessment of Access to Services by Disadvantaged Groups in Northern Ireland (Scoping Paper)	December 2014
Review of the Care of Older People in Acute Hospitals	March 2015
RQIA Quality Assurance of the Review of Handling of all Serious Adverse Incidents Reported between January 2009 and December 2013	December 2014
Review of the Diabetic Retinopathy Screening Programme	May 2015
Review of Risk Assessment and Management in Addiction Services	June 2015
Review of Medicines Optimisation in Primary Care	July 2015
Review of Brain Injury Services in Northern Ireland	September 2015
Review of HSC Trusts' Arrangements for the Registration and Inspection of Early Years Services	December 2015

Review	Published
Review of Eating Disorder Services in Northern Ireland	December 2015
Review of Advocacy Services for Children and Adults in Northern Ireland	January 2016
Review of the Implementation of the Palliative and End of Life Care Strategy (March 2010)	January 2016
Review of Community Respiratory Services in Northern Ireland	February 2016
Review of the Northern Ireland Ambulance Service	March 2016
Review of HSC Trusts' Readiness to Comply with Allied Health Professions Professional Assurance Framework	June 2016
RQIA Publishes Overview of Quality Improvement Systems and Processes in Health and Social Care	June 2016
RQIA Review of Governance Arrangements Relating to General Practitioner (GP) Services in Northern Ireland	July 2016

The Regulation and Quality Improvement Authority

9th Floor

Riverside Tower

5 Lanyon Place

BELFAST

BT1 3BT

Tel 028 9051 7500

Fax 028 9051 7501

Email info@rqia.org.uk

Web www.rqia.org.uk

@RQIANews

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

HSC Health and Social Care

INTERIM WHISTLE BLOWING POLICY

Application of policy	This is an interim policy and only applicable to SPPG staff members who are hosted by BSO under the hosting principles arrangements. This policy will be superseded by a DoH whistleblowing policy applicable to all DoH staff including SPPG. This will be issued in the coming months.

Produced by the Governance and Safety Directorate
Strategic Planning and Performance Group (SPPG) of the Department of Health

March 2022

MAHI - STM - 097 - 10304

Title:	Strategic Planning and Performance Group of the Department of Health (SPPG) Interim **Whistleblowing Policy**		
Accountable:	Director of Strategic Performance		
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Directorate:		Governance and Safety Directorate	

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1. INTRODUCTION

All of us, at one time or another, may have concerns about what is happening at work. The Strategic Planning and Performance Group (SPPG) of the Department of Health want you to feel able to raise your concerns about any issue troubling you with your managers, at any time. It expects its managers to listen to those concerns, take them seriously and take action to resolve the concern, either through providing information which gives assurance or taking action to resolve the concern. However, when the concern feels serious because it is about a possible danger, professional misconduct or financial malpractice that might affect patients, colleagues, or the SPPG itself, it can be difficult to know what to do.

The SPPG recognises that many issues are raised by staff and addressed immediately by line managers - this is very much encouraged. This policy and procedure is aimed at those issues and concerns which are **not resolved, require help to get resolved or are about serious underlying concerns.**

Whistleblowing refers to staff reporting suspected wrongdoing at work, for example, concerns about patient safety, health and safety at work, environmental damage or a criminal offence, such as, fraud.

You may be worried about raising such issues and may think it best to keep it to yourself, perhaps feeling it is none of your business or that it is only a suspicion. You may also feel that raising the matter would be disloyal to colleagues, to managers or to the organisation. It may also be the case, that you have said something but found that you have spoken to the wrong person or raised the issue in the wrong way and are not sure what to do next.

Remember that if you are a healthcare professional you may have a professional duty to report a concern. **If in doubt, please raise it.**

Rather than wait for proof; raise the matter when it is still a concern. If something is troubling you of which you think we should know about or look into, please let us know. The SPPG has implemented these whistleblowing arrangements for you to raise any concern where the interests of others or the organisation itself are at risk.

2. AIMS AND OBJECTIVES

The SPPG is committed to running the organisation in the best way possible. The aim of the policy is to promote a culture of openness, transparency and dialogue which at the same time:

- reassures you that it is safe and acceptable to speak up;
- upholds patient confidentiality;
- contributes towards improving services provided by the SPPG
- assists in the prevention of fraud and mismanagement;
- demonstrates to all staff and the public that the SPPG is ensuring its affairs are carried out ethically, honestly and to high standards;

- provide an effective and confidential process by which you can raise genuine concerns so that patients, clients and the public can be safeguarded.

The SPPG roles and responsibilities in the implementation of this policy are set out at **Appendix A.**

3. SCOPE

The SPPG recognises that existing policies and procedures, which deal with conduct and behaviour at work (Disciplinary, Grievance, Conflict Bullying and Harassment, the Complaints Procedure and the Accident/Incident Reporting Procedure) may not always be appropriate to extremely sensitive issues which may need to be handled in a different way.

This policy provides a procedure for all staff of the SPPG, including permanent, temporary and bank staff, staff in training working within the SPPG, independent contractors engaged to provide services, volunteers and agency staff who have concerns where the interests of others or of the organisation itself are at risk. **If in doubt - raise it!**

Examples may include:

- malpractice or ill treatment of a patient or client by a member of staff;
- where a potential criminal offence has been committed, is being committed or is likely to be committed;
- suspected fraud;
- breach of Standing Financial Instructions;
- disregard for legislation, particularly in relation to Health and Safety at Work;
- the environment has been, or is likely to be, damaged;
- a miscarriage of justice has occurred, is occurring, or is likely to occur;
- showing undue favour over a contractual matter or to a job applicant;
- research misconduct; or
- information on any of the above has been, is being, or is likely to be concealed.

This list is not intended to be exhaustive or restrictive

If you feel that something is of concern, and that it is something which you think the SPPG should know about or look into, you should use this procedure. If, however, you wish to make a complaint about your employment or how you have been treated, you should follow the BSO's local grievance procedure or Conflict Bullying and Harassment policy for making a complaint about Bullying and/or Harassment which can be obtained from your manager.

This policy complements professional and ethical rules, guidelines and codes of conduct and freedom of speech. It is not intended to replace professional codes and mechanisms which allow questions about professional competence to be raised. (However such issues can be raised under this process if no other more appropriate avenue is apparent).

4. SUSPECTED FRAUD

Where these concern's relate to a potential fraud regarding a staff member (SPPG employee of BSO), this should be reported through to the BSO. Details of how to report this to the BSO Fraud Liaison Officer (FLO) are included in more detail in the BSO's Fraud Policy, Fraud Response Plan and Bribery Policy and are summarised below.

Where these concerns relate to Programme / Service delivery which, post-migration, is the responsibility of the Department of Health (DoH) then this should be reported through to the SPPG FLO (same arrangements as HSCB FLO), e.g. suspected FHS Contractor fraud or Prescription Fraud. The existing HSCB Anti-Fraud and Anti-Bribery Policy and Response Plan provides more detail on how to report suspected frauds of this nature and can be found at the following link: http://insight.hscb.hscni.net/download/policies/finance/HSCB-Anti-Fraud-and-Anti-Bribery-Policy-and-Response-Plan-2021.pdf which can be used pending the full update of the DoH's Fraud Policy and Response Plan, to incorporate SPPG specific arrangements.

Suspicions of fraud or bribery should initially be raised with the appropriate line manager but where you do not feel this is not appropriate the following officers may be contacted:

- DoH SPPG Fraud Liaison Officer (FLO) – non-employee related suspected fraud / bribery, i.e. Programme or Service delivery suspected fraud / bribery
- BSO Fraud Liaison Officer – suspected fraud / bribery relating to BSO (including SPPG) employees only

Employees can also contact the regional HSC fraud reporting hotline on **0800 096 33 96** or report their suspicions online to www.repporthealthfraud.hscni.net These avenues are managed by Counter fraud and Probity Services (CFPS) on behalf of the HSC and reports can be made on a confidential basis.

The BSO's or SPPG's (i.e. the legacy HSCB's pending final update of DoH's) Fraud Response Plan will be instigated immediately on receipt of any reports of a suspicion of fraud or bribery.

The prevention, detection and reporting of fraud and bribery and other forms of corruption are the responsibility of all those working for the BSO or under its control. The BSO and SPPG expect all staff and third parties to perform their duties impartially, honestly, and with the highest integrity. This includes being alert to, and reporting any, suspected fraud and / or bribery relating to service provision in the wider context.

5. SPPG'S COMMITMENT TO YOU

5.1 Your safety

The SPPG lead, managers and the trade unions/professional organisations are committed to this policy. If you raise a genuine concern under this policy, you will not

be at risk of losing your job or suffering any detriment (such as a reprisal or victimisation). The SPPG will not tolerate the harassment or victimisation of anyone who raises a genuine concern.

The SPPG expects you to raise concerns about malpractices. If any action is taken that deters anyone from raising a genuine concern or victimises them, this will be viewed as a disciplinary matter.

It does not matter if you are mistaken or if there is an innocent explanation for your concerns, you will be protected under the law. However, it is not uncommon for some staff to maliciously raise a matter they know to be untrue. In cases where staff maliciously raises matters they know to be untrue, protection under the law cannot be guaranteed and the BSO (under the hosting arrangement) reserves the right to take disciplinary action if appropriate.

5.2 Confidentiality

With these assurances, the SPPG hopes that you will raise concerns openly. However, we recognise that there may be circumstances when you would prefer to speak to someone in confidence first. If this is the case, you should say so at the outset to Designated Advisors/ Advocates who can be contacted at SPPGwhistleblowing@hscni.net

The SPPG is committed to maintaining confidentiality for everyone involved in a concern. This includes the person raising the concern and the person(s) whom the concern is about. Confidentiality will be maintained throughout the process and after the issue has been resolved.

If you ask for your identity not to be disclosed, we will not do so without your consent unless required by law. You should however understand that there may be times when we will be unable to resolve a concern without revealing your identity, for example, where personal evidence is essential. In such cases, we will discuss with you whether and how the matter can best proceed.

5.3 Anonymity

Remember that if you do not disclose your identity, it will be much more difficult for us to look into the matter. It will also not be possible to protect your position or give you feedback. So, while we will consider anonymous reports in the exact same manner as those which are not anonymised, these arrangements are not best suited to deal with concerns raised anonymously.

If you are unsure about raising a concern you can get independent advice from Public Concern at Work (see contact details under Independent Advice).

6. RAISING A CONCERN

If you are unsure about raising a concern, you can get independent advice at any stage from your trade union/professional organisation, or from one of the organisations listed in Section 7. You should also remember that you do not need to

have firm evidence before raising a concern. However, you should explain as fully as possible the information or circumstances that gave rise to the concern.

6.1 Who should I raise a concern with?

In many circumstances the easiest way to get your concern resolved will be to raise it with your line manager. But where you do not think it is appropriate to do this, you can use any of the options set out below.

If raising it with your line manager does not resolve matters, or you do not feel able to raise it with them, you can contact the Designated Advisor/ Advocate for SPPG at SPPGwhistleblowing@hscni.net

If you still remain concerned after this, you can contact the DoH Corporate Management Directorate via email at complaints@health-ni.gov.uk
All these people have been trained in receiving concerns and will give you information about where you can go for more support. If for any reason you do not feel comfortable raising your concern internally, you can raise concerns with external bodies (refer to section 7 below).

If exceptionally, the concern is about the SPPG Lead, then it should be made (in the first instance) to the DoH Corporate Management Directorate via email at complaints@health-ni.gov.uk, who will decide on how the investigation will proceed.

6.2 Independent advice

If you are unsure whether to use this policy, or if you require confidential advice at any stage, you may contact your trade union/professional organisation.

Advice is also available through the independent charity Public Concern at Work (PCaW) on 020 7404 6609.

6.3 How should I raise my concern?

You can raise your concerns with any of the people listed above, in person, by phone or in writing (including email).

Whichever route you choose, please be ready to explain as fully as you can the information and circumstances that gave rise to your concerns.

7. RAISING A CONCERN EXTERNALLY

The SPPG hopes this policy reassures you of its commitment to have concerns raised under it taken seriously and fully investigated, and to protect an individual who brings such concerns to light.

Whilst there may be occasions where individuals will wish to report their concerns to external agencies or the PSNI, the SPPG would hope that the robust implementation

of this policy will reassure staff that they can raise such concerns internally in the first instance.

However, the SPPG recognises that there may be circumstances where you can raise a concern with an outside body including those listed below:

- A prescribed person, such as:
  - General Chiropractic Council, General Dental Council, General Medical Council, General Osteopathic Council, Health & Care Professional Council, Northern Ireland Social Care Council, Nursing and Midwifery Council, Pharmaceutical Society Northern Ireland, General Optical Council
- The Regulation and Quality Improvement Authority;
- The Health and Safety Executive;
- Serious Fraud Office,
- Her Majesty's Revenue and Customs,
- Comptroller and Auditor General;
- Information Commissioner,
- Northern Ireland Commissioner for Children and Young People,
- Northern Ireland Human Rights Commission

Disclosure to these organisations/persons will be protected provided you honestly and reasonably believe the information and associated allegations are substantially true.

We would wish you to raise a matter with the external agencies listed above than not at all. Public Concern at Work (or your union) will be able to advise you on such an option and on the circumstances in which you may be able to contact an outside body safely.

8. THE MEDIA

You may consider going to the media in respect of their concerns if you feel the SPPG has not properly addressed them. You should carefully consider any information you choose to put into the public domain to ensure that patient/client confidentiality is maintained at all times. The SPPG reserves the right to take disciplinary action if patient/client confidentiality is breached.

Communications with the media are coordinated by the DoH Press Office on behalf of the SPPG. Staff approached by the media should direct the media enquiry to this department in the first instance.

9. CONCLUSION

While we cannot guarantee that we will respond to all matters in the way that you might wish, we will strive to handle the matter fairly, impartially and properly. By using these whistleblowing arrangements you will help us to achieve this.

Please note, this document has been developed to meet best practice and comply with the Public Interest Disclosure (NI) Order 1998 (the Order) which provides employment protection for whistleblowing.

The Order gives significant statutory protection to staff who discloses information reasonably in the public interest. To be protected under the law an employee must act with an honest and reasonable belief that a malpractice has occurred, is occurring or is likely to occur. Disclosures may be made to certain prescribed persons or bodies external to the HSCB listed in the Order. The Order does not normally protect employees making rash disclosures for example to the media, when the subject could have been raised internally.

10. APPENDICES

Appendix A - Roles and Responsibilities
Appendix B - Procedure
Appendix C - Advice for Managers

11. EQUALITY, HUMAN RIGHTS & DDA

This policy has been drawn up and reviewed in the light of Section 75 of the Northern Ireland Act (1998) which requires the HSCB to have due regard to the need to promote equality of opportunity. It has been screened to identify any adverse impact on the nine equality categories.

The policy has been screened without mitigation.

12. PERSONAL & PUBLIC INVOLVEMENT (PPI) /CONSULTATION PROCESS

This policy has been adopted by the SPPG in line with regional guidance. Appropriate consultation has been carried out with colleagues across all relevant HSC bodies.

13. ALTERNATIVE FORMATS

This document can be made available on request in larger font, Braille, audiocassette and in other minority languages to meet the needs of those who are not fluent in English.

14. SOURCES OF ADVICE IN RELATION TO THIS DOCUMENT

The Policy Author, responsible Director as detailed on the policy title page should be contacted with regard to any queries on the content of this policy.

APPENDIX A

ROLES AND RESPONSIBILITIES

The SPPG

- To listen to our staff, learn lessons and strive to improve patient care;
- To ensure that this policy enables genuine issues that are raised to be dealt with effectively;
- To promote a culture of openness and honesty and ensure that issues are dealt with responsibly and taken seriously;
- To ensure that employees who raise any issues are not penalised for doing so unless other circumstances come to light which require this, e.g. where a member of staff knowingly raises an issue regarding another member of staff which they know to be untrue;
- To share learning, as appropriate, via organisations shared learning procedures.

DoH Corporate Management Directorate

- The DoH Corporate Management Directorate has responsibility for oversight of the culture of raising concerns within the DoH.

Senior Manager

- To take responsibility for ensuring the implementation of the whistleblowing arrangements.

Managers

- To take any concerns reported to them seriously and consider them fully and fairly;
- To recognise that raising a concern can be a difficult experience for some staff and to treat the matter in a sensitive manner if required;
- To seek advice from other professionals within the SPPG where appropriate;
- To invoke the formal procedure and ensure the Designated Advisors/ Advocates are informed, if the issue is appropriate;
- To ensure feedback/ learning at individual, team and organisational level on concerns and how they were resolved.

Whistleblowing adviser/ advocate

- To ensure that any safety issue about which a concern has been raised is dealt with properly and promptly and escalated appropriately through all management levels;
- To intervene if there are any indications that the person who raised a concern is suffering any recriminations;

- To work with managers and HR to address the culture in an organisation and tackle the obstacles to raising concerns.

This list is not intended to be exhaustive or restrictive

All Members of Staff

- To recognise that it is your duty to draw to the SPPG's attention any matter of concern;
- To adhere to the procedures set out in this policy;
- To maintain the duty of confidentiality to patients and the SPPG and consequently, where any disclosure of confidential information is to be justified, you should first, where appropriate, seek specialist advice for example from a representative of a regulating organisation such as the Nursing & Midwifery Council or the General Medical /Dental Council.

ROLE OF TRADE UNIONS AND OTHER ORGANISATIONS

All staff have the right to consult and seek guidance and support from their Professional Organisations, Trade Union or from statutory bodies such as the Nursing & Midwifery Council, the General Medical Council, Health Professional Council and the Social Care Council for Northern Ireland.

APPENDIX B

EXAMPLE PROCEDURE FOR RAISING A CONCERN

STEP ONE (Informal)

If you have a genuine concern about what you believe might be malpractice and have an honest and reasonable suspicion that the malpractice has occurred, is occurring, or is likely to occur, then the matter should be raised in the first instance with your Line Manager. This may be done verbally or in writing.

You are entitled to representation from a trade union/ fellow worker or companion to assist you in raising your concern.

STEP TWO (informal)

If you feel unable to raise the matter with your Line Manager, for whatever reason, please raise the matter with our designated Advisors/ Advocates via the designated email which is SPPGwhistleblowing@hscni.net

This person/s has been given special responsibility and training in dealing with whistleblowing concerns. They will:

- treat your concern confidentially unless otherwise agreed;
- ensure you receive timely support to progress your concerns;
- escalate to the board any indications that you are being subjected to detriment for raising your concern;
- remind the organisation of the need to give you timely feedback on how your concern is being dealt with;
- ensure you have access to personal support since raising your concern may be stressful.

If you want the matter dealt with in confidence, please say so at the outset so that appropriate arrangements can be made.

STEP THREE (formal)

If these channels have been followed and you still have concerns, or if you feel that the matter is so serious that you cannot discuss it with any of the above, this should be raised with:

- the DoH Corporate Policy Directorate at complaints@health-ni.gov.uk

These people have been trained in receiving concerns and will give you information about where you can go for more support. If for any reason you do not feel comfortable raising your concern internally, you can raise concerns with external bodies (refer to section 7 below).

If exceptionally, the concern is about the SPPG lead, then it should be made (in the first instance) to the DoH Corporate Management Directorate via email at

complaints@health-ni.gov.uk, who will decide on how the investigation will proceed. *(Refer to HSCB Whistleblowing Contacts)*

STEP FOUR (formal)

You can raise your concerns formally with the external bodies listed at Section 7:

WHAT WILL WE DO?

We are committed to listening to our staff, learning lessons and improving patient care. On receipt, the concern will be recorded and, where possible, you will receive an acknowledgement within three working days.

A central register will record the date the concern was received, whether you have requested confidentiality, a summary of the concerns and dates when we have given you updates or feedback. While your identity may be included within the allegation or report, the register will not include any information which may identify you, nor should it include any information which may identify an individual or individuals against whom an allegation is made.

INVESTIGATION

Where you have been unable to resolve the matter quickly (usually within a few days) with your Line Manager, we will carry out a proportionate investigation – using someone suitably independent (usually from a different part of the organisation) and properly trained – and we will reach a conclusion within a reasonable timescale (which we will notify you of).

Wherever possible we will carry out a single investigation (so, for example, where a concern is raised about a patient safety incident, we will usually undertake a single investigation that looks at your concern and the wider circumstances of the incident). The investigation will be objective and evidence-based, and will produce a report that focuses on identifying and rectifying any issues, and learning lessons to prevent problems recurring.

We may decide that your concern would be better looked at under another process: for example, our process for dealing with bullying and harassment. If so, we will discuss that with you. We will advise you, where possible, and those identified as the subject of a concern, 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

Any employment issues (that affect only you and not others) identified during the investigation will be considered separately. Where an Agency worker raises a concern then it is the responsibility of the SPPG to take forward the investigation in conjunction with the Agency if appropriate

For the purposes of recording, if the concern is already, or has previously been, the subject of an investigation under another procedure e.g. grievance procedure it will not be appropriate to categorise it under the SPPG Whistleblowing Policy.

COMMUNICATING WITH YOU

We welcome your concerns and will treat you with respect at all times. We will discuss your concerns with you to ensure we understand exactly what you are worried about. We will endeavour to provide a response within 12 weeks of the concern being received. We will provide an update on progress by week 6 and again by week 10 of the investigation. We will share the outcome of the investigation report with you (while respecting the confidentiality of others).

HOW WE WILL LEARN FROM YOUR CONCERNS

The focus of the investigation will be on improving our services. Where it identifies improvements that can be made, we will track them to ensure necessary changes are made and are working effectively. The final outcome and 'lessons learned' will be documented and approved as final by the responsible Director. In addition the SPPG Lead will independently assess the findings and recommendations for assurance that the matter has been robustly considered and appropriately addressed.

DoH Corporate Management Directorate OVERSIGHT

The DoH Corporate Management Directorate will be given high level information about all concerns raised by our staff through this policy and what we are doing to address any problems. We will include similar high level information in the Departmental annual report. The SPPG supports staff raising concerns and want you to feel free to speak up.

REVIEW & REPORTING

We will review the effectiveness of this policy and local processes at least annually, with the outcome published and changes made as appropriate. We will provide information on the number of whistleblowing cases on an annual basis to the relevant Directorate within Department of Health setting out the actions and outcomes.

APPENDIX C

ADVICE FOR MANAGERS RESPONDING TO A CONCERN

1. Thank the staff member for raising the concern, even if they may appear to be mistaken;

2. Respect and heed legitimate staff concerns about their own position or career;

3. Manage expectations and respect promises of confidentiality;

4. Discuss reasonable timeframes for feedback with the member of staff;

5. Remember there are different perspectives to every story;

6. Determine whether there are grounds for concern and investigate if necessary as soon as possible. Where appropriate alert those identified as the subject of the concern. If the concern is potentially very serious or wide-reaching, consider who should handle the investigation and know when to ask for help. If asked, managers should put their response in writing;

7. Managers should ensure that the investigator is not connected to the concern raised and determine if there is any actual, potential or perceived conflict of interest which exists prior to disclosing full details of the concern. Should a conflict of interest arise during the investigation the investigator must alert the manager. (Note: Any such conflict must be considered, and acted on, by the manager);

8. Managers should bear in mind that they may have to explain how they have handled the concern;

9. Feed back to the whistle-blower and those identified as the subject of a concern (where appropriate) any outcome and/or proposed remedial action, but be careful if this could infringe any rights or duties which may be owed to other parties;

10. Consider reporting to the DoH Corporate Management Directorate via email at complaints@health-ni.gov.uk, and/or an appropriate regulator the outcome of any genuine concern where malpractice or a serious safety risk was identified and addressed; and

11. Record-keeping - it is prudent to keep a record of any serious concern raised with those designated under the policy, and these records should be anonymous where necessary. Please ensure the Designated Advisor/ Advocate is informed of any concern raised under this policy via email at SPPGwhistleblowing@hscni.net

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Datix Risk Management System

SPPG GOVERNANCE TEAM OPERATIONAL MANUAL FOR THE ADMINISTRATIVE PROCESS IN RELATION TO SERIOUS ADVERSE INCIDENTS AND EARLY ALERTS

NOTE

All communication between SPPG/PHA and reporting organisation must be conveyed between the SPPG Governance department and Governance departments in respective reporting organisations. This will ensure all communication both written and verbal relating to the SAI, is recorded on the SPPG Datix Risk Management system.

However, on occasion DROs have went directly to the Professional Team with queries rather than through the Governance Team within Trusts.

It was therefore agreed that if a DRO informs the SPPG Governance Team of speaking directly to a Trust professional the SPPG Governance Team will update DATIX and inform the Trust Governance Lead. Trust Governance Teams will also inform SPPG Governance Team when they are also made aware of Trust Professionals speaking directly to DROs.

*When actioning each email, **always** remember to:*

- Update DATIX Investigate
- Complete Extra Fields where necessary
- Save Documents to G: Drive/shared drive in PDF format
- Insert Documents to DATIX
- Categorise email actioned within Serious Incidents Mailbox by:
  - Selecting Red to indicate New SAI Notification,
  - Colour appropriate to reporting organisation, and
  - Colour appropriate to Governance Officer
- Drag sent emails from your personal sent items to Serious Incidents sent items

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- Elderly Services and Physical Disability and Sensory Impairment
- Mental Health and Learning Disability Services
- Prison Health

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SAI PROCESS AND IDENTIFICATION OF REGIONAL LEARNING FLOW CHART – KEY STAGES

SAI occurs within HSC organisation / Special Agency, ISP or FPS

SAI Notification completed and submitted to SPPG seriousincidents@hscni.net within **72 hours** indicating level of review i.e. Level 1, 2 or 3

SPPG assigns SPPG/PHA DRO and **acknowledges** by email receipt of SAI

Level 1 Review – SPPG request SEA Learning Summary Report to be submitted to SPPG within **8** weeks

Level 2 Review – SPPG request TOR and Membership of Review Team to be submitted to SPPG within **4 weeks** and RCA Report within **12 weeks** of notification

Level 3 Review – All timescales must be agreed with the DRO at the outset for TOR, Membership of Review Team and the RCA Report.

HSC organisation / Special Agency or commissioned service completes internal review (SEA/RCA Review)

Completed Learning Summary / Review Report submitted to SPPG within **timescales applicable to the level of review as detailed in Step 4 above**

DRO considers Learning Summary/Review Report in conjunction with professionals/officers (including RQIA and/or Secondary Care Medicines Governance Lead where applicable)

Secondary Care Medicines Governance Team identifies Regional Learning from a medication related SAI

DRO/Professional Group advises on adequacy of review and action plan and signs off learning summary/ review report identifying any Regional Learning

*(If the DRO is not satisfied additional information may be requested. Responses for level 1 reviews to be provided **within 2 weeks** level 2 and 3 reviews to be provided within **6 weeks**.)*

Secondary Care Medicines Governance Team Lead through seriousincidents@hscni.net liaises with the allocated DRO to communicate Regional Learning identified and agree format for sharing learning

Regional Learning identified is approved as follows:

SAI Professional Group Agrees regional learning options:
- Referral to Existing work-stream, Network/Group for action;
- Newsletter article i.e. Learning Matters, Medsafe, GMS;
- Inclusion in NI Medicines Governance Team Quarterly Report.

Regional SAI Review Sub Group Agrees regional learning options:
- Rapid / Immediate Alert;
- Learning / Reminder of Best Practice Letter;
- Propose Thematic Review;
- Establish a Task and Finish Group;
- Refer to other regulatory body;
- Training Events / Workshops / Seminars

Regional Learning referred to QSE for noting/ approval

Regional Learning Approved by QSE *(refer to Flowchart for the Approval and Dissemination of Regional Learning)*

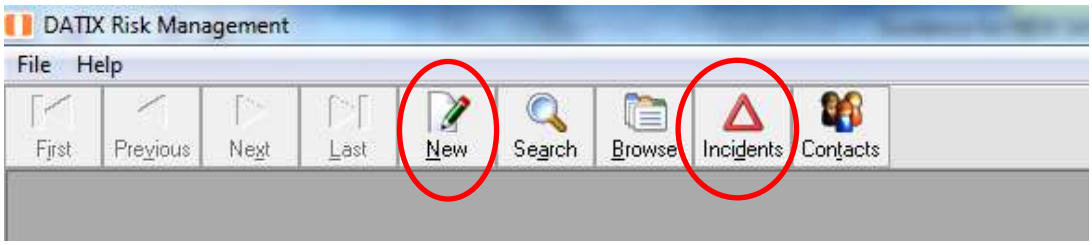
SPPG advises HSC organisation / Special Agency or commissioned service on outcome.

2 LOGGING NEW INCIDENTS

However, in relation to SAIs, when notifications are received with personal information it is important that the email/notification is saved to the corporate record before any information is redacted. The Governance Team then redact the form before circulating to relevant professionals and note in the acknowledgement email that we have redacted the personal information before circulating as the SAI process is anonymous.

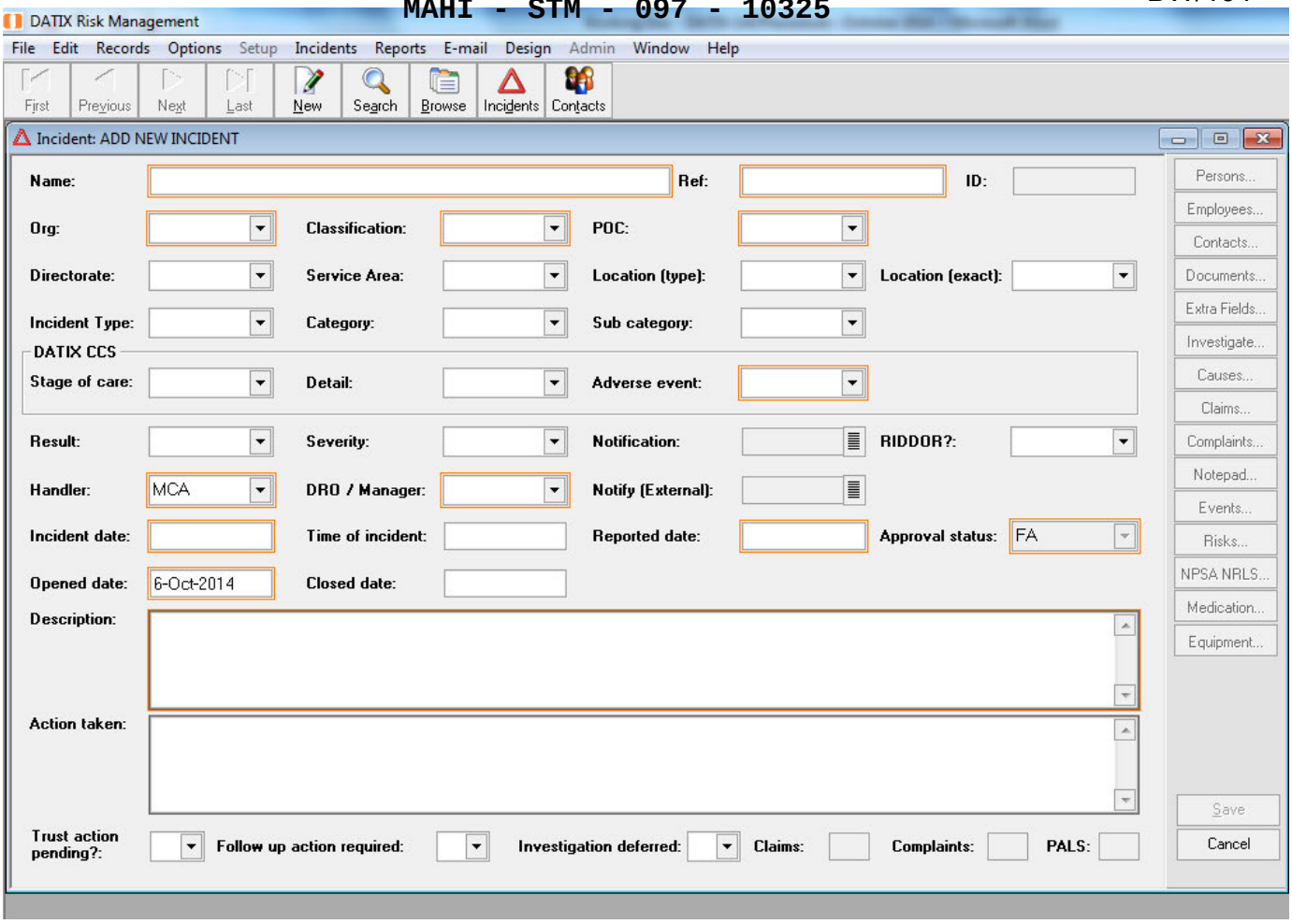
Step 1 – Create new Record

- In Datix, select Incidents and then New



Step 2 – Populate Record

- Populate Datix fields from information provided in SAI Notification Form - Fields with an orange box around them are mandatory fields and must be completed (Datix will not allow you to save the record until these are all complete)



Name: Copy Unique Incident identification No/Reference - **Box 2**

Ref: Insert Initial of Reporting Organisation (Datix generates an ID when record is saved)

ID: Generated by Datix when record is saved

Org: Select reporting organisation from drop down field- **Box 1**

Classification: Select as appropriate from drop down field – **Box 9**: If No it is classed as a 'SAI' , if yes select 'SAI Never Event'

POC: Select PoC - **(Box 7)** However, if handler disagrees with PoC advised by Trust, select appropriate POC and include Trust POC indicated in box 7 into Extra Fields 'HSC Trust POC'.

Directorate: Select as appropriate from drop down field – In general directorates should be as follows:

- POC1 – Public Health
- POC -

Service Area: Select as appropriate from drop down field

Location (type): Box 3 - Select as appropriate from drop down field

Location (exact): Box 3 - Select as appropriate from drop down field

Incident Type: Select as appropriate from drop down field

Category: Select as appropriate from drop down field

Sub-Category: Select as appropriate from drop down field

DATIX CCS: Stage of Care / Detail / Adverse Event – Below **box 8** (If handler doesn't agree, code accordingly) - Select as appropriate from drop down field – See CHILD DEATH NOTIFICATIONS

Result: Select as appropriate from drop down field

MAHI - STM - 097 - 10326

Notification: Select as appropriate from drop down field (**Box 18**)- query Early Alert & SAI?

DRO/Manager: Select either UNALLOCATED until a DRO has been assigned **OR** insert name of assigned DRO as per flowcharts (Appendix 3)

Notify (External): Select those Trust has informed - **Box 17**

Incident date: Copy from **Box 4**

Time of Incident: This information is not always available but if it is noted on the form include in Datix field (may be noted in box 4 or 8)

Reported date: Insert date incident received by SPPG

Description: Copy and paste from SAI Notification Form

- Description of Incident – **Box 8**
- Gender, Age and DOB - **Box 8**
- Why Incident Considered Serious (and criteria ticked by Trust**) Box 13**
- Current Condition of Service User – **Box 10** (if applicable)
- Has the Service User/Family been advised the incident is being investigated as a SAI **Box 15**

Action Taken: Copy and paste from SAI Notification Form **(Box 9)**

Trust Action Pending: Leave blank

- For those SAIs where a drug is referenced in the description click on the 'Medication' tab on the right-hand side of the Datix screen. When it is opened select the name of the drug from the drop down list in the 'Drug involved' tab.

Step 3 – Save Record

- **Save.** This generates an ID number into the ID Field. Copy ID number into **Ref field** (after initial of reporting organisation – i.e. S1234, N3214)

Step 4 – Populate Extra Fields

Extra Fields - Insert Dates:

Level 1 Learning Summary Due - this is calculated by counting 8 weeks from date of notification to SPPG
- 8 week date is inserted into **SEA/RCA** due date field

Level 2 TOR due - this is calculated by counting 4 weeks from date of notification to SPPG
- 4 week date is inserted into Level 2 TOR due field

RCA due - this is calculated by counting 12 weeks from date of notification to SPPG
- 12 week date is inserted into SEA/RCA due date field

Level 3 Dates are agreed between Trust and DRO

Level 2 & 3 Complete Extra Fields: **Status**: ToR & Membership Due
SPPG Follow up Date: Insert the date after the ToR is due

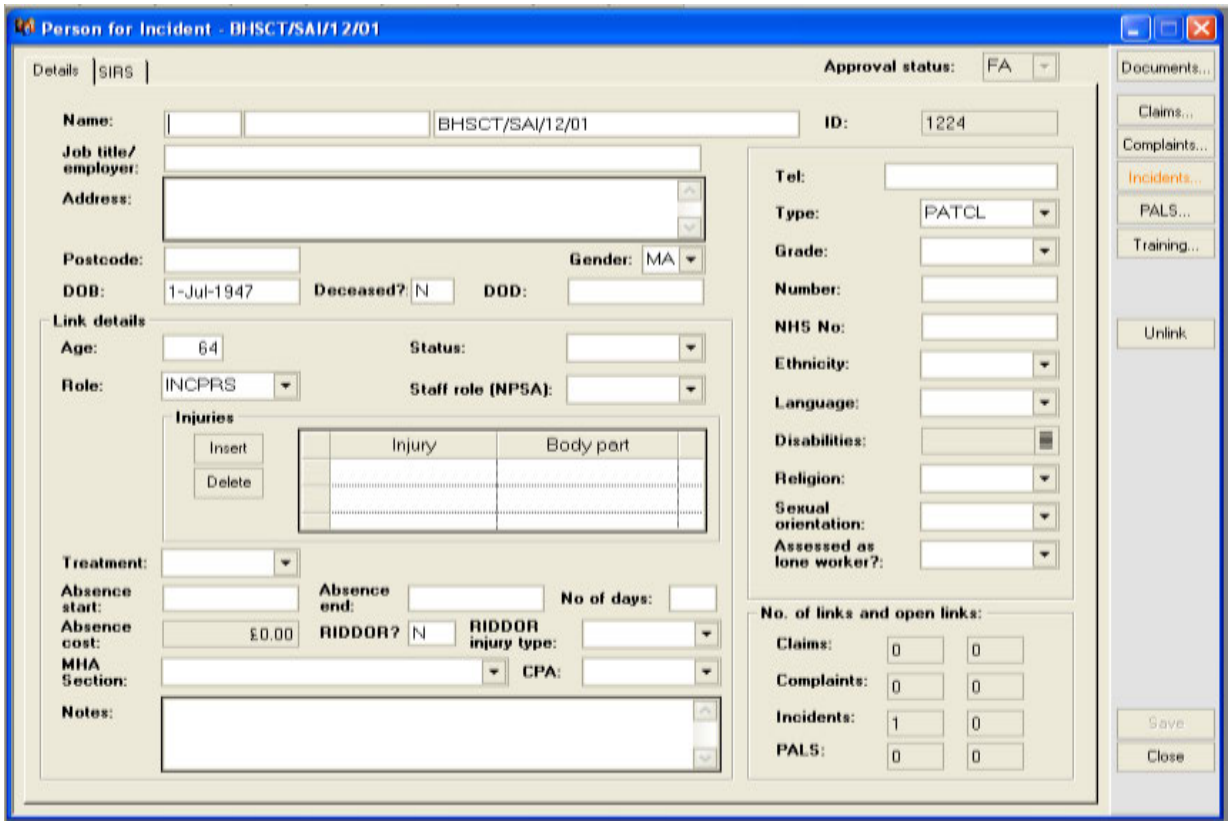
(the date for the ToR & Membership will not be agreed until a later date, when confirmed completed Status and SPPG follow up fields as above)

SAVE

Step 5 – Populate Person Field

Click person and new

- Name – Unique Incident identification No/Reference - Box 2
- Gender – box 8
- DOB – box 8 - when you complete this field, Datix will update Age
- DOD – usually box 4 or box 8 - when you complete this field, Datix will automatically complete the Deceased field
- Role (*usually person injured/affected*)
- Type (*usually patient/service user*)



SAVE and CLOSE

When SAI notifications are received with personal information it is important that the email/notification is saved to the corporate record before any information is redacted. The Governance Team then redact the form before circulating to relevant professionals and note in the acknowledgement email that we have redacted the personal information before circulating as the SAI process is anonymous.

Step 6 – Acknowledgement to Reporting Organisation

- Reply to notification email from Trust
- Use appropriate template (Appendix 2, T1 or T2, depending on level of review)

Step 7 – Request for DRO/Assign DRO

- See Section 3

Step 8 – Save Documents to G: Drive/shared drive in PDF format

- Create sub-folder on G: Drive/shared drive as follows select G: Common: SAI: Reporting

Organisation - Create new folder (Ref: i.e. B1234).

- Save the following Documents to G: Drive/shared drive in PDF format (File – Print – Select PDF – Save)
  - Notification Email
  - SAI Notification Form - SPPG Ref E.G. SAI Notification Form – N1234
  - Acknowledgement Email
  - Request for DRO or DRO Assigned

Step 9 – Insert Documents to DATIX

- Pull documents from G:Drive/central drive to Datix records
- Click on Documents –
- Click on Insert - Select from folder on G: Drive (i.e. BHSCT, NHSCT etc
- Select record name i.e. B1234 or N4567
- Select appropriate document i.e. Notification Email, SAI Notification Form, Acknowledgement Email or Request for DRO/DRO Assigned – This will open "document edit field".
- In description, click on file name i.e. document to be uploaded and click open – This will open dialogue box – in description type file name i.e. notification email and in Type field, select appropriate document type i.e. email, form, report etc
- Select **SAVE**

Step 10 – Update DATIX Investigate

- Select Investigate Tab
- Under **"Comments/Action Taken"** - type the date that Incident was received, acknowledged and request for DRO circulated/DRO assigned.
- Select **SAVE**

Step 11 – Categorise In-box

- Categorise email actioned within Serious Incidents Mailbox by:
  - Select Red to indicate New SAI Notification, and
  - Colour appropriate to reporting organisation

3 ASSIGN DESIGNATED REVIEW OFFICER (DRO)/REQUEST DRO

1 DRO/Manager is a mandatory field. When logging a new incident, select either UNALLOCATED until a DRO has been assigned **OR** insert name of assigned DRO as per flowcharts (Appendix 3 and follow steps below to Assign a DRO or Request for a DRO.

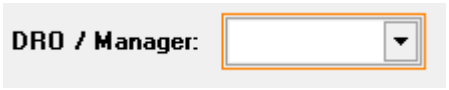
2 ASSIGN DRO/DIRECT ALLOCATION

Flowcharts have been developed to allow direct allocation of DROs for SAIs notified to the SPPG for the following programmes of care

- Acute
- Maternal and Child Health (Including Acute Paediatrics)

- Elderly Services and Physical Disability and Sensory Impairment
- Mental Health and Learning Disability Services
- Prison Health

Consult the relevant flowchart (Appendix 3) for named DRO. In Datix, select the appropriate DRO from the drop down box.



Assign DRO

Find notification email from Trust and click Forward
Use wording from T4 – Appendix 1

3 **Save Documents to G:Drive/Shared Drive in PDF format**
- DRO Assigned

4 **Insert Documents to Datix**

5 **Update Datix Investigate**

6 ## REQUEST FOR DRO

If there is no flowchart, a DRO must be requested. (In the meantime select unallocated)
- Find notification email from Trust and click Forward
- Consult Regional Listing of Names of SAI Leads for Nomination of DRO (Appendix 2) to ascertain who the request should be sent to.
- Use wording from T3 - Appendix 1

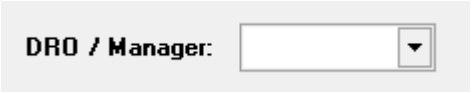
7 **Save Documents to G:Drive/Shared Drive in PDF format**
- Request for DRO

8 **Insert Documents to Datix**

9 **Update Datix Investigate**

A Lead Officer will identify an appropriate DRO and advise Serious Incidents.

10 Upon receipt of the email from the Lead Officer confirming the DRO, select the appropriate DRO from the drop down box.



SAVE

11 **Assign DRO**

Forward the confirmation of DRO email from the Lead Officer to the newly assigned DRO ensuring the notification email from the Trust is below and the notification is attached (this shows the email thread of how newly assigned DRO was identified).

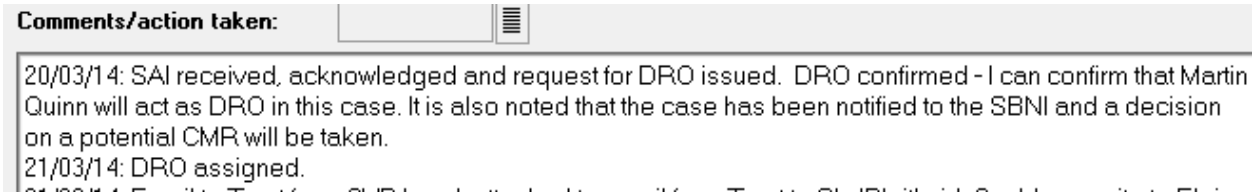
Use wording from T4 – Appendix 1

12 **Save Documents to G:Drive/Shared Drive in PDF format as follows:**

- Confirmation of DRO
- DRO Assigned

13 **Insert Documents to Datix**

14 **Update Investigate Field**

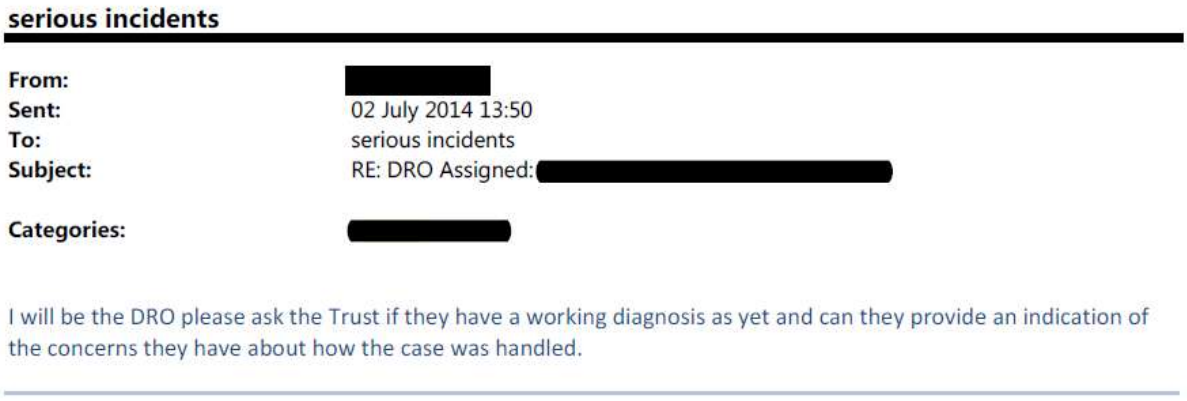


SAVE

4 IMMEDIATE ACTION TAKEN BY DRO

Upon DRO receiving a new SAI notification, they may notify Serious Incidents of immediate action to be taken. If this is the case, Serious Incidents will forward an appropriate request to the Reporting Organisation highlighting specific immediate action to be taken by the Trust.

1 Email received from DRO with request for immediate action



serious incidents

From: [redacted]
Sent: 02 July 2014 13:50
To: serious incidents
Subject: RE: DRO Assigned: [redacted]

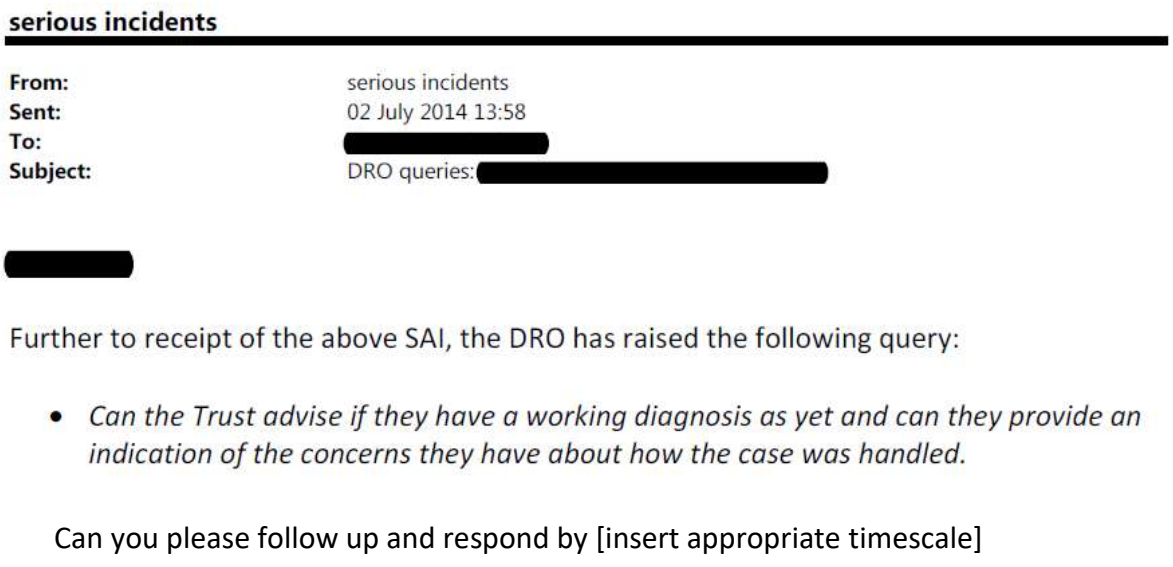
Categories: [redacted]

I will be the DRO please ask the Trust if they have a working diagnosis as yet and can they provide an indication of the concerns they have about how the case was handled.

2 Find Notification Email from Trust and click reply. Word an appropriate request

NOTE:

- DO NOT forward DRO's email to Reporting Organisation.
- Delete any reference to named officers



serious incidents

From: serious incidents
Sent: 02 July 2014 13:58
To: [redacted]
Subject: DRO queries: [redacted]

[redacted]

Further to receipt of the above SAI, the DRO has raised the following query:

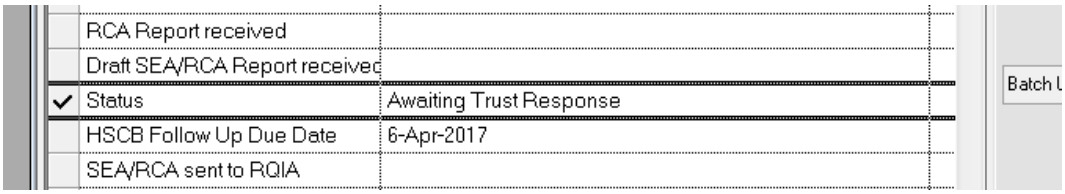
- *Can the Trust advise if they have a working diagnosis as yet and can they provide an indication of the concerns they have about how the case was handled.*

Can you please follow up and respond by [insert appropriate timescale]

3
- TIMESCALES – responses to additional information requests must be provided in a timely manner:
  - All levels - 1 week

When emailing the Trust, include the date you expect to receive the response by (insert 1 week)

Insert the date after the **response is due** in extra fields (SPPG Follow up Due Date)



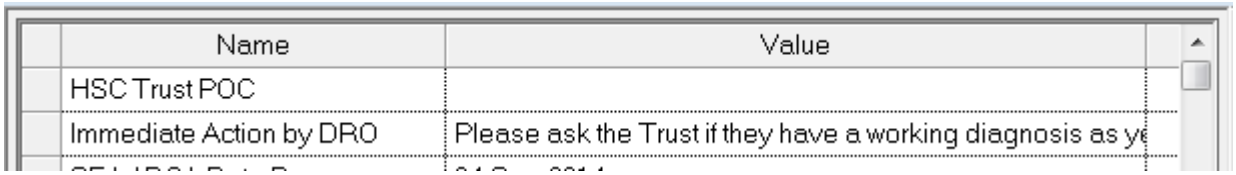
This will assist with follow-ups when running your daily report.

4 Save the email from the DRO and the email to the reporting organisation to the G: Drive/Shared Drive

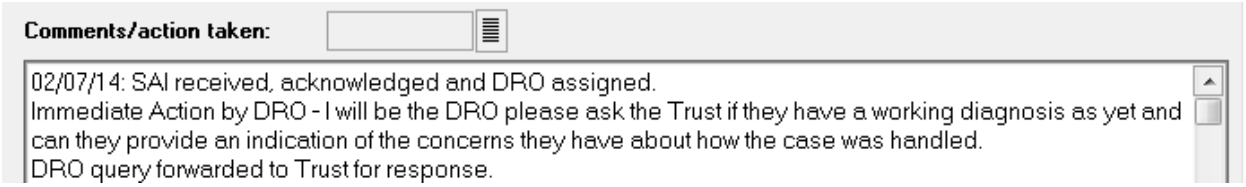
- Request for Immediate Action from DRO
- Immediate Action forwarded to Trust for response

5 Insert documents to Datix

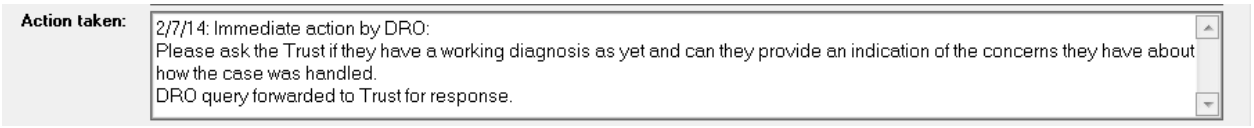
6 **Extra Fields** – Immediate Action by DRO field
This is a limited text file – insert a summary of DROs action



7 **Update Datix Investigate**

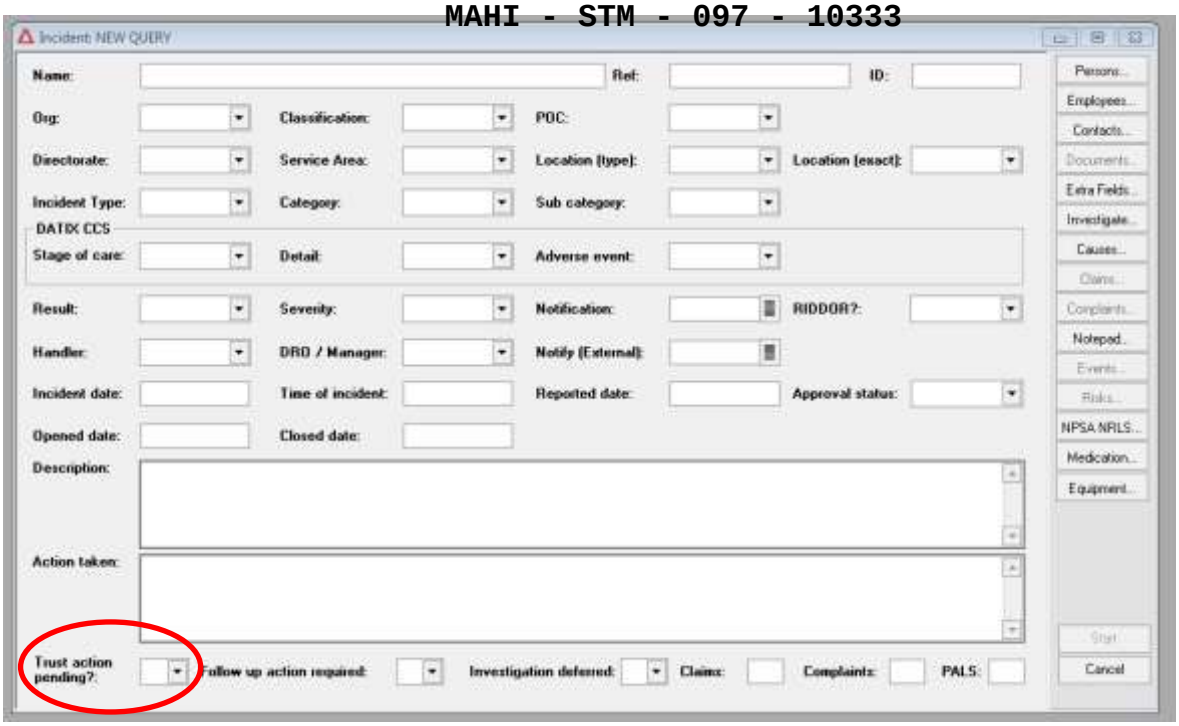


8 **Update Action Taken box on front screen- query- see handwritten notes on manual.**



9 **Trust Action Pending**

IMPORTANT: Remember to update this box - Select Yes (Y) to indicate action is required by a Trust



This is a YES or NO field. It is important that this field is completed for each SAI and updated as the review proceeds.

- Select Yes (Y) if action is required by a Trust (e.g. Family Checklist) or a response from the Trust to a DRO query
- Leave blank if action is required by SPPG/PHA/RQIA

5 RECEIPT OF LEARNING SUMMARY REPORT FOR LEVEL 1 REVIEW

Following a review, the reporting Organisation submits a completed Learning Summary Report and a SAI Review Report Checklist. A Checklist should accompany all levels of SAI completed Review Reports.

1 Learning Summary received into Serious Incidents Mailbox

2 **Acknowledge receipt of Learning Summary Report****
- Reply to email from Trust attaching SEA report
- Use appropriate template (T5, Appendix1)

** If a checklist has not been submitted with the Review Report, when acknowledging receipt of the Learning Summary Report, request the Trust to submit the SAI Checklist by return.

3 **Extra Fields**

Insert date Learning Summary received by SPPG

SEA Report received	3-Nov-2014

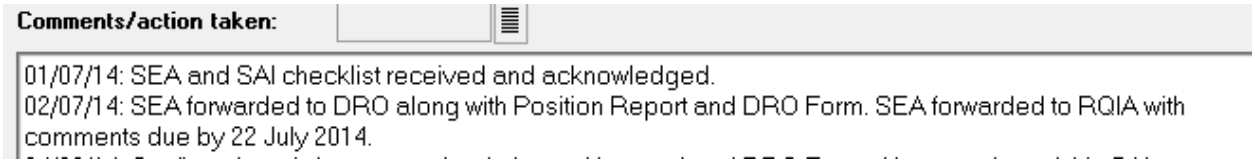
If appropriate complete extra fields with Date Report forwarded to RQIA – Learning Summary/RCA sent to RQIA.

SCREEN SHOT?

If a checklist has been received, complete extra fields

Refer to Appendix ?

4 **Update Investigate field** - This is updated at this stage so that all actions will be captured in the position report.



NOTE: If RQIA were included in the initial notification, they must receive a copy of the Learning Summary report. RQIA are given 3 weeks to provide any comments to DRO – See Appendix 4.

5 **Generate a position report**
Documents – Templates – 74 – New Position Report

MAHI - STM - 097 - 10335

6 **Generate a DRO Learning Form (where there is no professional group meeting)**
Documents – Templates – 78 – DRO Form

7 Forward email from the Trust with Learning Summary Report attached to the named DRO.

For covering email see T7 – Appendix 1
Ensure a Datix position report and the DRO form is attached to this email

8 If RQIA were included in the initial notification, they must receive a copy of the Learning Summary Report.

- Forward the Trust email with the Learning summary attached to RQIA.
- For covering email see T8 - Appendix 1

9 Save documents to G:Drive/shared drive in PDF format

- Email from Trust with Learning Summary Report
- Learning Summary Report
- SAI Checklist***
- Email to DRO
- Email to RQIA (if appropriate)
- Acknowledgement of Learning Summary/Checklist to Trust

*** When saving the Checklist, name the checklist document as **SAI Checklist**.

	Created	Type	Description	Printed	ID
	3-Sep-2014	CHKSAI	SAI Checklist		69515

10 Insert documents to Datix

6 RECEIPT OF LEARNING SUMMARY REPORT FOR LEVEL 1 REVIEW WHERE A LEVEL 2 OR LEVEL 3 REVIEW IS RECOMMENDED

Following a Level 1 review, it may be determined the SAI is more complex and requires a more detailed review.

1 Learning Summary received indicating that the incident is to be investigated as a Level 2 or Level 3. This will be evident from either the cover email from the Trust or Section 3, Question 18 of the Learning Summary Report.

2
- Forward Learning Summary Report to DRO advising that the Trust have now confirmed that the incident is to be investigated as a Level 2 or Level 3. (T7.2, Appendix 1).
  *If the date for submission of the RCA is outside the 12 weeks timescale (Question 20 of Learning Summary Report) use the appropriate wording from the template to seek approval from the DRO

  - The Terms of Reference and Review Team Membership should be outlined in Section 4, Questions 21 and 22) of the Learning Summary Report. Seek approval from the DRO.

    *If the Terms of Reference/Review Team Membership have been omitted, follow-up with the Trust.

If RQIA were included in the initial notification, they must receive a copy of the Learning Summary Report.
- Forward the Trust email with the Learning Summary Report attached to RQIA.
- For covering email see T8, Appendix 1.

3 **Extra Fields**

Insert date Learning Summary received by SPPG

	SEA Report received	3-Nov-2014

If a checklist has been received, complete extra fields

INSERT SCREEN SHOT NEW FIELDS

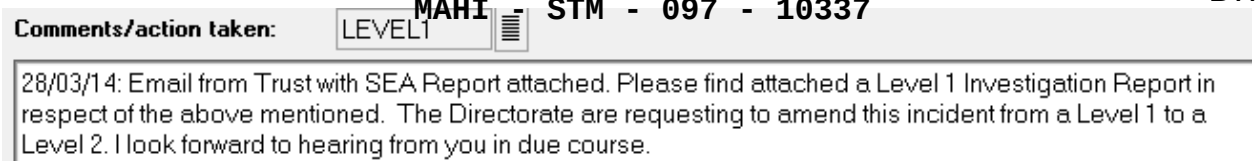
4 Save documents to G:Drive/shared drive in PDF format

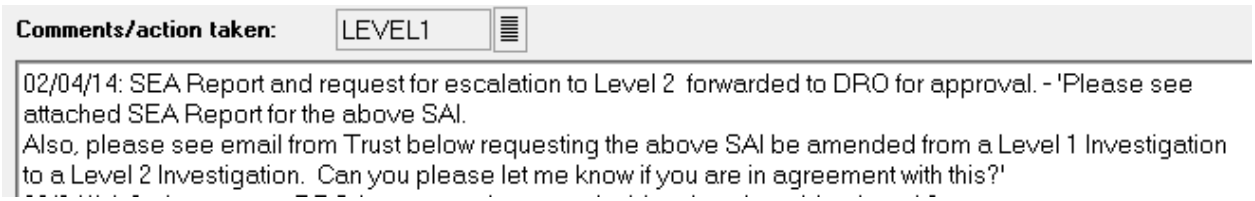
- Email from Trust with Learning Summary Report and escalation request
- Learning Summary Report
- SAI Checklist
- Terms of Reference and Membership (if received with Learning Summary)
- Email to DRO with Learning Summary Report and escalation request (if applicable)
- Email to RQIA (if appropriate)

5 Insert Documents to DATIX

6 Update DATIX Investigate

MAHI - STM - 097 - 10337





AWAIT DRO DECISION TO ESCALATE TO LEVEL 2 or LEVEL 3 (if applicable)

Once the DRO approves this request, the Trust need to be advised of the DRO's decision.

7	If the Trust **<u>have</u>** completed additional sections of the Learning Summary Report outlining membership and terms of reference of the team to complete Level 2 or Level 3 review: • Reply to email from Trust requesting move to Level 2 or 3 • Use appropriate wording template T5.2 – Appendix 1	If the Trust **<u>have not</u>** completed additional sections of the Learning Summary Report outlining membership and terms of reference of the team to complete Level 2 or Level 3 review: • Reply to email from Trust requesting move to Level 2 or 3 • Use appropriate wording from template T5.2 – Appendix 1
8	**Update Extra Fields** Level 2 TOR Received RCA Date Due	**Update Extra Fields** Level 2 TOR Due RCA Date Due

9 **Save documents to G:Drive/shared drive in PDF format**

- DRO response to escalation request
- Escalation approval to Trust

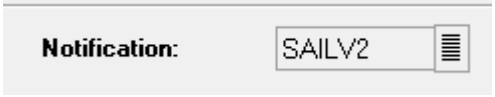
10 Insert Documents to DATIX

11 Update DATIX Investigate

12 Change Level of Review

The front screen should always show the current level of review

On front screen – change Notification field from Level 1 to Level 2 or 3



In investigate (drop down box beside Comments/action taken) select the level of review initially advised by Trust i.e. Level 1 in this case.

MAHI - STM - 097 - 10338

13 Save documents to G:Drive/shared drive in PDF format

- DRO response to escalation request
- Escalation approval to Trust

14 Insert Documents to DATIX

15 Update DATIX Investigate

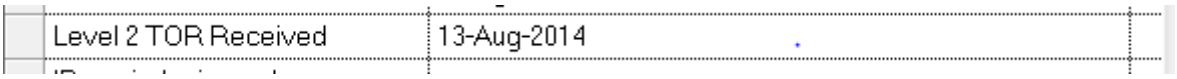
7 RECEIPT OF TERMS OF REFERENCE (ToR) AND MEMBERSHIP OF REVIEW TEAM FOR A LEVEL 2/LEVEL 3 REVIEW

Update 18 December 2020

If the name and designation are not on a ToR received from the Trust, Governance Team to go back to the Trust asking for the name and designation by return of email. Forward the ToR to the relevant DRO noting that you have asked the Trust to confirm the name and designation. This can then be forwarded to the DRO upon receipt.
Please note if it is only the name and designation missing from the ToR it can be recorded as 'TOR Received' and a follow up date can be entered to follow up on the confirmation from the Trust. They cannot be approved until this information is available
Follow up free text 'Status' field to read **awaiting name and designation**.

1 Complete Extra Fields

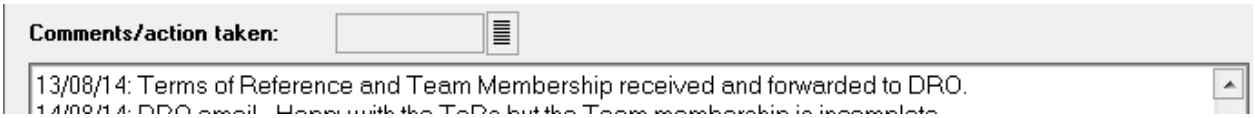
- Insert date Terms of Reference/Team Membership received



2 Forward Terms of Reference and Membership of Review Team to DRO

Use Template **T9**, Appendix 1

3 Update Investigate



4 Save documents to the G: Drive/Shared Drive
- Email from Trust with TOR and Membership
- Terms of Reference and Membership – Document Type - TORRCA
- ToR and Membership forwarded to DRO

5 Insert documents to Datix

6 If no response is received from the DRO the relevant AGM for will follow up with DRO

7 When approval has been received, inform reporting organisation using Template **T9.1**.

8 Save documents to the G: Drive/Shared Drive
- DRO approves TOR and Membership
- Email to Trust confirming DRO approval of TOR and Membership

9 Insert documents to Datix

11 Update Investigate

12 Update Datix

- **SPPG Follow Up Due Date**: leave blank
- **Status**: In process

8 RECEIPT OF RCA REPORT FOR LEVEL 2 or LEVEL 3 REVIEW

Following a review, the reporting Organisation submits a completed redacted RCA review report. A Checklist should accompany all levels of SAI completed Review Reports when forwarding to SPPG.

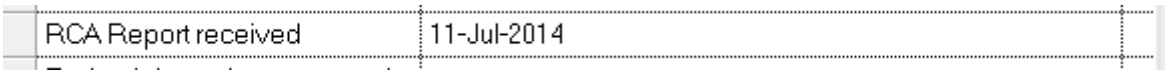
1 RCA received

2 Acknowledge receipt of RCA/Checklist*
- Reply to email from Trust attaching RCA report
- Use appropriate template (T6 - Appendix 1)

*If a checklist has not been submitted with the Review Report, when acknowledging receipt of the RCA Report, request the Trust to submit the SAI Checklist by return.
Insert SPPG follow up Due Date for 1 week.

3 Extra Fields

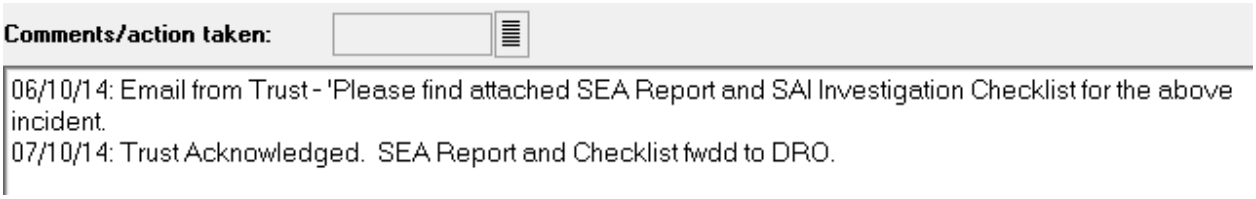
insert date RCA received by SPPG



If a checklist has been received, complete extra fields. NEW EXTRA FIELDS TO BE INSERTED
INSERT SCREEN SHOT

Update New Field on Datix - Final Report Received 'Y'

4 **Update Investigate field** - This is updated at this stage so that all actions are captured in the position report. Need to change extract below



NOTE: If RQIA have been informed, they receive a copy of the RCA report. Given 3 weeks to provide any comments for DRO – See T8 - Appendix 1.

Complete extra fields with Date Report forwarded to RQIA – Learning Summary/RCA sent to RQIA.

5 **Generate a position report**
Documents – Templates – 74 – New Position Report

6 **Generate a DRO Form (where there is no professional group meeting)**
Documents – Templates – 78 – DRO Form

7 Forward email from the Trust with RCA attached/checklist attached to the named DRO.

For covering email see T7, 7.1 & 7.2 – Appendix 1 as appropriate
Ensure a DATIX position report and DRO Form (if there is no professional group) is attached to this email

8 If RQIA were included in the initial notification, they must receive a copy of the Review Report. Give 3 weeks to provide any comments for DRO – See appendix 4

- Forward the Trust email with the RCA attached to RQIA.
- For covering email see T8 – Appendix 1

9 Save documents to G:Drive/shared drive in PDF format

- Email from Trust with RCA Report
- RCA Report
- SAI Checklist***
- Email to DRO
- Email to RQIA (if appropriate)
- Acknowledgement of RCA/Checklist to Trust

*** When saving the Checklist, name the checklist document as **SAI Checklist**.

	Created	Type	Description	Printed	ID
	3-Sep-2014	CHKSAI	SAI Checklist		69515

10 Insert documents to Datix

9 DRO QUERIES

Following receipt of a Learning Summary Report/RCA report, the DRO may notify Serious Incidents of queries/request for further clarification from the Trust. If this is the case, Serious Incidents will forward an appropriate request to the Reporting Organisation highlighting specific DRO query/clarification sought to the Trust for response.

1 Email received from DRO with queries on Review Report

serious incidents

From: [redacted]
Sent: 29 August 2014 17:03
To: serious incidents
Cc: [redacted]
Subject: RE: SEA REPORT AND CHECKLIST: [redacted]

[redacted]

I have reviewed this report and after consultation with HSCB colleagues I would make the following comments, and request further detail;

1. Was the fall witnessed or unwitnessed? I think the latter but it is stated as witnessed in the overview (and as unwitnessed later in the report). Please clarify
2. It is not clear if the GP phoned for the ambulance or if that was delegated to a receptionist,
3. Also, it is not clear what information was given from the GP practice to NIAS to determine the type of ambulance required, can this be clarified?
4. Does the GP or practice specify the type of ambulance, or does NIAS do this dependent on information given about the patient, can this be clarified with NIAS?
5. A better recommendation (number 4) would be that the GP should give full details of patients condition including mobility to NIAS?
6. There does appear to have been a potential delay in obtaining the co-codamol, but there is no information given about when the prescription was phoned through / delivered to the Community Pharmacy. Please provide further detail?
7. What is the RQIA response to your concerns regarding record keeping. I assume SAI 32865 relates to the same PNH, this report also has a recommendation regarding record keeping.

2 Find Notification Email from Trust and reply. Word an appropriate email

NOTE:

- DO NOT forward DRO's email to Reporting Organisation.
- Delete any reference to named officers
- TIMESCALES – responses to additional information requests must be provided in a timely manner:
  - Level 1 review – SPPG follow-up due date: 2 week
  - Level 2 or 3 review - SPPG follow-up due date: 6 weeks, or less depending on complexity of query

Insert the date the **response is due** in extra fields (SPPG Follow up Due Date) INSERT SCREEN SHOT

This will assist with follow-ups when running your weekly report using this field to flag-up the dates responses are due.

When emailing the DRO query to the Trust, include the date you expect to receive the response by (as per timescales agreed)

EXAMPLE

serious incidents

From: serious incidents
Sent: 03 September 2014 14:33
To: [redacted]
Subject: DRO queries: [redacted]

[redacted]

Further to receipt of the SEA report for the above incident, the DRO has reviewed this report and after consultation with HSCB colleagues would make the following comments, and request further detail;

1. *Was the fall witnessed or unwitnessed? I think the latter but it is stated as witnessed in the overview (and as unwitnessed later in the report). Please clarify*
2. *It is not clear if the GP phoned for the ambulance or if that was delegated to a receptionist,*
3. *Also, it is not clear what information was given from the GP practice to NIAS to determine the type of ambulance required, can this be clarified?*
4. *Does the GP or practice specify the type of ambulance, or does NIAS do this dependent on information given about the patient, can this be clarified with NIAS?*
5. *A better recommendation (number 4) would be that the GP should give full details of patients condition including mobility to NIAS?*
6. *There does appear to have been a potential delay in obtaining the co-codamol, but there is no information given about when the prescription was phoned through / delivered to the Community Pharmacy. Please provide further detail?*
7. *What is the RQIA response to your concerns regarding record keeping. I assume SAI 32865 relates to the same PNH, this report also has a recommendation regarding record keeping.*

3 **SAVE documents to G:Drive/shared Drive**

- Email from DRO with queries/clarification
- Email to Trust for response

4 Insert documents to Datix

5 Update Datix Investigate

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Comments/action taken:

29/08/14: DRO email - I have reviewed this report and after consultation with HSCB colleagues I would make the following comments, and request further detail:-

1. Was the fall witnessed or unwitnessed? I think the latter but it is stated as witnessed in the overview (and as unwitnessed later in the report). Please clarify
2. It is not clear if the GP phoned for the ambulance or if that was delegated to a receptionist.
3. Also, it is not clear what information was given from the GP practice to NIAS to determine the type of

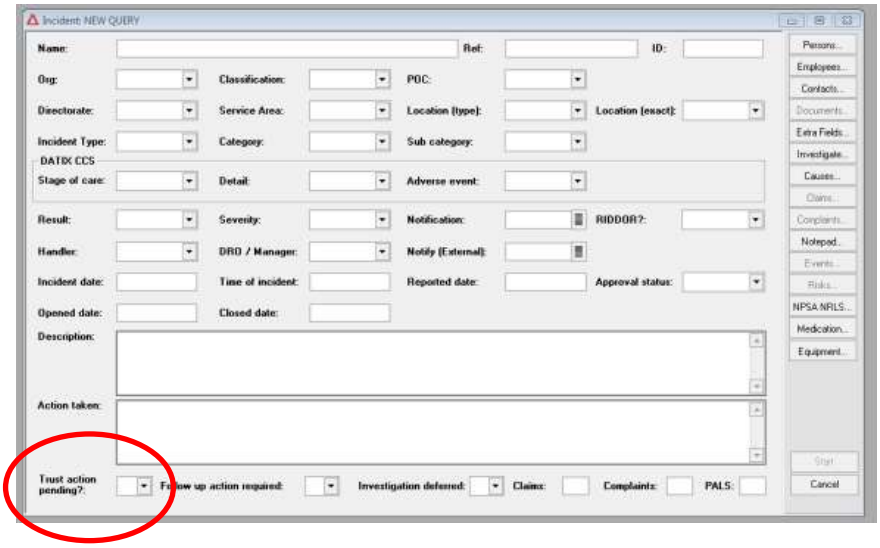
7. What is the RQIA response to your concerns regarding record keeping. I assume SAI 32865 relates to the same PNH, this report also has a recommendation regarding record keeping.

I would be grateful for a response within 4 weeks.

03/09/14: DRO queries forwarded to Trust for response by 1 October 2014.

6 Trust Action Pending

IMPORTANT: Remember to update this box to indicate that action is pending by the Trust by selecting Y from drop down box.



This is a YES or NO field. It is important that this field is completed for each SAI and updated as the review proceeds.

- Select Yes (Y) if action is required by a Trust (e.g. Family Checklist) or a response from the Trust to a DRO query
- Leave blank if action is required by SPPG/PHA

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10 TRUST RESPONSE TO DRO QUERIES

1 Email received from Trust with response to DRO queries

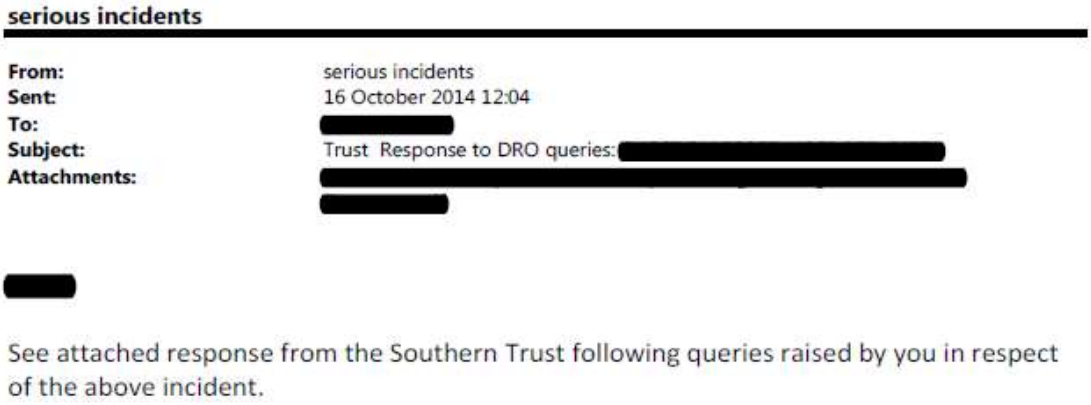
From: [redacted]
Sent: 14 October 2014 12:09
To: serious incidents
Subject: Encryption:- Response for DRO [redacted]
Attachments: [redacted]

Categories: SHSCT actioned

Please find attached a response from the appropriate Directorate.

Regards.

2 Forward Trust Response email to DRO



serious incidents

From: serious incidents
Sent: 16 October 2014 12:04
To: [redacted]
Subject: Trust Response to DRO queries: [redacted]
Attachments: [redacted]

[redacted]

See attached response from the Southern Trust following queries raised by you in respect of the above incident.

NOTE If RQIA received the report, check if their comments have been received. If not, and it is still within the 3 week timescale for RQIA to respond, note on the cover email to DRO that comments are due from RQIA by (insert date)

3 **SAVE documents to G:Drive/shared Drive**

- Trust response to DRO Queries
- Trust response forwarded to DRO

4 Insert documents to Datix

5 **Trust Action Pending**

- **IMPORTANT:** Remember to update this box - Leave blank to indicate action is required by SPPG/PHA

Include comment re asking DRO if OK to share- insert comment

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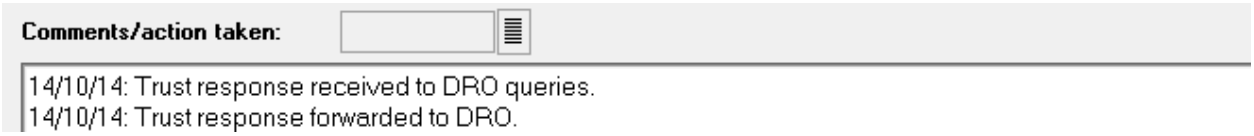
6 Update investigate box



11 CLOSURE OF SAI

When the DRO has received all relevant and necessary information the timescale for closure of the SAI will be within 12 weeks, unless in exceptional circumstances which will have been agreed between the Reporting Organisation and the DRO. (Extract from SAI Procedure, section 12.6)

A SAI can be closed by:

- **Completion of a DRO form.**
  The following POC's complete a DRO form
  - Family and Childcare
  - Elderly
  - Mental Health & Learning Disability
  - Physical Disability and Sensory Impairment
  - Health Promotion and Disease Prevention
  - Primary Health and Adult Community
  - POC-Corporate Business/Other

Or

- The incident being **reviewed/discussed at the appropriate SAI review team meeting** and recommended for closure
  The following POC's have a professional meeting
  - Acute Services
  - Maternity and Child Health

DO NOT close an SAI unless the checklist has been received

COMPLETION OF A DRO FORM

1 Generate DRO Form and send to DRO for completion
Documents – Templates - Template 78

For SAIs relating to Mental Health/Learning Disability a separate DRO Form has been created
Documents – Templates – Template 83
The DRO will list Keywords on the DRO Form to be entered onto Datix. See Appendix xxx and xxx for list of Key Words

2 Upon receipt of a completed DRO form

- Update Investigate Box with the following information from the DRO Form
  - Date: Email from DRO confirming closure. Completed DRO form received.

  DRO COMMENTS
  (copy and paste text from Section 1 of DRO Form)

  FOLLOW UP OF RECOMMENDATIONS / ACTIONS:
  (copy and paste text from Section 3 of DRO Form)

  LEARNING
  (copy and paste text from Section 4 of DRO Form)
  Date: Incident closed. Confirmation of closure to Trust and RQIA (if applicable).

3 LEARNING

Ensure any learning identified in Section 3 of the DRO form is copied into the Lessons Learned field

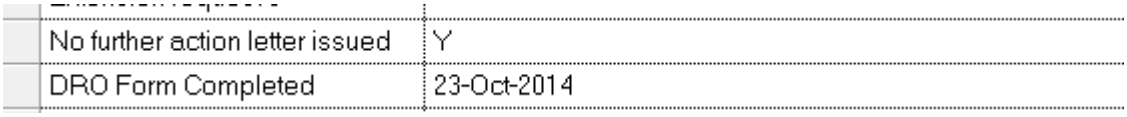
If Learning has been identified, this should be listed for review at the next meeting of the SAI Review Sub-Group. To list the learning for discussion

- Run a position report for the incident – Documents – Templates – 74 – New Position Report
- Save the position report and completed DRO form to G:Drive G:\Common\GOVERNANCE\Regional SAI Review Group\SAI REview Subgroup\2014 – select appropriate meeting
- Ensure this course of action is documented in the review box i.e. Learning identified and placed on agenda for discussion at next meeting of SAI Review Sub-Group meeting on [insert date of meeting]
- Complete comments/action taken box by selecting the appropriate drop down box

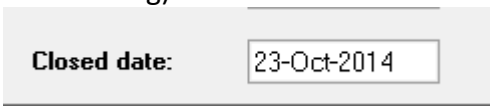
This indicates that the SAI Review Sub-Group has considered learning for this SAI

4 Complete EXTRA FIELDS

- DRO Form Completed – Date field (insert date DRO form received)
- No Further action issued - Y (indicates that closure has been confirmed with the Trust)



- On front screen, complete field Closed date by inserting date SAI was closed (i.e. date of Review Team Meeting).



5 Issue confirmation of closure email to Trust by using the appropriate template copy to RQIA (See T10 - Appendix 1)

- Closure Email to Trust for Learning Summary/RCA Report where **no** learning identified
- Closure Email to Trust for SEA/RCA Report where **LEARNING** has been identified
- Local Learning??? Can DRO form be copied to Trust with closure email??

6 Save Documents to G:Drive/shared drive in PDF format

- Confirmation of closure email from DRO
- Completed DRO form
- Confirmation of closure to Trust
- Confirmation of closure to RQIA (if appropriate)

8 Insert Documents to Datix

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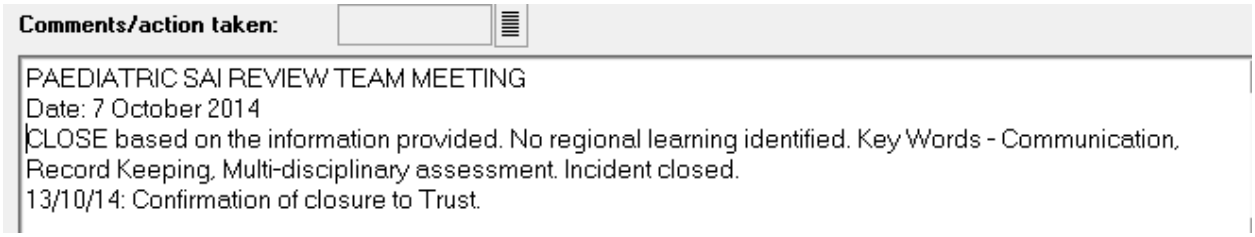
CLOSED AT SAI REVIEW TEAM MEETING

1 SAI is considered at the appropriate SAI Review Team Meeting.

2 Following the meeting an Action Log is issued identifying the outcome of the review and the action.

ID	TRUST REF - Summary	HSCB REF	OUTCOME OF REVIEW AND ACTION (close / further info / other prof input)	KEY WORDS
XXXX	Trust Reference Description of incident	XXXX	CLOSE based on the information provided. No regional learning identified.	Communication Record Keeping Multi-disciplinary assessment

3 • Update Investigate Box with the following information from the Action Log



Note: If RQIA were included in the Initial Notification note that confirmation of closure was sent to RQIA.

4 LEARNING

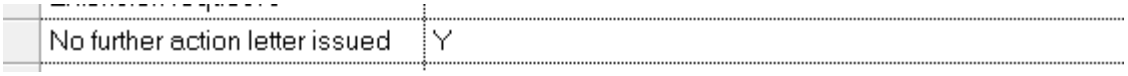
Ensure any learning identified is copied into the Lessons Learned field

If Learning has been identified, this should be taken to the next meeting of the SAI Review Sub-Group. To list the learning for discussion

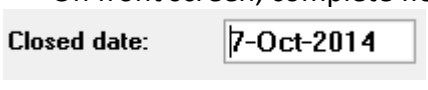
- Run a position report for the incident
- Save the position report and completed DRO form to G:Drive G:\Common\GOVERNANCE\Regional SAI Review Group\SAI REview Subgroup\2014 – select appropriate meeting
- Ensure this course of action is documented in the review box i.e. Learning identified and placed on agenda for discussion at next meeting of SAI Review Sub-Group meeting on [insert date of meeting]
- Complete Extra Fields?

5 Complete EXTRA FIELDS

- No Further action issued - Y (indicates that closure has been confirmed with the Trust)



- On front screen, complete field Closed date by inserting date SAI was closed.



6 Issue confirmation of closure email to Trust
Use the appropriate template (See Appendix 1)
T10 Closure Email to Trust for Learning Summary/RCA Report where no learning identified
T10 Closure Email to Trust for Learning Summary /RCA Report where LEARNING has been identified

7 Issue confirmation of closure email to RQIA (**attach** a copy of completed DRO form where appropriate)

Cover email T10 – Appendix 1

8 Save Documents to G:Drive/shared drive in PDF format

- Action Log from XXX SAI Review Team
- Confirmation of closure to Trust/DRO
- Confirmation of closure to RQIA (if appropriate)

9 Insert Documents to Datix

12 REQUEST FOR DE-ESCALATION (SAI WITHDRAWN)

1 Email/letter received from Reporting Organisation requesting de-escalation of SAI.

For level 1 SAI's – list for Incident Reveiew Review Group to discuss. Outcome will be communication via the Incident review log.

For Level 2 SAI's Check DRO for incident and get SPPG Ref.

2 Forward Trust Email/letter to DRO

Email Subject: Request for De-escalation: Trust Ref: XXXXXX SPPG Ref: XXXX

Incident: Summary of Incident

Please see attached email/letter from XXXXXX Trust requesting de-escalation of the above incident. Please confirm your approval to this request.

*The DRO will review the request to de-escalate and will inform the reporting organisation and RQIA (where relevant) of the decision as soon as possible and at least within **10 working days** from the request was submitted, as per Section 7.6 of the SAI Procedure*

3 Save emails to G:Drive/Shared Network

- Email from Trust requesting De-escalation
- Email to DRO seeking approval to de-escalation request

4 Insert Documents to Datix

5 Update **Investigate:**

(Date): Email from Trust requesting consideration be given to de-escalating the SAI. Request forwarded to DRO for approval noting timescale as per point 2 above.

6 Upon receipt of reply from DRO, communicate this to the Reporting Organisation – cc: DRO and RQIA is applicable

Example of wording for email if Request approved

Email Subject: Request for De-escalation: Trust Ref: XXXXXX SPPG Ref: XXXX

The DRO has considered your request for de-escalation and I wish to advise that this incident has been de-escalated and there are no further issues in relation to this case. This incident has now been closed on the Datix system.

7 Save emails to G:Drive/Shared Network

- Email from DRO re De-escalation
- Email to Trust re de-escalation request (copy to RQIA is applicable)

8 Insert Documents to Datix

9 Update **Investigate:**

(Date): Email from DRO approving de-escalation. Trust (RQIA is applicable) notified.

10 Update Datix front screen

- **Classification:** Select De-escalated SAI from drop down box

- **Closed Date: I**nserting date SAI de-escalated

11 Mark Actioned/Categorise In-box

12.1 SAI considered for Case Management Review

Following notification and initial review of a SAI, more information may emerge that determines the need for a specialist investigation, such as a Case Management review (CMR).

1 The Trust will notify serious incidents if the SAI has been referred to SBNI for consideration of a CMR.

2 Respond to the email from the Trust requesting H&C Number (**Template CMR 1**).

3 Forward an email to the DRO noting that the incident has been referred to SBNI for consideration of a CMR (**Template CMR 2**).

Update Datix:

- Select **Extra Fields** mark **Investigations deferred** as 'Y'.

- **SPPG Follow Up Due Date**: 1 week (to follow up H&C Number from Trust – when the H&C number is received ensure a follow up date is entered for 6 weeks from date incident was referred to follow up with M Burke)
- **Status**: H&C Number Requested - SAI being considered for CMR

- Upon receipt of the H&C number

Update Datix:

- Select **Persons** tab, then enter the number in **NHS No**:

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Process following SBNI decision re CMR

- If the SBNI decide **to hold** a CMR:

  Upon confirmation from Margaret Burke*, SBNI, that a CMR will be held for this incident send an email to the Trust, copied to DRO and RQIA if applicable (**Template CMR 3**)

  Update Datix:

  - Enter the date in **closed date** on front screen on Datix.
  - **Investigation Deferred**: Remove the 'Y' and leave blank
  - **SPPG Follow Up Due Date**: leave blank
  - **Status**: CMR

- If the SBNI decide **not to hold** a CMR

  Upon confirmation from Margaret Burke*, SBNI, that a CMR will **not** be held for this incident forward an email to the DRO (**Template CMR 3**):

  Update Datix:

  - **Investigation Deferred**: Remove the 'Y' and leave blank
  - **SPPG Follow Up Due Date**: 1 week
  - **Status**: DRO to confirm approval of timescales

- Following confirmation from DRO

  Upon confirmation from the DRO update the Trust as per timescales for completion of ToR & Team Membership (if applicable) and Review Report (**Template CMR 4**).

  Update Datix:

  - **Level 2 ToR due**: enter date we type over the old ToR date due, is that OK??
  - **LSR/RCA Revised Due Date**: enter revised date
  - **SPPG Follow Up Due Date**: enter date after ToR due date
  - **Status**: ToR Due

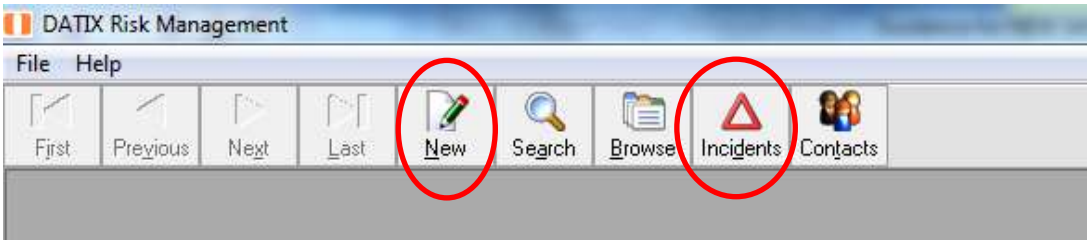
Effective 24 June 2022 - Trusts to provide an update at bi monthly Performance meeting on all Deferred SAIs.

13 EARLY ALERTS (See Appendix ?? for Early Alert Process)

Early Alert Process is not anonymous therefore we are not required to remove any reference to personal information.

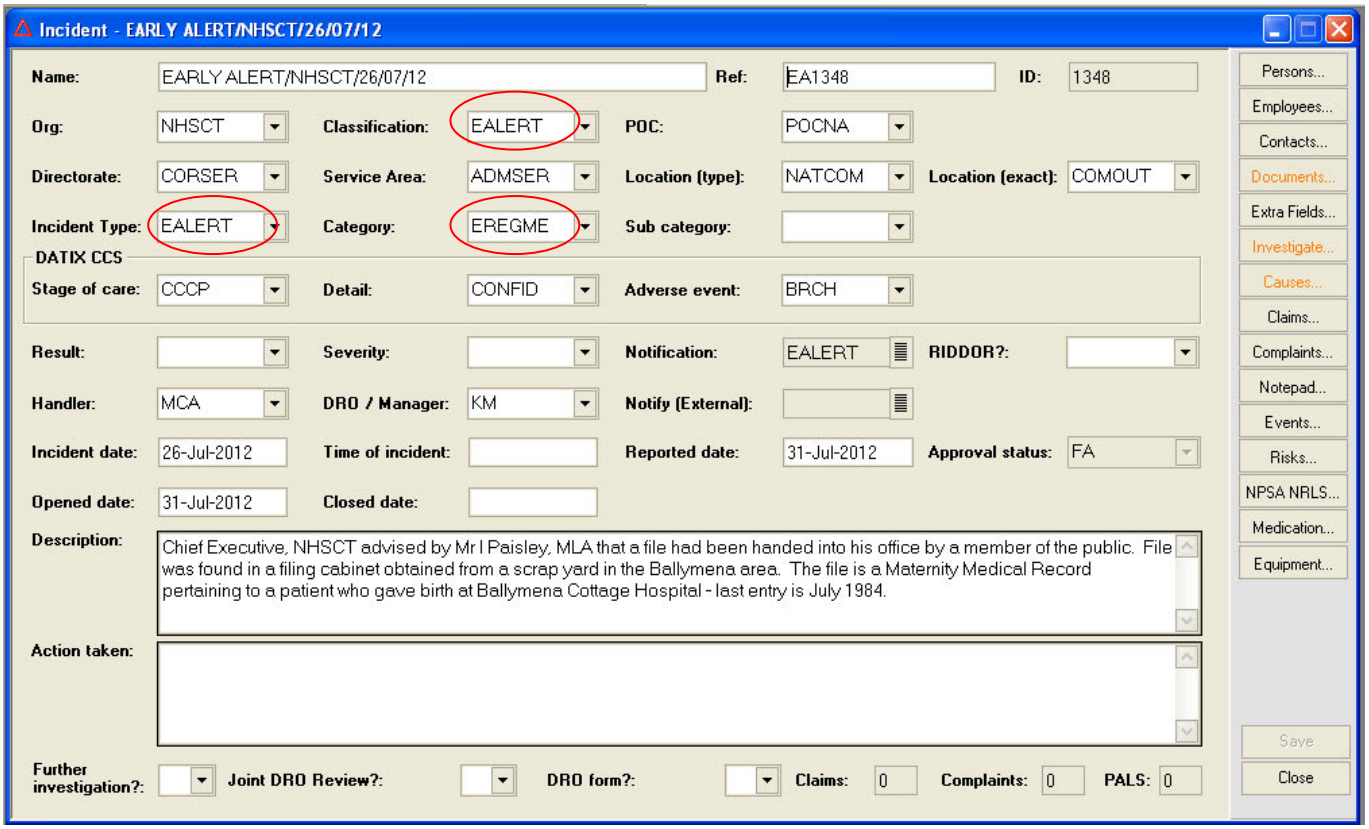
1 Create new Record

- In Datix, select Incidents and then New



2 Complete as many fields as possible from information contained in Early Alert

Name: = EARLY ALERT/TRUST/DATE OF EARLY ALERT (e.g. EARLYALERT/BHSCT/12/09/14) UNLESS the Trust specifically allocates the Early Alert with a Name/Number
Ref: = EA + ID number that Datix generates when record is saved



Org: Reporting Organisation
Classification: **Early Alert**
POC: }
Directorate: }

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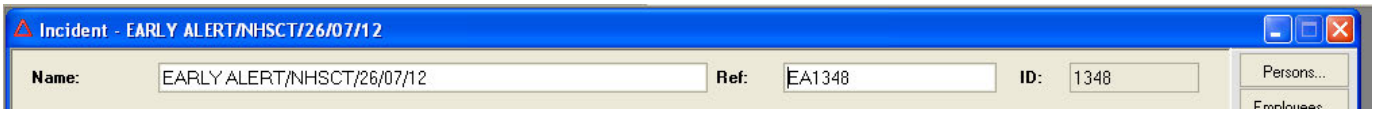
Service Area: } code as normal
Location: }
Incident Type: **Early Alert**
Category: This is the criteria on the Early Alert proforma (If the Trust tick more than one criteria, enter the first one in Category
Stage of Care: }
Detail: } code as normal
Adverse Event: }
Result: code as normal
Notification: Early Alert
DRO/Manager: Lead Officer-??
Description: Copy details from Early Alert proforma
Action Taken: Copy details from Early Alert proforma

3 **Save.** This generates an ID number. Copy ID number into **Ref Field**



4 **Save**

5 **Save Early Alert to G: Drive/shared drive**

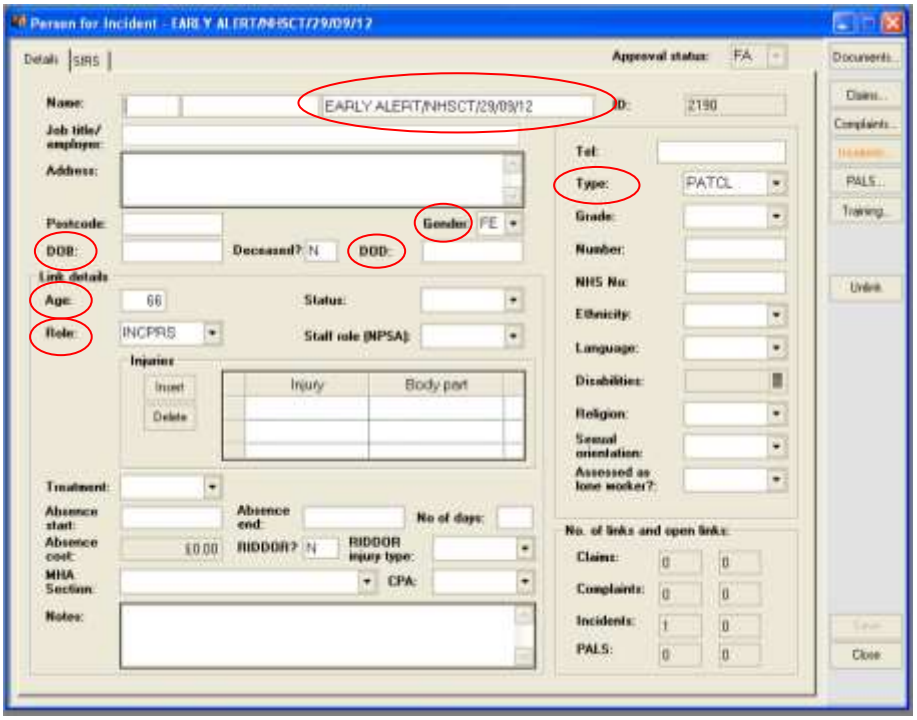
NOTE: Password Protect Early Alert Notification with: ealert2011 when forwarding to Lead Officer

- Create sub-folder on G: Drive/shared drive as follows select G: Common: SAI: Early Alerts: Reporting Organisation - Create new folder (Ref: i.e. EA1234).

6 Complete **Persons** field where information available i.e.

- Name
- Date of birth
- Date of death
- Gender
- Role
- Persons

SAVE



7 Save Documents to G: Drive

- Early Alert Notification Email
- Early Alert Proforma
- Email to Lead Officers

8 Save Documents to Datix (Documents section of Datix record)

- Early Alert Notification Email
- Early Alert Proforma
- Email to Lead Officers

9 In Datix Actions and Review – comments/actions taken:

DATE: Early Alert received and saved to be circulated in Daily report

10 In Inbox mark actioned

- Red to indicate New Early Alert
- Colour appropriate to reporting Trust
- Move email to Early Alert Sub Folder of Inbox

11 Insert 4 week date into SPPG Follow Up Due Date

If an SAI is subsequently received for the Early Alert, the Early Alert is automatically closed by Governance Staff

13 Notification: add SAI Report ?????
Closed Date: Insert date SAI Report received

Note in description the reference of SAI that Early Alert is linked to

14 Review:
Date: SAI Report received. Early Alert closed.

16 The Early Alery will be discussed at the Weekly Incidnet Reivew Group meeting. An action note will detail the action required.

Once confirmation has been received that Early Alert can be closed, complete on the Datix record

Closed Date:

17 Review:
Date: Copy and paste the extract from Incident Review Group Action note.

18 Add the details on the Early Alert to the closure report

Also save any emails between SeriousIncidents and the Lead Officer regarding the Early Alert

If a new Early Alert is linked to an open SAI.

- Close the Early Alert
- Link the EA to the SAI.
- If SAI is assigned a DRO, forward a copy of the EA for information. For a level 1 SAI assigned to a Professional Group, you are not required to forward the EA as it will be discussed at the Incident Review Group, as each Programme of Care is represented at this group.
- The Early Alert will be circulated in the daily report and following discussion at the Incident Review Group, members will advise if any further action if required.

If a new Early Alert is linked to a closed SAI.

- The EA will be circulated in the daily report and will be discussed at the Incident Review Group, members will advise if the EA can be closed and if any further action if required.
- Copy the EA to the DRO for information. For a level 1 SAI assigned to a Professional Group, you are not required to forward the EA.

14 INTERFACE INCIDENTS

Insert flowchart for Interface Incidents

NOTE: Password Protect Interface Notification with: interface@1 when forwarding to Lead Officer/CC list

Interface incidents are those incidents which have occurred in one organisation, but where the incident has been identified in another organisation. In such instances, it is possible the organisation where the incident may have occurred is not aware of the incident; however the reporting and follow up review may be their responsibility. It will not be until such times as the organisation, where the incident has occurred, is made aware of the incident; that it can be determined if the incident is a SAI.

Some of these incidents will subsequently be reported as SAIs and may require other organisations to jointly input into the review. In these instances refer to Appendix 13 of the SAI Procedure – Guidance on Joint Reviews.

1 HSC Interface Incident Notification Form received from organisation where the incident was identified

2 Log Interface Incident onto Datix following steps 2, 3 and 5 outlined in Section 2 – Logging New Incidents

NOTE the following fields will be different:

Name: Copy Trust Reference
Ref: = Initial of Reporting Organisation + II + ID number that Datix generates when record is saved
Classification: Select Interface Incident
Notification: Select Interface Incident Report
DRO/Manager: Assign Lead Officer as appropriate for the area in which the incident occurred
Description: Copy and paste from Interface Incident Notification Form

- Which Organisation/Provider (From Those Listed In Sections 6 And 7 Above) Should Take The Lead Responsibility For The Review And Follow Up Of This Incident? – XXXXX Trust
- Other Comments:

2 **Acknowledgement to Organisation who Reported Interface Incident**

- Reply to notification email from Trust
- Use appropriate template (T12 – Appendix 1)

3 ~~**Advise Organisation where Incident Occurred** (Integrated Care - this will be one of the Business Support Managers in the local Integrated Care Office)~~

- ~~Forward notification email from Organisation who reported Interface Incident~~
- ~~Use appropriate template (T12 – Appendix 1)~~
- ~~Copy to the Lead Officer for the Trust area in which the incident occurred. Also copy to the circulation list as per the PoC within the Regional Listing for SAIs – see template~~

~~**Forward Notification to the Early Alert / Interface Incident Distribution list** (Template 12.1)~~

4 **Save Documents to G: Drive/shared drive in PDF format**

- Create sub-folder on G: Drive/shared drive as follows select G: Common: SAI: Interface Incidents: Reporting Organisation - Create new folder (Ref: i.e. BII1234).
- Save the following Documents to G: Drive/shared drive
  - Interface Incident Notification Email
  - Interface Incident Notification Form
  - Acknowledgement Email
  - ~~Interface Notification forwarded to XXXXXX [insert organisation where incident occurred]~~

5 **Insert Documents to DATIX**

6 **Update DATIX**

Investigate: (date): Interface notification received and saved to be circulated in Daily report

~~**Extra Fields:** Enter SPPG Follow Up Due Date as per template~~

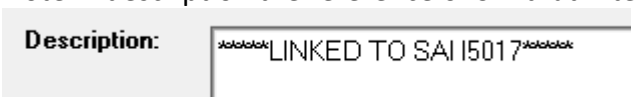
7 **In Inbox mark actioned**
- Red to indicate New Notification
- Black to indicate Interface Incident
- Colour appropriate to reporting Trust
- Move email to Interface Incident Sub Folder of Inbox

Organisation where the incident occurred considers notification in order to ascertain if the incident will be reported as a SAI.

If an SAI is subsequently received for the Interface Incident, the Interface Incident is closed

8 Closed Date: Insert date SAI Report received

Note in description the reference of SAI that Interface Incident is linked to



9 Update Investigate

10 Notify Reporting Organisation that a SAI has been received.
- Reply to notification email from Organisation who reported Interface Incident
- Use appropriate template (T12 – Appendix 1)

11 **Save Documents to G: Drive/shared drive in PDF format**

  - Closure email to [organisation who reported Interface Incident]

12 **Insert Documents to DATIX**

13 **Update DATIX Investigate**
Date: SAI notification received from [organisation incident occurred – Ref xxxxxx]. Interface Incident

closed. Trust advised.

The Officer responsible for the area where the incident occurred will log the SAI onto Datix

If a SAI is NOT received for the Interface Incident, this needs to be followed up

- Once a lead Trust/organisation has been notified regarding the interface incident they should be given 3-4 weeks to submit this as an SAI
- If no SAI is received within this timeframe the interface incident should be taken to the respective Review Team meeting or if there is no review team to the Regional SAI Review Sub-Group to decide whether it is felt this should be followed up regarding submission of an SAI.

14 Place the Interface Incident on the Agenda for the next meeting of the respective SAI Review Team/Regional SAI Review Sub-Group

15 Following consideration by the Group, an Action Log will be produced outlining the action agreed. If the Group agrees the interface incident meets the criteria of an SAI, Governance Team will write to the organisation where the incident occurred requesting they submit an SAI

- Forward notification email from Organisation who reported Interface Incident
- Use appropriate template (T12 – Appendix 1)

16 **Save Documents to G: Drive/shared drive in PDF format**

- Xxx Review Team Action Log

17 **Insert Documents to DATIX**

18 **Update DATIX Investigate**

EXAMPLE

28/10/14: XXXXX SERVICES SAI REVIEW TEAM MEETING ACTION LOG UPDATED 28 October 2014
Copy and paste action agreed from Action Log
31/10/14: Email to NHSCT requesting they report as an SAI by 14 November 2014.

15 CHILD DEATH NOTIFICATION PROCESS

Log same as an SAI but classify as a CDN

i.e. **Classification:** Select as appropriate from drop down field

(refer to template for mapping – Page 89)

Review section 8 of CDN form to link if it is related to a previously reported SAI or check if this is to be reported as an SAI.

Please note: all CDN Notifications are to be password protected using the password - CDN2016

Send CDN to Sinead Magill/Heather Reid/Eilidh McGregor /Emily Roberts and note if this relates to a previous SAI and include reference numbers or if the reporting organisation plans to submit this as an SAI;

Governance Team to acknowledge notification via email to reporting organisation – see template below

No further work required for Governance Team unless the CDN states there is to be an SAI submitted (therefore Governance Team to follow up as would be undertaken with Early Alerts/Interface Incidents and record on Datix re follow ups) – all communication will then be undertaken by Sinead and she will update Datix with all emails and correspondence

When the CDNs have been reviewed at the Maternity Review Group meeting no action is required from the Governance Team **UNLESS** an Action has been agreed for the Governance Team to following up an issue with the Trust

Acknowledgement Email

This communication acknowledges receipt of the Child Death Notification made to the SPPG cdnotifications@hscni.net mail box.

Regards,

Email circulating child death notification to relevant staff i. e Sinead Magill/Heather Reid/ Eilidh McGregor /Emily Roberts
Copy to Governance Team, i.e. Anne Kane, Jacqui Burns, Margaret McNally, Mareth Campbell, Geraldine McArdle, Elaine Hyde, Elaine Hamilton

Please note: all CDN Notifications are to be password protected using the password - CDN2016

Please find attached child death notification received from xxxxxx Trust on xx xxxxx 2017. This notification has been logged on the Datix system

Trust Ref: xxxxxxx
SPPG Ref: xxxxxxx

An acknowledgement of receipt of this notification has been forwarded to the XHSCT.

16 PHA/SPPG PROCESS FOR MANAGING SAIs THAT ARE SOLELY RELATED TO THE INDEPENDENT SECTOR (approved by SQAT on 24 July 2014)

Interface Notification received by Governance Team Inbox at seriousincidents@hscni.net and copied for information only to:

- Medical Director/Director of Public Health (Dr C Harper)
- AD Service Development/Screening (Dr J Little)
- Director of Nursing/AHPs (P Cullen)
- AD Nursing (O Brown)
- Safety Quality and Patient/Client Experience (M McElroy)
- Head of Service Contracts (D McAteer)
- AD Commissioning (P McLaughlin)

Governance Team record Interface Notification on DATIX and close

Governance Team forward Interface Notification to RQIA for action as appropriate

Governance Team place Interface Notification onto agenda for next Regional SAI Review Sub-Group meeting for information

July 2014

17 OVERDUE/OUTSTANDING REVIEW REPORTS – Letter to Chief Executives

On a monthly basis, SPPG Chief Executive writes to Trust Chief Executives attaching a report highlighting all outstanding review reports in their Trust area. Once the letters have been issued from the Chief Executive's office, an email will be issued to Serious Incidents advising that the letters have been issued. A copy of each letter and report can be accessed via the following link G:\Common\GOVERNANCE\SAI\Cx SAI reports to Cx

Datix must be updated as follows:

1 Extra Fields - complete the following fields

CE Overdue IR's issued	
CE Overdue IR's issue Number	

CE Overdue IR's issued Insert date of the letter to the Trust Chief Executive
CE Overdue IR's issue Number Insert the number of letters issued

Example
BHSCT/SAI/14/30 (B3905) was listed on the May, June and August reports.

CE Overdue IR's issued	21-Aug-2014
CE Overdue IR's issue Number	3

21-Aug-2014 is the date the latest letter was issued to the Trust

3 indicates that this is the third time the Trust have been notified that the report remains outstanding (listed on May, June and August reports).

2 Save documents (letter and status report) to G:Drive as
- Letter to Trust Chief Executive re: outstanding Review Reports
- XHSCT outstanding-overdue SAI Reports – Position @ xx-xx-xx

3 Insert documents to Datix

4
- Update investigate field
  E.g. 21/08/14 – Letter from SPPG CX to Trust CX attaching status report highlighting all review reports that remain outstanding as at 15 August 2014.

18 CODING

• CHILD DEATH NOTIFICATIONS

Datix Result Field

All child deaths notified are to be recorded in result field on Datix as **'DEACR2'**

Datix Adverse Event Field

1) Where the child death criteria in section 13 (*any death of a child in receipt of HSC services (up to eighteenth birthday). This includes hospital and community services, a Looked After Child or a child whose name is on the Child Protection Register)* has only been selected please record the Adverse Event as **'CHLDTH'** and not the adverse event as indicated by the reporting organisation on the notification form.

   Following review of the description of the incident within the notification form if you are unclear if the SAI has been reported under the child death criterion or another criterion and clarification regarding the correct coding is required this can be discussed directly with Jacqui or Mareth for clarification. Should further clarification be required Jacqui will raise for discussion at the relevant professional group.

2) Where the Child Death criteria **and** another criterion has been selected please code the Adverse Event Field in Datix with the relevant code as you would normally.

Child Death Suicides

With regards to notifications relating to Child Death Suicides these are all to be recorded in the Adverse Event field as '**SUICI'** regardless of the criterion selected by the reporting organisation.

• PAEDIATRIC CONGENITAL CARDIAC SERVICES

SAIs where the child has been transferred to another hospital for treatment should all be coded as **TRSCMS** (HSC Trust Commissioned) within the **Location Type** field.

To further enhance the coding of PCCS SAIs – some **additional fields to the Location Exact fields** have been introduced as follows: -

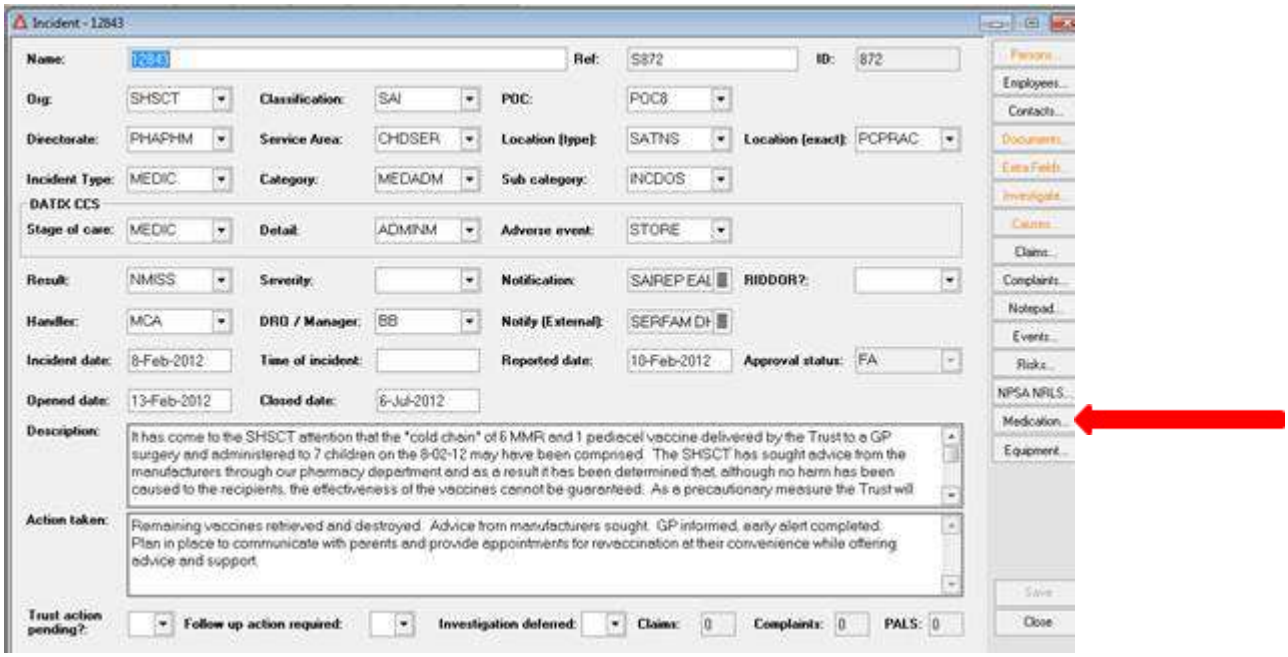
- **UKPCS** – UK Paediatric Congenital Cardiac Services this code is to be used when a child is transferred to a UK facility and a SAI is reported (including a child death) whilst receiving care in this facility

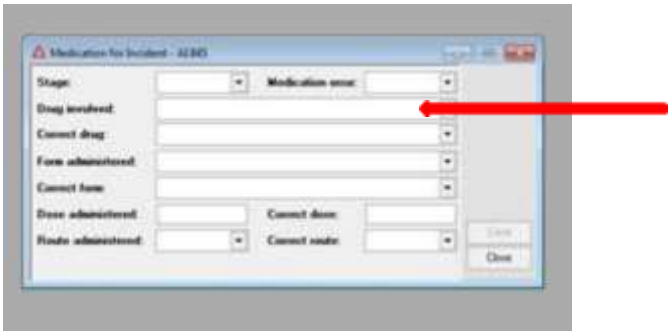
- **ROIPCS** – ROI Paediatric Congenital Cardiac Services this code is to be used where a child is transferred to a ROI facility and a SAI is reported (including a child death) whilst receiving care in this facility

- **NIHSPC** – NI Children's Hospice - this code is to be used where a child is transferred to the NI Children's Hospice and a SAI is reported (including a child death) whilst receiving care in this facility

- **MEDICATION RELATED SAIs**

Where a drug is referenced in the description of a SAI the Medication tab on the front screen of Datix is to be completed. When it is opened complete the 'Drug involved' field – see below.





19 TIMESCALES FOR FOLLOW-UPS WITH REPORTING ORGANISATIONS/ DESIGNATED REVIEW OFFICERS (DROs) *[Version as at 23 November 2016]*

1) Follow Ups with Reporting Organisations

- **Immediate Actions**

Following circulation of the SAI Notification the DRO may come back to Serious Incidents with a query for immediate action. Regardless of the level an urgent response should be requested but to be returned in no less than 1 week. (Bring Forward on Datix for one week and follow up).

- **Additional Information Requested following receipt of the Learning Summary / Review Report**

  Timescale for reporting organisation to respond to DRO queries is as follows:

  - Level 1 – **SPPG follow up Due Date**: 2 weeks
  - Level 2 or 3 – **SPPG follow up Due Date**: 6 weeks

  Time allowed for response is at the discretion of the Governance Officer depending on complexity of queries being forwarded to Trust (not to exceed 6 weeks for a level 2 unless instructed by DRO)

- **Terms of Reference (Please note outstanding ToR and Membership does not follow the routine guidelines of 2 reminders and telephone call before escalating)**

  Terms of Reference should be submitted 4 weeks after date of notification. Upon receipt of the Notification the SPPG Follow Up date should be the day after the ToR is due.

  If the ToR is not submitted by this date, follow up with an email requesting submission by [**insert date - 1 week from date of this email**] and reason for delay (ensure any Trust response is forwarded to the DRO).

  If not received within 1 week, the Terms of Reference will be listed as outstanding in the monthly report which is forwarded to the Trusts.

- **Checklists**
  If a checklist has not accompanied the SEA/ RCA report then email the reporting organisation requesting submission by return. (Bring Forward on Datix for one week and follow up).

2) Trust request for De-escalation of a SAI

The DRO will review the request to de-escalate and will inform the reporting organisation and RQIA (where relevant) of the decision as soon as possible and at least within **10 working days** from the request was submitted.

3) Follow Ups with DROs

Timescale for closure of a SAI
When the DRO has received all relevant and necessary information the timescale for closure of the SAI will be within 12 weeks, unless in exceptional circumstances which will have been agreed between the Reporting Organisation and the DRO.

SPPG follow up Due Date: 4 weeks for update from DRO

MAHI - STM - 097 - 10370

Note:

a) Follow up with DROs for POC 1 & 2 and Prison SAIs will be agreed at Professional Groups and then to be taken forward following the issue of action logs;

b) Timescales for response by reporting organisation may change from the above if the DRO has approved a specific timescale;

c) For follow ups re Early Alerts and Interface Incidents please refer to flowcharts.

MAHI - STM - 097 - 10371

Reminder / Escalation Process

If there has been no response to initial email to Trust / DRO follow the steps below:

1. 1st Reminder Email:

Forward initial email reminding the Trust / DRO that their response is outstanding (don't enter a date for response).

Status: e.g. 1st Reminder email sent to DRO / Trust

SPPG follow up Due Date: 1/2 weeks – depending on query / information outstanding

2. 2nd Reminder Email:

Forward previous emails and mark as urgent. Re-write the query / ask for whatever information is required in this email so that the recipient does not have to scroll through emails to find out what is required. Ask the DRO / Trust for an urgent response advising that if a response is not received the matter will be escalated.

Status: e.g. 2nd Reminder email sent to DRO / Trust

SPPG follow up Due Date: 1/2 weeks – depending on query / information outstanding

3. Telephone Call

Make a phone call to the Trust/DRO at this stage highlighting outstanding response – note all correspondence in investigate field.

4. Escalate

Use the template below to escalate Incidents to Geraldine / Elaine:

Trust	POC	Trust Ref	SPPG Ref:	Information Outstanding	Governance Team Action to Date
XXX	XXX	XXX	XXX	State what information is outstanding / awaited	**Example**: 15/12/16: DRO queries to Trust 06/01/17: 1st Reminder sent to Trust 13/01/17: 2nd Reminder sent to Trust 20/01/17: Telephone call to Trust by Governance Team 27/01/17: Escalation to Geraldine / Elaine

Status: Escalate

SPPG follow up Due Date: 1 week (this will be updated by Geraldine / Elaine when actioning the email from serious incidents)

If the outstanding information is not received following escalation by Geraldine / Elaine forward back to them noting that it remains outstanding. Geraldine / Elaine will then escalate to Assistant Governance Managers if required.

MAHI - STM - 097 - 10373

Daily Follow Ups

Org: (eg PCARE)

Classification: (eg EALERTS, SAI, INTFCE)

Extra Fields

Field Name: Select from Drop Down - SPPG Follow Up Due Date

Type in the box to the right: <28/05/16 *(enter tomorrow's date, this will bring up all follow ups due on or before todays date)*

Incidents to be followed up will then be listed *(there is no need to print off a report, take a note of them and work through them each day)*

SPPG/PHA KEY STAGES FLOW CHART FOR PROCESSING SHARED LEARNING TEMPLATES RECEIVED FROM TRUSTS

Trust submit Shared Learning template[1] to SPPG to: **seriousincidents@hscni.net**

SPPG Governance Team open new record on Datix and categorise as RAIL. ***(NB: If linked to a previously notified SAI/EA the RAIL record will be opened and closed and all correspondence saved to the SAI/EA Datix Record.)***

SPPG **acknowledges** by email receipt of Shared Learning to Trust

Shared learning linked to a SAI/EA – List for the relevant professional group

Shared learning not linked to SAI/EA – List for Incident Review meeting

If there is no relevant professional group

- If not linked to a previous SAI/EA the SPPG Governance Team will list this for the next relevant Incident Review Group meeting for decision to be reached on if there should be regional learning
- Action notes following meeting will advise any further action

If there is a relevant professional group

- If linked to a previous SAI/EA the SPPG Governance Team will list for professional group and DRO to consider if in their professional opinion regional learning should be issued;
- Action notes following meeting will advise any further action

SPPG/PHA Professional Group decide **not to issue regional learning**

SPPG/PHA Professional Group **agree regional learning** options:

- Referral to Existing Work stream, Network or Group for action;
- Newsletter Article i.e. Learning Matters, MedSafe, GMS;
- Inclusion in NI Medicines Governance Team Quarterly Report.

SPPG/PHA Regional SAI Review Sub Group **recommends regional learning** options:

- Rapid / Immediate Alert;
- Learning Letter / Alert;
- Learning / Good Practice reminder;
- Propose Thematic Review;
- Establish a task and finish group;
- Refer to other regulatory body;
- Training Events;
- Workshops / Seminars.

REGIONAL LEARNING referred to existing Work stream / Network / Newsletter publication team

↓

REGIONAL LEARNING referred to IRG for noting / approval

↓

PROPOSAL TO ISSUE REGIONAL LEARNING APPROVED by Safety Brief

(refer to the SPPG/PHA Flowchart for the Approval & Dissemination of Learning)

↓

SPPG Governance Team **advise Trust on outcome** following formal issue of Action Log *(where this is linked to an SAI/EA the regional learning is to be updated on Datix).*

APPENDIX 1

TEMPLATES

MAHI - STM - 097 - 10377

T1 SAI ACKNOWLEDGEMENT to Reporting Org - FOR LEVEL 1 REVIEW

(for POC 1 Level 1 reviews – see distribution list)

TO: REPORTING ORGANISATION
CC: RQIA (where relevant – see note below)

SUBJECT: ACKNOWLEDGEMENT – Trust Ref: XXXXX SPPG Ref: XXXXX

This communication acknowledges receipt of the Serious Adverse Incident Notification made to the Strategic Planning and Performance Group (SPPG) of the Department of Health seriousincidents@hscni.net mail box and confirms that the **INSERT REPORTING ORGANISATION** will complete a **LEVEL 1** Significant Event Audit (SEA) review relating to this SAI.

Trust Ref:

SPPG Ref:

In line with the Regional Procedure for the Reporting and Follow up of SAIs, November 2016, please provide a copy of the redacted **Learning Summary Report** by **INSERT DATE (8 weeks from date of notification)** and forward directly to seriousincidents@hscni.net.

****If the SAI is mental health related, is a Prison Healthcare SAI or is a Level 1 Never Event use the following to request the full SEA report:**

In line with the Regional Procedure for the Reporting and Follow up of SAIs, November 2016, please provide a copy of the redacted **Significant Event Audit (SEA) Report** by **INSERT DATE (8 weeks from date of notification)** and forward directly to seriousincidents@hscni.net.

*The DRO for this SAI is xxxxxxxxxxx (if DRO assigned from Flowchart)
*The DRO for this SAI will be confirmed in due course (if request has been issued for DRO)
Delete as appropriate

All communication between SPPG/PHA and reporting organisation must be conveyed between the SPPG Governance department and Governance departments in respective reporting organisations. This will ensure all communication both written and verbal relating to the SAI, is recorded on the SPPG DATIX risk management system.

If the SAI is related to a Child Death, check if the CDN has been received, if not include the following statement:
In line with Circular HSS (MD) 1/2016 - PROCESS FOR REPORTING CHILD DEATHS the SPPG/PHA await a Child Death Notification relating to this SAI, please submit to cdnotifications@hscni.net within 12 weeks of this SAI notification.
(Copy Sinead Magill into the acknowledgement email)

PLEASE NOTE THAT IF RQIA HAVE BEEN INCLUDED IN THE INITIAL NOTIFICATION (CHECK EMAIL ADDRESS AND REPORT FORM) THEN THEY MUST BE COPIED INTO THIS EMAIL AT seriousincidents@rqia.org.uk .
Please remember to remove highlighted text from email

MAHI - STM - 097 - 10378

T2 SAI ACKNOWLEDGEMENT to Reporting Org - FOR LEVEL 2 REVIEW

TO: REPORTING ORGANISATION
CC: RQIA (where relevant – see note below)

SUBJECT: ACKNOWLEDGEMENT – Trust Ref: XXXXX SPPG Ref: XXXXX

This communication acknowledges receipt of the Serious Adverse Incident Notification made to the Strategic Planning and Performance Group (SPPG) of the Department of Health seriousincidents@hscni.net mail box and confirms that the **INSERT REPORTING ORGANISATION** will complete a **LEVEL 2** Root Cause Analysis (RCA) review relating to this SAI.

Trust Ref:

SPPG Ref:

In line with the Regional Procedure for the Reporting and Follow up of SAIs, November 2016, please provide the following:

- the **Terms of Reference and Membership** of the review team by completing sections 2 and 3 of the SPPG RCA template and submitting directly to seriousincidents@hscni.net by no later than **INSERT DATE (4 weeks from date of notification)**
- submit a copy of the redacted **RCA Report** for this SAI by no later than **INSERT DATE (12 weeks from date of notification)** directly to seriousincidents@hscni.net.

*The DRO for this SAI is xxxxxxxxxxxx (if DRO assigned from Flowchart)
*The DRO for this SAI will be confirmed in due course (if request has been issued for DRO)
Delete as appropriate

All communication between SPPG/PHA and reporting organisation must be conveyed between the SPPG Governance department and Governance departments in respective reporting organisations. This will ensure all communication both written and verbal relating to the SAI, is recorded on the SPPG DATIX risk management system.

PLEASE NOTE THAT IF RQIA HAVE BEEN INCLUDED IN THE INITIAL NOTIFICATION (CHECK EMAIL ADDRESS AND REPORT FORM) THEN THEY MUST BE COPIED INTO THIS EMAIL AT seriousincidents@rqia.org.uk .

If the SAI is related to a Child Death, check if the CDN has been received, if not include the following statement:
In line with Circular HSS (MD) 1/2016 - PROCESS FOR REPORTING CHILD DEATHS the SPPG/PHA await a Child Death Notification relating to this SAI, please submit to cdnotifications@hscni.net within 12 weeks of this SAI notification.
(Copy Sinead Magill into the acknowledgement email)
Please remember to remove this text from email

T2.2 SAI ACKNOWLEDGEMENT to Reporting Org - FOR LEVEL 3 REVIEW

TO: REPORTING ORGANISATION

CC: RQIA (where relevant – see note below)

SUBJECT: ACKNOWLEDGEMENT – Trust Ref: XXXXX SPPG Ref: XXXXX

This communication acknowledges receipt of the Serious Adverse Incident Notification made to the Strategic Planning and Performance Group (SPPG) of the Department of Health seriousincidents@hscni.net mail box and confirms that the **INSERT REPORTING ORGANISATION** will complete a **LEVEL 3** Significant Event Audit (SEA) review relating to this SAI.

Trust Ref:

SPPG Ref:

In line with the Regional Procedure for the Reporting and Follow up of SAIs, November 2016, the timescales for submission of the Terms of Reference / Membership of the Review Team and the Level 3 RCA Review Report will be agreed by the reporting organisation and the SPPG/PHA DRO.

*The DRO for this SAI is xxxxxxxxxxx (if DRO assigned from Flowchart)

*The DRO for this SAI will be confirmed in due course (if request has been issued for DRO)

Delete as appropriate

All communication between SPPG/PHA and reporting organisation must be conveyed between the SPPG Governance department and Governance departments in respective reporting organisations. This will ensure all communication both written and verbal relating to the SAI, is recorded on the SPPG DATIX risk management system.

If the SAI is related to a Child Death, check if the CDN has been received, if not include the following statement:
In line with Circular HSS (MD) 1/2016 - PROCESS FOR REPORTING CHILD DEATHS the SPPG/PHA await a Child Death Notification relating to this SAI, please submit to cdnotifications@hscni.net within 12 weeks of this SAI notification.
(Copy Sinead Magill into the acknowledgement email)

PLEASE NOTE THAT IF RQIA HAVE BEEN INCLUDED IN THE INITIAL NOTIFICATION (CHECK EMAIL ADDRESS AND REPORT FORM) THEN THEY MUST BE COPIED INTO THIS EMAIL AT seriousincidents@rqia.org.uk .

Please remember to remove this text from email

MAHI - STM - 097 - 10380

T3 REQUEST FOR DRO

NOTE: Password Protect SAI Notification with: sai@1

(for POC 1 Level 1 reviews – see Acute Pilot Templates)

TO : LEAD OFFICERS REFER TO LIST
CC: DIRECTORS and ADs REFER TO LIST

SUBJECT: REQUEST FOR DRO - XXXXX

Please find attached a Serious Adverse Incident Notification from the **INSERT REPORTING ORGANISATION** received on XX XXXX 2016. This notification confirms that a **Level 1** Significant Event Audit (SEA) / **Level 2** Root Cause Analysis (RCA) / **Level 3** Root Cause Analysis (RCA) review will be undertaken.

The Trust has classified this incident as a NEVER EVENT. ***(Please remove if not applicable)***

This incident has been reported to the Strategic Planning and Performance Group (SPPG) of the Department of Health in line with the Regional Procedure for the Reporting and Follow up of SAIs, November 2016.

Trust Reference:

SPPG Reference:

Programme of Care:

(For Level 1)
An acknowledgement of receipt of this notification has been forwarded to the **INSERT REPORTING ORGANISATION**, requesting the **Learning Summary Report** by no later than **INSERT DATE (8 weeks from date of notification).**

(For Level 2)
An acknowledgement of receipt of this notification has been forwarded to the **INSERT REPORTING ORGANISATION**, requesting:

- the **Terms of Reference and Membership** of the review team by no later than **INSERT DATE (4 weeks from date of notification)** and;
- a copy of the redacted **RCA Report** for this SAI by no later than **INSERT DATE (12 weeks from date of notification).**

(For Level 3)
An acknowledgement of receipt of this notification has been forwarded to the **INSERT REPORTING ORGANISATION.** Please liaise with the Trust to agree timescales for submission of the Terms of Reference / Membership of the Review Team and the Level 3 RCA Review Report. Please ensure that all communication with the Trust is copied to serious incidents for datix purposes.

PLEASE CAN YOU ADVISE WHO THE LEAD DESIGNATED REVIEW OFFICER (DRO) WILL BE FOR THE FOLLOW UP OF THIS SAI BY RETURN.

T4 DRO ASSIGNED

NOTE: Password Protect SAI Notification with: sai@1

(for POC Level 1 reviews – see Acute Pilot template)

TO : DRO
CC: DIRECTORS and ADs REFER TO LIST
SUBJECT: DRO ASSIGNED – Trust Ref: XXXXX SPPG Ref: XXXXX

You have been identified as the DRO for the above SAI. **The Trust has classified this incident as a SAI NEVER EVENT.** ***(Please remove if not applicable)***

I attach the Serious Adverse Incident Notification from the **INSERT REPORTING ORGANISATION** received on XX XXXX 2018. This notification confirms that a **Level 1** Significant Event Audit (SEA) / **Level 2** Root Cause Analysis (RCA) / **Level 3** Root Cause Analysis (RCA) review will be undertaken.

This incident has been reported to the Strategic Planning and Performance Group (SPPG) of the Department of Health in line with the Regional Procedure for the Reporting and Follow up of SAIs, November 2016.

Trust Reference:

SPPG Reference:

Programme of Care:

See Q. 15 of Notification Form – if the Trust have ticked 'No' for immediate regional action use the following wording:

Please can you advise by email to seriousincidents@hscni.net on any immediate action you have taken or action required; the governance team will update the Datix record for this incident accordingly. **You do not need to respond if no immediate action is required**.

See Q. 15 of Notification Form – if the Trust have ticked 'Yes' for immediate regional action use the following wording:

The INSERT REPORTING ORGANISATION has indicated that this SAI requires **IMMEDIATE REGIONAL ACTION.** Please advise seriousincidents@hscni.net on any action required, the governance team will update the Datix record for this incident accordingly.

(For Level 1)
An acknowledgement of receipt of this notification has been forwarded to the **INSERT REPORTING ORGANISATION**, requesting the redacted **Learning Summary Report** by no later than **INSERT DATE (8 weeks from date of notification).**

(For Level 2)
An acknowledgement of receipt of this notification has been forwarded to the **INSERT REPORTING ORGANISATION**, requesting:

- the **Terms of Reference and Membership** of the review team by no later than **INSERT DATE (4 weeks from date of notification)** and;
- a copy of the redacted **RCA Report** for this SAI by no later than **INSERT DATE (12 weeks from date of notification).**

(For Level 3)

MAHI - STM - 097 - 10382

An acknowledgement of receipt of this notification has been forwarded to the **INSERT REPORTING ORGANISATION.** Please liaise with the Trust to agree timescales for submission of the Terms of Reference / Membership of the Review Team and the Level 3 RCA Review Report. Please ensure that all communication with the Trust is copied to serious incidents for datix purposes.

(For Poc1 and PoC2 only) - *Please remove if not applicable*

If you require advice in relation to **medication related issues** please contact:

- Angela Carrington, email: angela.carrington@belfasttrust.hscni.net (*relating secondary care issues*) or;
- Brenda Bradley and copy to Matthew Dolan (*relating to Primary Care issues*).

In the case of interface incidents where there are both primary and secondary care issues, all three above people should be contacted.

PLEASE NOTE THE TRUST HAVE NOTIFIED THIS INCIDENT TO RQIA. (SEE NOTE BELOW)

If you require any further information, please do not hesitate to contact me.

Please note that if RQIA have been included in the initial notification this should be highlighted as above. PLEASE REMEMBER TO REMOVE THIS TEXT FROM THIS COMMUNICATION IF THIS DOES NOT APPLY

MAHI - STM - 097 - 10383

T5 ACKNOWLEDGEMENT OF LEARNING SUMMARY REPORT

(for POC 1 Level 1 reviews – see Acute Pilot Templates)

T5.1 Acknowledgement of Learning Summary Report where the Trust have indicated no further review is required (see Q18 of Learning Summary Report)

TO: REPORTING ORGANISATION

SUBJECT: ACKNOWLEDGEMENT – XXXXX

Trust Ref:

SPPG Ref:

This communication acknowledges receipt of the Learning Summary Report submitted to the Strategic Planning and Performance Group (SPPG) of the Department of Health seriousincidents@hscni.net mail box in respect of the above Incident.

* If the Checklist has not been submitted/completed include the following:

The checklist for engagement/communication with Service User/Family/Carer has been omitted. Can you please submit a completed checklist to seriousincidents@hscni.net by return of email so this may be considered by the DRO in conjunction with the Learning Summary Report.

*The DRO for this SAI is xxxxxxxxxxxx

MAHI - STM - 097 - 10384

T5.2 Acknowledgement of Learning Summary Report where the Trust has indicated a further review is required (see Q18 of Learning Summary Report)

TO: REPORTING ORGANISATION

SUBJECT: ACKNOWLEDGEMENT – XXXXX

Trust Ref:

SPPG Ref:

This communication acknowledges receipt of the Learning Summary Report submitted to the Strategic Planning and Performance Group (SPPG) of the Department of Health seriousincidents@hscni.net mail box in respect of the above Incident.

*If the date for submission of the RCA is within 12 weeks use the following paragraph.

You have indicated on the Learning Summary Report that a Level 2/Level 3 review is required.
In line with the Regional Procedure for the Reporting and Follow up of SAIs, November 2016, please forward the redacted **RCA report** for this SAI by no later than DD /MM / YYYY to seriousincidents@hscni.net.

*If the date for submission of the RCA is outside the 12 weeks timescale use the following paragraph.

You have indicated on the Learning Summary Report that a Level 2/Level 3 review is required.
The DRO is considering the proposed date for submission of the RCA report and approval will be confirmed in due course.

* if ToR/ Review Team Membership have not been included at Section 4, questions 21 & 22 of the Learning Summary Report include the following

The Terms of Reference and Review Team Membership have been omitted from the Learning Summary Report. Can you please submit to seriousincidents@hscni.net by return of email.

MAHI - STM - 097 - 10385

T6 ACKNOWLEDGEMENT OF RCA REPORT

TO: REPORTING ORGANISATION

SUBJECT: ACKNOWLEDGEMENT - XXXXX

Trust Ref:

SPPG Ref:

This communication acknowledges receipt of the RCA Report submitted to the Strategic Planning and Performance Group (SPPG) of the Department of Health seriousincidents@hscni.net mail box in respect of the above Incident.

* If the Checklist has not been submitted/completed include the following:

The checklist for engagement/communication with Service User/Family/Carer has been omitted. Can you please submit a completed checklist to seriousincidents@hscni.net by return of email so this may be considered by the DRO in conjunction with the RCA report.

*The DRO for this SAI is xxxxxxxxxxx

T7 FORWARDING LEARNING SUMMARY REPORT /RCA REPORT TO DRO

NOTE: Password Protect Learning Summary Report/RCA Report with: sai@1
(for POC 1 Level 1 reviews – see Acute Pilot Templates)

T7.1 Forwarding Learning Summary Report where further review is not required/RCA Report to DRO

TO: DRO
SUBJECT: Learning Summary Report/RCA Report: Trust Ref: XXXXX SPPG REF: XXXXX

Please find attached the Learning Summary Report /RCA Report from the **INSERT REPORTING ORGANISATION** in relation to:

Trust Ref:

SPPG Ref:

Also attached is a SAI position report detailing all activity in relation to this incident.

(For Poc1 and PoC2 only) - *Please remove if not applicable*
If you require advice in relation to **medication related issues** please contact:

- Angela Carrington, email: [redacted] (*relating secondary care issues*) or;
- Brenda Bradley and copy to Matthew Dolan (*relating to Primary Care issues*).

In the case of interface incidents where there are both primary and secondary care issues, all three above people should be contacted.

For all POCs use the following text:
This SAI will be listed for the next Professional SAI Review Team Meeting for discussion / closure. However, please advise if any action is required prior to the meeting.

For MH/LD Level 1 advise the SEA report will be listed for review at the next meeting of the MHLD Level 1 Group and has been saved to the group's Network folder for you to access also indicate date of the meeting (e.g. 2021-04-27).

****Please note:** The **Learning Summary Report /RCA** Report has been forwarded to RQIA with comments due by **[insert 3 week date**].

*****delete if RQIA were not included in initial notification***

Guidance Notes for processing reports

- Update New Field on Datix - Final Report Received 'Y'
- Save new **New Reports** to the Porfessional Group Network folder along with position report. No password required except for **MHLD** Level 1 WHSCT SAI add password (WHSCTSAI)
  For MH/LD Level 1 a maximum of 10 First Review cases for listing at each meeting.
- Add report to agenda saved in network folder

- POC 2 - SAI Review Reports submitted where Heather is DRO forwarded to Eilidh McGregor and the SAI re-assigned.
  Note in investigate field for each **Upon receipt of SAI Review Report forward to Eilidh McGregor and assign Eilidh as DRO, copy to Heather to advise that the SAI has been re-assigned**

TO NOTE:

- **Full SEA reports** are to be submitted from all Trusts if transferable / regional learning is identified –within Learning Summary Section 3 of LSR entitled INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY SPPG/PHA'.

T7.2 Forwarding Learning Summary Report where the Trust has indicated a further review is required to DRO (see Q18 of Learning Summary Report)

(for POC 1 Level 1 reviews – see Acute Pilot Templates)

TO: DRO
SUBJECT: Learning Summary Report Trust Ref: XXXXX SPPG REF: XXXXX

Please find attached the Learning Summary Report from the **INSERT REPORTING ORGANISATION** in relation to:

Trust Ref:

SPPG Ref:

*If the date for submission (Question 20 of the Learning summary Report) of the RCA is within 12 weeks use the following paragraph.

The Trust has indicated a Level 2/Level3 review is required. The proposed date for submission of the RCA Report is DD /MM / YYYY.

*If the date for submission of the RCA is outside the 12 week timescale use the following paragraph.

The Trust have indicated on the Learning Summary Report that a Level 2/Level 3 review is required. As the proposed date, DD/MM/YYYY for submission of the RCA is outside the 12 week timescale please confirm your approval.

The Terms of Reference and Review Team Membership have been outlined in Section 4 of the Learning Summary Report. Following consideration, please advise seriousincidents@hscni.net if the Terms of Reference and Membership of the Review Team have been approved.

Please advise by [**insert date - 1 week from date of this email**].

*If the Terms of Reference/Review Team Membership have been omitted, follow-up with the Trust.

****Please note:** The **Learning Summary Report** has been forwarded to RQIA with comments due by **[insert 3 week date**].

***delete if RQIA were not included in initial notification*

MAHI - STM - 097 - 10389

T8 FORWARDING LEARNING SUMMARY REPORT/RCA REPORT TO RQIA

NOTE: Password Protect Learning Summary Report/RCA Report with: sai@1

(for POC 1 Level 1 reviews – see Acute Pilot Templates)

TO: RQIA

SUBJECT: Learning Summary Report /RCA Report: Trust Ref: XXXXX SPPG REF: XXXXX

Please find attached a copy of the Learning Summary Report / RCA Report submitted to the Strategic Planning and Performance Group (SPPG) of the Department of Health from the **INSERT REPORTING ORGANISATION** in respect of the following incident:-

Trust Ref:

SPPG Ref:

The DRO has asked that you provide any comments on the Learning Summary Report / RCA Report to seriousincidents@hscni.net by **[insert 3 week date].**

T9 EMAIL TO DRO FORWARDING TERMS OF REFERENCE AND TEAM MEMBERSHIP FOR LEVEL 2 REVIEW FOR APPROVAL

(NOTE: for POC 1 if a ToR is received - see Acute Pilot Templates: Template -P9)

TO: DRO

Cc: Assistant Governance Manager for the relevant Programme of Care

SUBJECT: TERMS OF REFERENCE AND TEAM MEMBERSHIP – Trust Ref: XXXXX SPPG Ref: XXXXX

Please see attached Terms of Reference and Review Team Membership received from the **INSERT REPORTING ORGANISATION** for the above incident.

If the incident was deferred on Datix use the following wording:

This incident was previously deferred on Datix. As the Terms of Reference and Team Membership have now been received the incident is no longer deferred and a copy of the redacted **RCA Report** for this SAI will be requested from the **INSERT REPORTING ORGANISATION** by no later than **INSERT DATE (8 weeks from date the ToR was received).**

Following consideration, please advise seriousincidents@hscni.net if the Terms of Reference and Membership of the Review Team have been approved. Please advise by [**insert date - 1 week from date of this email**].

If SAI is MH/LD Level 3 SAI use wording below

This SAI will be listed for the next Professional SAI Review Team Meeting

(If it is a Level 3 SAI ask the DRO to advise on timescale for submission of RCA Report)

(Ensure the new date is entered into LSR/RCA Revised Due Date in extra fields)

If the name and designation are not on a ToR received from the Trust - Refer to Page 21

Notes to Team

ToR and TM for Level 3 Mental Health and Learning Disability SAI's are to be listed for the Level 2/3 Group. Save Terms of Reference and Position Report into the network folder.

As of 17.06.22 the support team do not follow up on DRO approval of TOR, therefore follow up date no longer required. AGM will follow up with DRO for approval.

T9.1 EMAIL TO TRUST INFORMING IF TERMS OF REFERNCE AND TEAM MEMBERSHIP HAVE BEEN APPROVED BY DRO

(NOTE: for POC 1 if a ToR is received - see Acute Pilot Templates: Template -P9.1)

TO: REPORTING ORGANISATION

SUBJECT: TERMS OF REFERENCE AND TEAM MEMBERSHIP – Trust Ref: XXXXX SPPG Ref: XXXXX

The Terms of Reference and Review Team Membership received on XXXX have been approved.

I look forward to receipt of the final RCA report.

If the incident was deferred on Datix use the following wording:

This incident was previously deferred on Datix. As the Terms of Reference and Team Membership have now been received the incident is no longer deferred, please submit a copy of the redacted **RCA Report** for this SAI by no later than **INSERT DATE (8 weeks from date the ToR was received)** directly to seriousincidents@hscni.net.

(If it is a Level 3 SAI ask the DRO to advise on timescale for submission of RCA Report)

(Ensure the date is entered into LSR/RCA Date Due in extra fields)

T10 CLOSURE EMAILS

(NOTE: for POC 1, Level 1 Review - see Acute Pilot Templates: Template - P10)

Closure Email to Trust for Learning Summary Report/RCA Report where there has been no learning identified:

To: Reporting Organisation
Cc: DRO and RQIA (if appropriate)
SUBJECT: Closure of SAI Trust Ref: XXXX SPPG Ref: xxxx

The DRO and other relevant officers, having reviewed the Learning Summary Report/Review Report and any other information, are satisfied based on the information provided that this incident can be closed from their perspective. However, if further information is made available to the reporting organisation (for example the Coroner's Report), which impacts on the outcome of the initial review it should be communicated to the SPPG / PHA DRO via the serious incidents mailbox.

In line with the Regional Procedure for the Reporting and Follow up of Serious Adverse Incidents (November 2016), please note that it is the responsibility of the Trust to take forward any recommendations or further actions identified (*including, where appropriate, on-going or further liaison with service users or families*) and monitor these through the Trust's internal governance arrangements. This is an essential element in reassuring the public that lessons learned, where appropriate have been embedded in practice.

Closure Email to Trust Learning Summary Report/RCA Report where LEARNING has been identified

To: Reporting Organisation
Cc: DRO and RQIA (if appropriate)
SUBJECT: Closure of SAI Trust Ref: XXXX SPPG Ref: XXXX

The DRO and other relevant officers, having reviewed the Learning Summary Report/Review Report and any other information, are satisfied based on the information provided that this incident can be closed from their perspective. However, if further information is made available to the reporting organisation (for example the Coroner's Report), which impacts on the outcome of the initial review it should be communicated to the SPPG / PHA DRO via the serious incidents mailbox.

Learning from this incident is being considered by the SPPG/PHA for regional dissemination. If learning is agreed the Trust will be advised in due course.

In line with the Regional Procedure for the Reporting and Follow up of Serious Adverse Incidents (November 2016), please note that it is the responsibility of the Trust to take forward any local recommendations or further actions identified (*including, where appropriate, on-going or further liaison with service users or families*) and monitor these through the Trust's own internal governance arrangements. This is an essential element in reassuring the public that lessons learned, where appropriate have been embedded in practice.

~~**T10 CLOSURE EMAIL TO RQIA**~~

MAHI - STM - 097 - 10393

(NOTE: for POC 1, Level 1 Review - see Acute Pilot Templates: Template - P10)

To: RQIA

SUBJECT: Closure of SAI: Trust Ref: XXXX SPPG Ref: XXXX

I wish to confirm the following SAI has been closed on Datix by the SPPG:

Trust Ref:

SPPG Ref:

MAHI - STM - 097 - 10394

T11 EARLY ALERTS

NOTE: Password Protect Early Alert with: ealert2011

To: Early Alert Distribution List
Cc: any relevant colleagues (red font on manual)
Subject: Early Alert Notification - Trust Ref: XXXXXXXX SPPG Ref: EAXXXX

Please find attached Early Alert Notification received on XXX.

Trust Reference:	XXX
SPPG Reference:	XXX
Programme of Care:	XXX

The attached Notification will be considered at the weekly Incident Review Meeting, any required action will be taken forward following the meeting.

Serious Incidents to note: Governance Team **do not** need to enter a follow up when sending out Initial Early Alert Notification Forms, any follow up action will be communicated through the action log from the Incident Review Meeting. (Remove Text)

Closure of Early Alerts:

When closing an Early Alert on Datix please advise the Reporting Organisation that the Early Alert has been closed and the rationale for doing so, i.e advise that the Early Alert record has been closed following receipt of a SAI (Ref xxx) or if the Lead Officer / Incident Review Group have advised that a SAI is not required and therefore the early Alert has been closed.

Early Alert – OOHs

Going forward all out of hours/urgent care Early Alerts are to be forwarded to below list of people upon receipt:

Louise McMahon

Dr Margaret O'Brien

Dr Ciara McLaughlin

Dr Sloan Harper

Joanne Kelly

Director of Integrated Care P.A.

In the email please advise that;

'This Early Alert will be discussed at the Weekly Incident Review Group where any required action will be agreed and taken forward'.

T12 INTERFACE INCIDENTS

ACKNOWLEDGEMENT EMAIL TO REPORTING ORGANISATION

To: Reporting Organisation
Subject: Acknowledgement – Interface Incidents Notification: Trust Ref: XXXX; SPPG Ref: XXXXX

I acknowledge receipt of this Interface notification and will provide a response in due course.

MAHI - STM - 097 - 10396

~~**T12.1 INTERFACE INCIDENTS**~~

~~**NOTE: Password Protect Interface Notification with: interface@1 when forwarding to Lead Officer/CC list**~~

~~**To**: Early Alert/Interface Incident Distribution List~~

~~**Copied to**: any relevant colleagues (red font on manual)~~

~~**Subject:** Interface Incident: Trust Ref: XXXXXXXXX; SPPG REF: IIXXXXX~~

~~The attached Notification will be considered at the weekly Incident Review Meeting, any required action will be taken forward following the meeting.~~

~~**Serious Incidents to note**: Governance Team **do not** need to enter a follow up when sending out Initial Notification, any follow up action will be communicated through the action log from the Incident Review Meeting. (Remove Text)~~

T12.1a INTERFACE INCIDENTS

NOTE: Password Protect Interface Notification with: interface@1 when forwarding to Lead Officer/CC list

EMAIL TO ORGANISATION WHERE INCIDENT OCCURRED IF INCIDENT REVIEW GROUP REQUEST SAI

To: Organisation where incident occurred (Integrated Care - this will be one of the Business Support Managers in the local Integrated Care Office)

Subject: Interface Incident: Trust Ref: XXXXXXXXX; SPPG REF: IIXXXXX **MAHI - STM - 097 - 10397**

Please find attached a HSC Interface Incident Notification received from [insert name of organisation who reported interface incident]. This Interface Incident has been received under the Regional Procedure for the Reporting and Follow-Up of SAIs which came into effect November 2016.

In line with Section 3.4 of the Regional Procedure (see below) can you advise if this Incident meets the criteria for a SAI which will subsequently be reported by the XXXXXXX Trust.

3.4 Reporting of HSC Interface Incidents

Interface incidents are those incidents which have occurred in one organisation, but where the incident has been identified in another organisation. In such instances, it is possible the organisation where the incident may have occurred is not aware of the incident; however the reporting and follow up review may be their responsibility. It will not be until such times as the organisation, where the incident has occurred, is made aware of the incident; that it can be determined if the incident is a SAI.

In order to ensure these incidents are notified to the correct organisation in a timely manner, the organisation where the incident was identified will report to the SPPG using the HSC Interface Incident Notification Form (see Appendix 3). The SPPG Governance Team will upon receipt contact the organisation where the incident has occurred and advise them of the notification in order to ascertain if the incident will be reported as a SAI.

Some of these incidents will subsequently be reported as SAIs and may require other organisations to jointly input into the review. In these instances refer to Appendix 13 – Guidance on Joint Reviews.

Please advise by [**insert 1 week**] if you will be submitting this as a SAI.

T12.2 INTERFACE INCIDENTS – Closure Email

(for POC 1 Interface Incidents – see Acute Pilot Templates)

To: Reporting Organisation
Copied To: Lead Officer
Subject: Interface Incident Notification: Trust Ref: XXXXXXXXXX; SPPG Ref: IIXXXXX

The following paragraph is to be used if a SAI has been received:

I would advise that a SAI notification has been received from [insert organisation where incident occurred] for the above incident, therefore this Interface Incident has been closed by the Strategic Planning and Performance Group (SPPG) of the Department of Health.

The following paragraph is to be used if a SAI has not been received and the DRO/relevant review team have confirmed that a SAI is not required:

To: Reporting Organisation
Copied To: Organisation where Incident Occurred / Lead Officer
Subject: Interface Incident Notification: Trust Ref: XXXXXXXXXX; SPPG Ref: IIXXXXX

The DRO and other relevant officers having reviewed the Interface Incident have confirmed that a SAI should not be submitted. The Interface Incident can now be closed.

MAHI - STM - 097 - 10399

T12.3 INTERFACE INCIDENTS – No SAI Received

(for POC 1 Interface Incidents – see Acute Pilot Templates)

REQUEST FOR SAI TO BE SUBMITTED FOLLOWING NOTIFICATION OF AN INTERFACE INCIDENT

The following template is to be used following notification of an Interface Incident where NO SAI has been submitted and the relevant review team have determined a SAI should be submitted.

TO: Organisation where incident occurred
Copied To: Lead Officer
Subject: Interface Incident XXXXX – SPPG Ref: XXXXXX
Attach copy of Interface Incident Notification Form

You will have received the attached Interface Incident reported by [insert Reporting Organisation]. This incident was recently discussed by the [insert PoC] SAI Review Team where it was agreed this should be reported as a SAI (include Level if stipulated by Review Team) by [insert Organisation where incident occurred]. We would therefore expect to receive this by [insert 2 weeks].

If you have any issue with this request, can you please contact [insert name of Governance Lead as below]

Acute SAI Review Team
Acute Paediatrics SAI Review Team
POC where there is no Review Team

[redacted]

Please copy seriousincidents@hscni.net into all correspondence.

CDN Process

T13 CD Initial Notification - Acknowledgement to Reporting Org

TO: REPORTING ORGANISATION

SUBJECT: Acknowledgement of CD Initial Notification – Trust Ref: XXXXX SPPG Ref: XXXXX

This communication acknowledges receipt of the Child Death Notification made to the Strategic Planning and Performance Group (SPPG) of the Department of Health cdnotifications@hscni.net mail box.

Your Ref: XXXX

SPPG Ref: XXXX

In line with Circular HSS (MD) 1/2016 - Process For Reporting Child Deaths the SPPG / PHA await the full CDN Report relating to this notification, please submit to cdnotifications@hscni.net no later than **INSERT DATE (12 weeks from date of notification).**

Regards,

Governance Team:

- **SPPG Follow Up Due Date: not required**
- **Save all documentation to Datix (Documents & Investigate)**

MAHI - STM - 097 - 10401

T13.1 CD Notification - Circulation Email

TO: Sinead Magill

CC: blank

SUBJECT: CD Initial Notification – Trust Ref: XXXXX SPPG Ref: XXXXX

Please find attached child death notification received from the **XXXX** on **XXXX**. This notification has been logged on the Datix system.

Trust Ref: XXXXXXX

SPPG Ref: XXXXXXX

An acknowledgement of this notification has been sent to the XXX requesting that the completed CDN Report is submitted to cdnotifications@hscni.net by **INSERT DATE (12 weeks from date of notification).**

Regards,

Governance Team:

- **SPPG Follow Up Due Date**: not required
- Save all documentation to Datix (Documents & Investigate)
- **CDN Report Due Date**: Enter 12 week date

MAHI - STM - 097 - 10402

T13.2 CDN Report - Acknowledgement to Reporting Org

TO: REPORTING ORGANISATION

CC:

SUBJECT: Acknowledgement of CDN Report – Trust Ref: XXXXX SPPG Ref: XXXXX

This communication acknowledges receipt of the CDN Report to the Strategic Planning and Performance Group (SPPG) of the Department of Health cdnotifications@hscni.net mail box.

Your Ref: XXXXXX

SPPG Ref: XXXXXX

Regards,

Governance Team:

- **SPPG Follow Up Due Date**: not required
- Save all documentation to Datix (Documents & Investigate)

T13.3 CDN Report - Circulation Email

TO: Heather Reid / Eilidh McGregor / Sinead Magill / Emily Roberts

CC: Heather McKendry

SUBJECT: CDN Report – Trust Ref: XXXXX SPPG Ref: XXXXX

Name of DRO,

Please find attached the completed CDN Report received from the XXX on XXX. This report has been saved to the Datix record.

Trust Ref: XXXXX

SPPG Ref: XXXXX

An acknowledgement of receipt of this CDN Report has been forwarded to the XXXX.

Regards,

Governance Team:

- **SPPG Follow Up Due Date**: not required
- Save all documentation to Datix (Documents & Investigate)
- **CDN – Review Report Received**: Enter date report received (if this is a subsequent report do not change the review report received date)

MAHI - STM - 097 - 10403

Circulation of Notifications / Nomination of DROs

Daily Report

Governance Team to run report each morning to include all SAI / Interface and Early Alert Notificatins form the previous working day. Report is forwarded to SQ & Nusirsing Team for review, areas of concern are highlighted and nursing team advise if any additional colleagues are to be copied in. Report is then sent back to Governance Team to be circulated from the Serious Incidents Mailbox.

Circulation of Daily Report

When relevant copy to:
Dr Tracey Owen – Screening
Raymond Curran – Ophthalmology
Mr Joe Brogan - Pharmacy
Mr Michael Donaldson- Dentistry
Dermot McAteer – Ind. Sector Provider
Stephen Stewart – IT related Issues
Alison Ferris – Choking
Angela Carrington – Medication related Incidents

Out of Hours / Urgent Care Early Alerts
- upon receipt, forward to;
Louise McMahon
Dr Margaret O'Brien
Dr Ciara McLaughlin
Dr Sloan Harper
Joanne Kelly [redacted]
Director of Integrated Care P.A.

Copy to:

Aidan Dawson
Dr Joanne McClean
Dr Brid Farrell
Brendan Whittle
Michelle Tennyson
Lisa McWilliams
Louise McMahon
Tracey McCaig
Shirlie Murtagh

Denise Boulter
Anne-Marie Phillips
Paul Millar
Jane McMillan
Dr Jackie McCall
Eilish Deeney
Siobhan Rogan
Matthew Dolan
Claire Logan
Eamon Farrell
Grainne Cushley
David Calvin
Roisin Doyle
Brendan Forde
Ciara McKillop

Hospital + Community Care Assistant and Deputy Directors;
Bride Harkin
Cara Anderson
Catherine Cassidy
David Petticrew
Paul Turley
Sophie Lusby
Teresa Magirr
Veronica Gillen

Anne Kane
Geraldine McArdle

~~MAHI - STM - 097 - 10404~~

Daily Report Governance Team to run report each morning to include all SAI / Interface and Early Alert Notificatins form the previous working day. Report is forwarded to SQ & Nusirsing Team for review, areas of concern are highlighted and nursing team advise if any additional colleagues are to be copied in. Report is then sent back to Governance Team to be circulated from the Serious Incidents Mailbox.	
	Jacqui Burns Mareth Campbell Martin Poots Elaine Hamilton Donna Britton

- **For allocation of DRO to SAIs see relevavnt flowchart/listing as per POC**

Nomination of DROs for SAI Notificatons

(PROGRAMME OF CARE / LEVEL OF REVIEW	Assign to / Request Nomination from	COPIED TO
Acute Services including Acute Independent Service Providers (ISP) **POC1**	**Level 1 SAIs:** Assign to Acute Professional Group Dr Farrell D Boulter AM Phillips J McCall C Logan D Calvin E Hamilton **Level 2 & 3 SAIs:** See Flow Chart for Allocation of DRO	**Individual Notifications do not need to be sent for Level 1 reviews as all colleagues above are on circulation list for Daily Report.** (AGM) for group – E Hamilton
Maternity/Child Health/ Acute Paediatrics **POC2**	**Level 1 Maternity SAIs:** Assign to Maternity Group Denise Boulter Alison Little Catherine Coyle	

(PROGRAMME OF CARE / LEVEL OF REVIEW	Assign to / Request Nomination from	COPIED TO
	Jacqui Burns *All child death SAI to be copied to Sinead Magill **Level 1 Paediatric SAIs:** Assign to Paediatric Group Denise Boulter Heather Reid Jacqui Burns Eilidh McGregor *All child death SAI to be copied to Sinead Magill **Level 2 & 3 SAIs:** See Flow Chart for Allocation of DRO *All child death SAI to be copied to Sinead Magill	(AGM) for group – J Burns
Family and Childcare (inc CAHMS) **POC3**	**Level 1 SAIs:** Assign to Family&Childcare (incCAHMS) Group Maurice Leeson Pamela Mooney Deirdre Coyle Fiona Gunn Marian Hall Paul Millar Una Lernihan Denise Boulter Sheila Smyth Maxine Gibson Gerard O'Hanlon Margaret Lynch Bronwyn Campbell Tommy Doherty Mareth Campbell **Level 2 & 3 SAIs:** Forward to Maurice Leeson and Una Lernihan for allocation.	(AGM) for group – M Campbell

(PROGRAMME OF CARE / LEVEL OF REVIEW	Assign to / Request Nomination from	COPIED TO
Elderly **POC4**	**Level 1 SAIs:** Assign to Older Peoples &PDSI Group A-M Phillips R Doyle Sandra Aitcheson R Donaldson J McMillan Grace Reihill Caroline Lecky Deirdre Cunningham Mary Emerson Caroline Holloway Ann-Marie Fox Fionnuala McClelland Ceara Gallagher Alison Ferris Brendan Forde M Laverty Martin Poots **Level 2 & 3 SAIs:** See Flow Chart for Allocation of DRO	(AGM) for group – M Poots
Mental Health/ Learning Disability **POC5 - MH** **POC6 – LD**	**Level 1 SAIs:** Assign to MHLD Group Mary Emerson Martina McCafferty Dessie Lowry Denise Boulter Eilish Deeney J Burns **Level 2 & 3 SAIs:** See Flow Chart for Allocation of DRO	(AGM) for group – J Burns
Physical Disability and Sensory Impairment **POC7**	**Level 1 SAIs** to be assigned as per Elderly SAIs above **Level 2 & 3 SAIs:** See Flow Chart for Allocation of DRO	(AGM) for group – J Burns

(PROGRAMME OF CARE / LEVEL OF REVIEW	Assign to / Request Nomination from	COPIED TO
POC9	**Level 1 SAIs:** to be assigned as per Acute SAIs above **Level 2/3 SAIs:** Forward to the following colleagues for allocation of DRO: **GMS** - Dr Margaret O'Brien **Pharmacy** - Mrs Brenda Bradley **Optometry** - Ms Margaret McMullan **Dentistry** - Donncha O'Carolan Brid Hendron	(AGM) for group – E Hamilton
Corporate Business **POCNA**	**Level 1 SAIs:** Assign to Corporate Services Group Ken Moore Patricia Crossan Karen Braithwaite Shirlie Murtagh Richard McVeigh D Britton **Level 2/3 SAIs:** **Estates related Issues** – assign on a rotational basis to Hazel Gillis and Charlene Shonga **Information Governance related Issues** – assign directly to Ken Moore **IT related issues** – forward to Stephen Stewart to assign DRO	(AGM) for group – D Britton
Prison Health Circulation List		
Prison Health is not a PoC: Assign to POC 5	**Level 1 SAIs:** to be assigned as per MH/LD Level 1 SAIs above **Level 2 & 3 SAIs:** Assign to Dessie Lowry copy Siobhan Donald	(AGM) for group – J Burns

MAHI - STM - 097 - 10408

APPENDIX 3

FLOWCHARTS FOR ALLOCATION OF DRO FOR SAIs NOTIFIED TO SPPG IN RELATION TO:

- Acute
- Maternal and Child Health (Including Acute Paediatrics)
- Elderly Services and Physical Disability and Sensory Impairment
- Mental Health and Learning Disability Services
- Prison Health

MAHI - STM - 097 - 10410

Allocation of DRO for LEVEL 2 and LEVEL 3 ACUTE SAIs notified to SPPG (updated August 2020)

ACUTE Serious Adverse Incident (Level 2 or 3) notified to SPPG. Governance Team record SAI notification on DATIX and allocate to either a medical, nursing or AHP DRO based on the following:

- Falls in Hospital → Forward SAI to Anne-Marie Phillips as DRO
- Pressure Ulcers → Forward SAI to Anne-Marie Phillips as DRO
- NIAS SAIs → Forward SAI to Eamon Farrell as DRO (copy Paul Cavanagh)
- Adult Safeguarding → Forward SAI to Roisin Doyle as DRO
- Choking/Dysphagia → Forward SAI to Alison Ferris as DRO
- SAIs of a primarily professional nursing issue → Forward SAI to Denise Boulter to **allocate** a DRO
- SAIs of a primarily AHP nature → Forward SAI to Michelle Tennyson to **allocate** a DRO
- All other Acute SAIs to be allocated to a Medical, Nursing or AHP DRO on a rotational basis as follows:

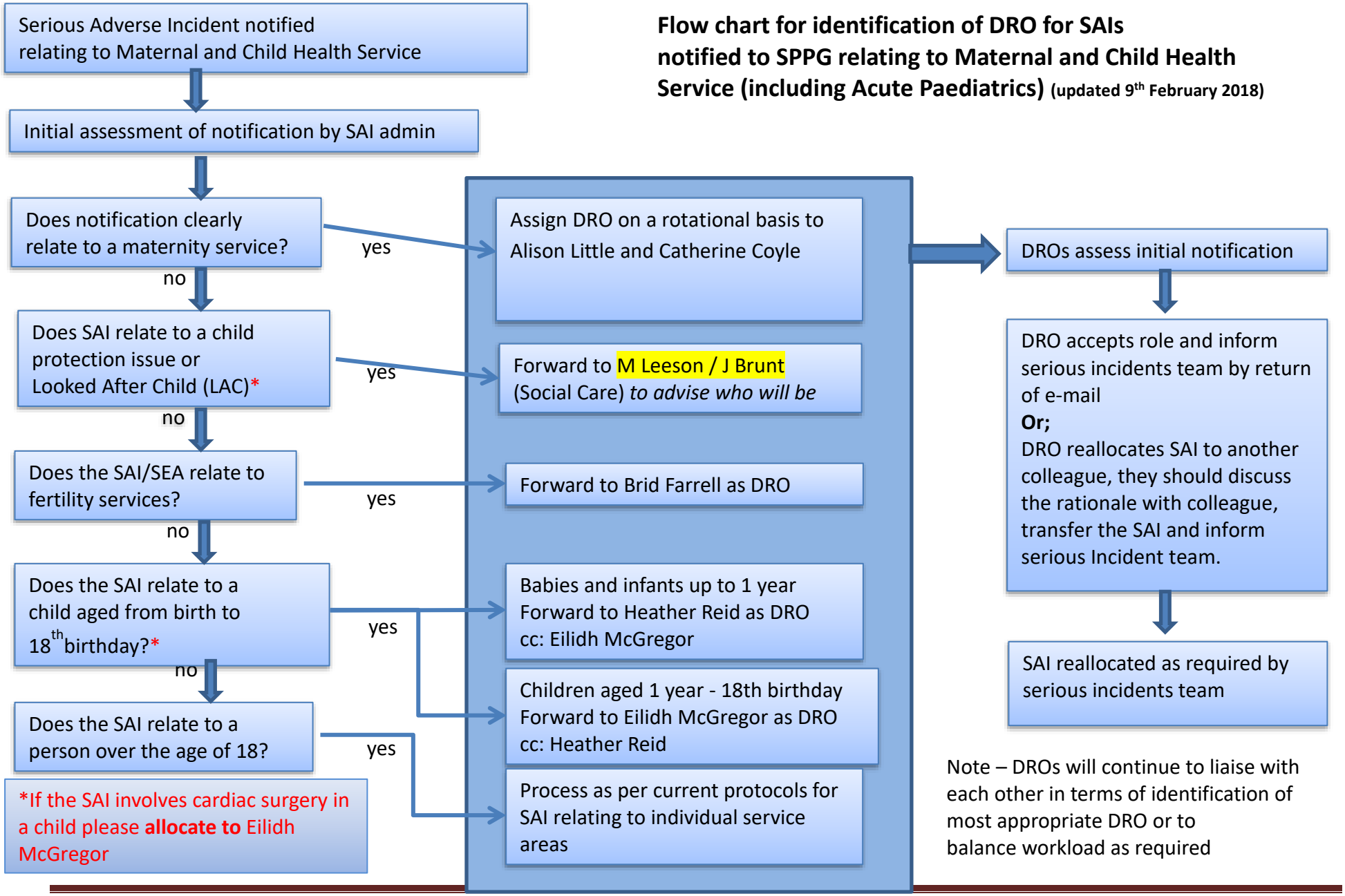
~~Anne-Marie Phillips~~
Dr Jackie McCall
~~Caroline Graham~~
Denise Boulter
Eamon Farrell
Dr Louise Herron
~~Dr Sinead McGuinness~~
~~Dr Joanne McClean~~

- Copy Directors and senior staff into all SAIs (as per Regional Listing)
- Denise Boulter will provide support in relation to allocation of SAIs or support to DROs i.e. queries or when DROs are on leave from a **nursing perspective**. Anne-Marie Phillips should be contacted if Denise is unavailable.
- Angela Carrington will provide advice in relation to **medication related issues**

03.08.20 - Dr Farrell has advised that Dr McClean & Dr McGuiness are not to be allocated as DROs at present.

17.09.20 – Caroline Graham moved to contact tracing

Flow chart for identification of DRO for SAIs notified to SPPG relating to Maternal and Child Health Service (including Acute Paediatrics) (updated 9th February 2018)



MAHI - STM - 097 - 10412

ALLOCATION OF DRO FOR LEVEL 2/3 SAIs NOTIFIED TO SPPG IN RESPECT OF ELDERLY SERVICES AND PHYSICAL DISABILITY AND SENSORY IMPAIRMENT

(Updated December 2020)

SAI Notification Received

Governance Team record on DATIX and allocate to Social Work, Medical or Nursing DRO based on the following:

- Falls in Nursing Home – allocate to Nursing DRO (advice can be sought from Medical /Social Work/AHP colleagues)
- Falls in Residential Home –Roisin Doyle to advise who the Lead DRO will be (advice can be sought from Medical/Nursing/AHP colleagues)
- Adult Safeguarding SAIs – allocate to Roisin Doyle
- Choking / Dysphagia SAI's – allocated to Alison Ferris
- All other Elderly Services/PDSI SAIs – allocate to Social Work DRO (advice can be sought from Nursing/Medical/AHP colleagues)
- **If the allocated DRO considers that the SAI should be allocated to another colleague, they should discuss the rationale with them, transfer the SAI and inform Serious Incident team.**

BELFAST TRUST		
SW	Medical	Nursing
Roisin Doyle to allocate DRO	Dr B Farrell to allocate Medical support	Sandra Aitcheson to allocate DRO

NORTHERN TRUST		
SW	Medical	Nursing
Roisin Doyle to allocate DRO	Dr B Farrell to allocate Medical support	Sandra Aitcheson to allocate DRO

SOUTH EASTERN TRUST		
SW	Medical	Nursing
Roisin Doyle to allocate DRO	Dr B Farrell to allocate Medical support	Caroline Lecky and copy to S Aitcheson

SOUTHERN TRUST		
SW	Medical	Nursing
Roisin Doyle to allocate DRO	Dr B Farrell to allocate Medical support	Deirdre Cunningham and copy to Sandra Aticheson

WESTERN TRUST		
SW	Medical	Nursing
Roisin Doyle to allocate DRO	Dr B Farrell to allocate Medical support	Siobhan Donald and copy to Sandra Aticheson

- Denise Boulter will provide support in relation to allocation of SAIs or support to DROs i.e. queries or when DROs are on leave from a **nursing perspective**. Anne-Marie Phillips should be contacted if Denise is unavailable.
- Roisin Doyle will provide support in relation to allocation of SAIs or support to DROs i.e. queries or when DROs are on leave from a **social work perspective**.

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MENTAL HEALTH AND LEARNING DISABILITY SERVICES (Level 2 & 3)

(Updated Dec 2021)

SAI Notification Received

MHLD Level 2/3 SAI reviews to be allocated to DROs on a rotational basis as follows:

- Julie Haslett
- Lorna Conn
- Joy Peters
- Geraldine Hamilton
- ~~*Caroline Mc McGonigle*~~
- ~~*Martina McCafferty*~~
- *Eilish Deeney*
- *Ann Butler*

- **Adult Safeguarding** SAIs – allocate to Roisin Doyle
- **Choking / Dysphagia** SAI's – Alison Ferris
- **Prison Healthcare** SAI's – allocate to Dessie Lowry

Copy Directors/Assistant Directors (as per Regional Listing for allocating DROs)

It was agreed from 22/12/21 and until further notice DROs: *Caroline Mc Conigle / Martina McCafferty* are not to be allocated new cases due to current caseloads.

DRO allocations will be reviewed, going forward, at monthly Professional Group.

ALLOCATION OF DRO FOR SAIs NOTIFIED TO SPPG IN RELATION TO PRISON HEALTHCARE

(Updated September 2019)

SAI Notification Received from SEHSCT to SPPG and RQIA

↓

Governance Team record on DATIX and allocate as follows:

All Prison Health SAIs to be assigned to **Dessie Lowry** and copied to Siobhan Donald

↓

Prison Health Related SAIs with Multi-disciplinary support from			
Social Care and Children	**Nursing**	**Medical**	**Allied Health Professions**
Mary Donaghy	Siobhan Donald	Dr Jackie McCall	Mary Emerson
	Dessie Lowry	Dr Rachel Edwards	
		Dr Damien Bennett	
		Dr Denise O Hagan	

↓

SPPG Governance Team will forward the Review Report/Learning Summary Report to RQIA, together with an email advising of the 3 week timescale from receipt of review report/LSR for RQIA to forward comments for consideration by DRO.

APPENDIX 4

REPORTING AND FOLLOW UP OF SAIs INVOLVING RQIA MENTAL HEALTH/LEARNING DISABILITY & INDEPENDENT/REGULATED SECTOR

ADMINISTRATIVE PROTOCOL

On receipt of a SAI notification and where a HSC Trust has also copied RQIA into the same notification, the following steps will be applied:

1. SPPG acknowledgement email to Trust advising on timescale for review report will also be copied to RQIA.

2. On receipt of the review report from Trust, the SPPG Governance Team will forward to the SPPG/PHA Designated Review Officer (DRO).

3. At the same time, the SPPG Governance Team will also forward the review report to RQIA, together with an email advising of a **3 week** timescale from receipt of review report, for RQIA to forward comments for consideration by the DRO.

4. The DRO will continue with his/her review liaising (where s/he feels relevant) with Trust, RQIA and other SPPG/PHA professionals until s/he is satisfied SAI can be closed.

5. If no comments are received from RQIA within the 3 week timescale, the DRO will assume RQIA have no comments.

6. When the SAI is closed by the DRO, an email advising the Trust that the SAI is closed will also be copied to RQIA.

All communications to be sent or copied via:

SPPG Governance Team: ***seriousincidents@hscni.net***
and RQIA: **seriousincidents@rqia.org.uk**

DOCUMENT TYPES

ACTION	Action Plan
CERTIF	Certificate
CHKSAI	SAI Checklist
EMAIL	E-mail
FAX	Fax
FILENT	File Note
FORM	Form
GUIDEL	Guideline
INVICE	Invoice
LETTER	Letter
MEDREC	Medical Record
MEMO	Memorandum
MINUTE	Minutes
OTHER	Other document type
PHOTO	Photograph
POLICY	Policy
PROCED	Procedure
REPORT	Report
STAMNT	Statement
TMBRS	RCA Team Members
TORRCA	RCA Terms of Reference

APPENDIX 5

Adult Learning Disability - SAI Keywords

	Keyword	**Definition**	**Datix Field:** Key Words LD (Adults) **(DD Codes)**
1	Challenging behaviour		**ABEHAV**
2	Resettled	*Resettled within the last three years form long stay hospital*	**BRSTLD**
3	Co-morbid physical health problem		**CCMBPH**
4	Co-morbid mental illness		**DCMBMH**
5	Part II or Part III Order	*Detained in hospital; in Guardianship; Supervision & Treatment Orders*	**EPT2R3**
6	24 hour care	*Inpatient; residential or nursing home; supported housing*	**F24HRS**
7	Community LD Service	*All other LD services*	**GCMNTY**
8	Information sharing / communication	*In-house; with GP; with family; with another agency*	**HCOMMS**
9	Transfer / Interface Issue	*Including numerous transitions between Trust services; from children to adult services; between Trusts; inpatient to community; from prison to community; between jurisdictions*	**IINTER**
10	Record keeping	*Record keeping issue that may have been a contributory factor*	**JRCRDS**
11	Good standard of report	*Identifying an exemplar that could be used for best practice example / learning*	**KGSTDR**

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APPENDIX 6

Adult Mental Health- SAI Keywords

	Keyword	Definition	Datix Field: Key Words MH (Adults) (DD Codes)
1	Serious Mental Illness	*Primary diagnosis* as defined in MH (1986) Order (normally schizophrenia; bi-polar disorder; clinical depression; serious PTSD or social phobia impairing cognitive and / or social functioning; eating disorder etc.)	**ASMILL (Main Group)** • **ASMI01 -** Eating Disorder • **ASMI02 -** Psychotic illness • **ASMI03 -** Bi-polar • **ASMI04 -** Clinical Depression
2	MHO Exclusions	*Primary diagnosis* Personality Disorder; promiscuity or other immoral conduct; sexual deviancy or dependence on alcohol or drugs	**BXCLUS (Main Group)** • **BXCL01 -** Alcohol / drug dependence • **BXCL02 -** Personality disorder
3	Common Mental Health problem	*Primary diagnosis* Mild to moderate depression, anxiety, PTSD; social phobias etc. Adjustment disorder	**CCMNMH**
4	Social Stressors	*Not related to mental illness* Family breakdown; chaotic lifestyle; under threat; debt; bereavement; job loss; exam anxiety etc.	**DSOFCT**
5	Part II or Part III Order	Detained in hospital; in Guardianship; Supervision & Treatment Orders	**EPR2R3**
6	Information sharing / communication problem	In-house; with GP; with family; with another agency	**FCOMMS**
7	Transfer / Interface Issue	Including numerous transitions between Trust services; from children to adult services; between Trusts; inpatient to community; from prison to community; between jurisdictions	**GINTER**

	Keyword	Definition	Datix Field: Key Words MH (Adults) (DD Codes)
8	Statutory duty issues	*ASW process; Form 5 & 6; MHRT; OCP; CJ licencing*	**HSDUTY**
9	Non Engagement	*High number of CNA / DNA or refused services*	**INOENG**
10	Record keeping	*Record keeping issue that may have been a contributory factor*	**JRCRDS**
11	Good standard of report	*Identifying an exemplar that could be used for best practice example / learning*	**KGSTDR**
12	Family Focused Practice	*Parent with a mental health issue, impact upon dependent Children wellbeing, emotional wellbeing of carers, family strengths, family stressors, parent and child relationship, past, present and future*	**LFAMFP**

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Form Identifier	"[H & C number]" **Persons - NHS Number**

Child Death Notification form

1. CHILD'S DETAILS

Date of birth	**Persons - DOB**

2. DETAILS OF THE DEATH

Hospital / Place of death name	"[Hospital or place of death where child died.]" **Location Type (facility)**		
Ward	"[Ward or Unit where child died.]" **Location Exact (area within)**		
Date of Death	**Persons - DOD**	Time:	**Time of Incident**
Death outside NI	"[Details if death occurred outside NI.]" **TRSCMS – ROI PCCS and UKPCCS** **TBA - Extra field Name of Hospital? ? Code in the Location Exact?**		

Brief clinical details	"[Enter brief clinical details of case.]" **FS – Description of incident**
Admission diagnosis	"[Enter brief admission diagnosis, if known.]" **? Extra field – confirm with Joanne**

3. OUTCOME - MCCD

MCCD	Cause of Death	Interval
Ia	"[Record exact details as entered on MCCD]" **TBC**	
Ib	"[Record exact details as entered on MCCD]" **TBC**	
Ic	"[Record exact details as entered on MCCD]" **TBC**	

II	"[Record exact details as entered on MCCD]" **TBC**	

4. OUTCOME - CORONER

Coroner contacted – 'discussed' – MCCD issued.	"[Yes or No]" **New field**	Date	"[date Coroner contacted]" **DATE FIELD**
Coroner notified: - for Coroner's PM.	"[Yes or No]" **EF = HM Coroner Informed at death?** **Y / N FIELD**	Date	"[date Coroner contacted]" **DATE FIELD**
Coroner notified: MCCD/proforma requested.	"[Yes or No]" **New field**	Date	"[date Coroner contacted]"
Cause of Death	"[Enter cause of death, if known.]" "[Attach or enter Coroner's verdict when known.]" **New field**		

5. FURTHER QUESTIONS

Was there an expectation, <u>realised at the time of admission,</u> that this patient would die during this admission?	"[Yes or No]" **Update result code**
Further details.	"[Enter details here]"
Did the patient receive palliative End of Life Care?	"[Yes or No]" **New Field EF**
Did the patient receive treatment from the multi-disciplinary Specialised Palliative Care Team?	"[Yes or No]" **New Field EF** **? Query**

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Form Identifier	"[H & C number]"

6. MORTALITY & MORBIDITY MEETING DETAILS

M&M meeting date	"[M&M meeting date.]" Investigation – Date started
Discussion details	"[Record brief details of M&M discussion.]" ? is this the record of the meeting Attachment for Governance to insert to record
Lesson learned Action agreed	"[Details of any lessons learned.]" **Record as free text with intention to identify generic themes which can be captured in lessons learned multi field**
	"[Details of any action agreed, timescale + who is responsible.]"
Lesson learned Action agreed	"[Details of any lessons learned.]"
	"[Details of any action agreed, timescale + who is responsible.]"
Lesson learned Action agreed	"[Details of any lessons learned.]"
	"[Details of any action agreed, timescale + who is responsible.]"
Lesson learned Action agreed	"[Details of any lessons learned.]"
	"[Details of any action agreed, timescale + who is responsible.]"
Lesson learned Action agreed	"[Details of any lessons learned.]"
	"[Details of any action agreed, timescale + who is responsible.]"

7. FINAL CATEGORISATION

Categorise death using the scale below	"[Enter category number]" New EF Multi

1. There were no areas of concern or for consideration in the management of this patient.
2. There were areas for consideration but they made no difference to the eventual outcome.
3. There were areas of concern but they made no difference to the eventual outcome.
4. There were areas of concern which may have contributed to this patient's death.
5. There were areas of concern which CAUSED the death of this patient who would have been expected to survive.

An area of concern is where it is believed that areas of care should have been better.

An area for consideration is where it is believed that areas of care could have been improved whilst recognising that there may be issues for debate.

8. SERIOUS ADVERSE INCIDENT (SAI) REFERRAL

Has a SAI previously been reported?	"[Yes or No]"	"[SAI incident number.]" HSC Trust Unique Ref Number
Following a M&M review, has a SAI needed to be reported?	"[Yes or No]"	"[SAI incident number.]" HSC Trust Unique Ref Number

9. REPORTER DETAILS

Date of Completion	"[Enter date form is completed.]"		
Full name	"[Enter full name of the person completing form.]"		
Title	"[Enter job title.]"		
Organisation:	"[Full Department name.]"	Tele:	"[Full telephone number.]"
E-mail address	"[Email address.]"		

Please return this form to: cdnotifications@hscni.net

Any updates or amendments to be incorporated into this manual are to be notified to:

Geraldine McArdle [redacted]

Elaine Hyde [redacted]

Health and Social Care Board

Health & Social Care Board
12-22 Linenhall Street
BELFAST BT2 8BS

Tel : 0300 555 0115
Web Site : www.hscboard.hscni.net

Dr Michael McBride
Chief Executive
Belfast Health and Social Care Trust
Trust HQ, A Floor
Tower Block
Belfast City Hospital
Belfast BT9 7AB

17 June 2015

Dear Michael

Serious Adverse Incidents (SAIs) – Outstanding Investigation Reports

Please find attached a report detailing the outstanding investigation reports in the Belfast Trust as at 31 May 2015.

Also attached is a chart which highlights the increasing number of outstanding SAI investigation reports during the past twelve months.

The HSCB will continue to monitor this activity on a bi-monthly basis via current SAI reporting arrangements. Should theTrust wish to discuss issues relating to the submission of SAI investigation reports, a meeting with HSCB/PHA can be arranged.

If you require any further clarification, please contact Mrs Anne Kane.

Yours sincerely

Valerie Watts

Valerie Watts
Chief Executive

Enc

cc Dr Cathy Jack
Claire Cairns
Michael Bloomfield
Dr Carolyn Harper
Mary Hinds
Anne Kane

MAHI - STM - 097 - 10426

BHSCT Outstanding / Overdue SAI Investigation Reports – Position at 31 May 2015

Level of Investigation	Number of SAIs
SAI Report Level 1	26
SAI Report Level 2	18
SAI Report Level 3	1
Total	**45**

HSC Trust Reference	HSCB Ref	Reported date	Current Level of Investigation	Investigation Report due	Number of weeks overdue
SEA LEVEL ONE					
BHSCT/SAI/14/78	B4406	4-Jun-2014	SAI Report Level 1	**2-Jul-2014**	48
BHSCT/SAI/14/118	B4880	14-Aug-2014	SAI Report Level 1	**11-Sep-2014**	37
BHSCT/SAI/14/155	B5239	21-Oct-2014	SAI Report Level 1	**18-Nov-2014**	28
BHSCT/SAI/14/163	B5392	13-Nov-2014	SAI Report Level 1	**11-Dec-2014**	24
BHSCT/SAI/14/165	B5440	18-Nov-2014	SAI Report Level 1	**16-Dec-2014**	24
BHSCT/SAI/14/182	B5621	23-Dec-2014	SAI Report Level 1	**20-Jan-2015**	19
BHSCT/SAI/14/185	B5641	24-Dec-2014	SAI Report Level 1	**21-Jan-2015**	19
BHSCT/SAI/15/005	B5756	12-Jan-2015	SAI Report Level 1	**9-Feb-2015**	16
BHSCT/SAI/15/011	B5885	30-Jan-2015	SAI Report Level 1	**27-Feb-2015**	13
BHSCT/SAI/15/015	B5927	9-Feb-2015	SAI Report Level 1	**9-Mar-2015**	12
BHSCT/SAI/15/019	B5995	18-Feb-2015	SAI Report Level 1	**18-Mar-2015**	11
BHSCT/SAI/15/022	B6040	23-Feb-2015	SAI Report Level 1	**24-Mar-2015**	10
BHSCT/SAI/15/023	B6042	24-Feb-2015	SAI Report Level 1	**24-Mar-2015**	10
BHSCT/SAI/15/029	B6073	2-Mar-2015	SAI Report Level 1	**30-Mar-2015**	9
BHSCT/SAI/15/030	B6100	6-Mar-2015	SAI Report Level 1	**3-Apr-2015**	8
BHSCT/SAI/15/037	B6213	26-Mar-2015	SAI Report Level 1	**23-Apr-2015**	5
BHSCT/SAI/15/038	B6214	26-Mar-2015	SAI Report Level 1	**23-Apr-2015**	5
BHSCT/SAI/15/039	B6215	26-Mar-2015	SAI Report Level 1	**23-Apr-2015**	5
BHSCT/SAI/15/041	B6246	1-Apr-2015	SAI Report Level 1	**29-Apr-2015**	5
BHSCT/SAI/15/042	B6290	9-Apr-2015	SAI Report Level 1	**7-May-2015**	3
BHSCT/SAI/15/044	B6345	17-Apr-2015	SAI Report Level 1	**15-May-2015**	2
BHSCT/SAI/15/045	B6348	17-Apr-2015	SAI Report Level 1	**15-May-2015**	2
BHSCT/SAI/15/046	B6347	17-Apr-2015	SAI Report Level 1	**15-May-2015**	2
BHSCT/SAI/15/047	B6380	21-Apr-2015	SAI Report Level 1	**19-May-2015**	2
BHSCT/SAI/15/048	B6430	29-Apr-2015	SAI Report Level 1	**27-May-2015**	1
BHSCT/SAI/15/049	B6453	1-May-2015	SAI Report Level 1	**29-May-2015**	0
RCA LEVEL TWO					
BHSCT/SAI/13/82	B3429	29-Nov-2013	SAI Report Level 2	**21-Feb-2014**	66
BHSCT/SAI/14/39	B3979	21-Mar-2014	SAI Report Level 2	**13-Jun-2014**	50
BHSCT/SAI/14/62	B4256	13-May-2014	SAI Report Level 2	**5-Aug-2014**	43
BHSCT/SAI/14/91	B4501	23-Jun-2014	SAI Report Level 2	**18-Sep-2014**	36
BHSCT/SAI/14/103	B4652	15-Jul-2014	SAI Report Level 2	**7-Oct-2014**	34
BHSCT/SAI/14/129	B4962	28-Aug-2014	SAI Report Level 2	**1-Jan-2015**	21
BHSCT/SAI/14/169	B5473	24-Nov-2014	SAI Report Level 2	**16-Feb-2015**	15
BHSCT/SAI/14/174	B5548	5-Dec-2014	SAI Report Level 2	**27-Feb-2015**	13

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HSC Trust Reference	HSCB Ref	Reported date	Current Level of Investigation	Investigation Report due	Number of weeks overdue
BHSCT/SAI/14/158	B5298	30-Oct-2014	SAI Report Level 2	**2-Mar-2015**	13
BHSCT/SAI/14/179	B5598	12-Dec-2014	SAI Report Level 2	**6-Mar-2015**	12
BHSCT/SAI/14/180	B5605	16-Dec-2014	SAI Report Level 2	**10-Mar-2015**	12
BHSCT/SAI/14/136	B5020	10-Sep-2014	SAI Report Level 2	**11-Mar-2015**	12
BHSCT/SAI/15/003	B5719	7-Jan-2015	SAI Report Level 2	**1-Apr-2015**	9
BHSCT/SAI/15/006	B5797	15-Jan-2015	SAI Report Level 2	**9-Apr-2015**	7
BHSCT/SAI/14/175	B5551	5-Dec-2014	SAI Report Level 2	**13-Apr-2015**	7
BHSCT/SAI/14/177	B5571	9-Dec-2014	SAI Report Level 2	**13-Apr-2015**	7
BHSCT/SAI/15/014	B5925	9-Feb-2015	SAI Report Level 2	**4-May-2015**	4
BHSCT/SAI/15/020	B5999	18-Feb-2015	SAI Report Level 2	**13-May-2015**	3
RCA LEVEL THREE					
BHSCT/SAI/14/128	B4951	27-Aug-2014	SAI Report Level 3	**25-Nov-2014**	27

Draft / Interim Report submitted

Health and Social Care Board

Health & Social Care Board
12-22 Linenhall Street
BELFAST BT2 8BS

Tel : 0300 555 0115
Web Site : www.hscboard.hscni.net

Dr Cathy Jack
Chief Executive
Belfast Health and Social Care Trust
Trust HQ, A Floor
Tower Block
Belfast City Hospital
BELFAST BT9 7AB

30 July 2020

Dear Cathy,

Serious Adverse Incidents (SAIs) – Outstanding Review Reports and Terms of Reference

As you may be aware, in recent years I have routinely written to your predecessor, Martin Dillon, on a quarterly basis to highlight concerns on outstanding SAI review reports. In addition, senior officers from HSCB and PHA have met with Trust staff who have a responsibility for the SAI processes within BHSCT. Despite this, there continues to be an issue with the timely submission of SAI review reports as well as terms of reference for level two and three SAIs; all of which is now further compounded as a result of the Covid-19 pandemic.

Below is a breakdown of the number of SAI review reports and terms of reference outstanding from the BHSCT as at 30th June 2020.

	Year				
	2017	**2018**	**2019**	**2020**	**Total**
SAI Review Reports	4	10	60	38	**112**
Terms of Reference	0	0	3	3	**6**

A report is attached which provides a further breakdown of the above detailing all outstanding review reports and terms of reference for your information.

The report also highlights six terms of reference outstanding, three of which are overdue since 2019. It is equally important that terms of reference are submitted on a timely basis as this delay clearly impacts on the overall completion of the final report. In that respect and to assist HSCB/PHA staff, I would ask that you ensure any future terms of reference submitted to the HSCB for approval, include both name and designation when listing membership of review teams.

I have also attached a chart which highlights the number of outstanding SAI review reports in the BHSCT over a number of reporting periods. You will note that there is a continued increase over the last 24 months with a total of 112 now overdue at the end of June 2020. In particular, over 50% of these outstanding reports relate to the Acute Services programme of care.

We recognise that this is a particularly challenging time for all HSC staff and you will note from my recent correspondence on 22 May 2020 we will continue to work closely with Trust colleagues in order to try and normalise SAI arrangements. In that respect, it would be useful if you could provide me with a plan on how you intend to address the current backlog. I would request that this information is forwarded to serious.incidents@hscni.net and copied to geraldine.mcardle@hscni.net by Monday, 31st August 2020.

In the meantime, if you require any further clarity on the above or associated attachments, please contact Mrs Anne Kane or Mrs Denise Boulter.

Yours sincerely

Valerie Watts
Chief Executive

Enc

cc Claire Cairns
Patricia Crossan
Denise Boulter
Denise Boulter
Dr Hugo Van Woerden
Rodney Morton
Anne Kane

MAHI - STM - 097 - 10430

BHSCT Outstanding / Overdue SAI Review Reports – Position at 30th June 2020

Level of Review	Number of Review Reports Outstanding
Level 1	75
Level 2	36
Level 3	1
Total	**112**

HSC Trust Reference	HSCB Ref	Reported date	Current Level of Review	SEA/LSR/RCA Report due	Number of weeks overdue
SEA/LSR LEVEL ONE					
BHSCT/SAI/17/006	9887	20/01/2017	Level 1	**17/03/2017**	**172**
BHSCT/SAI/17/052	11109	11/08/2017	Level 1	**06/10/2017**	**143**
BHSCT/SAI/18/055	13054	28/06/2018	Level 1	**23/08/2018**	**97**
BHSCT/SAI/18/62	13223	23/07/2018	Level 1	**17/09/2018**	**93**
BHSCT/SAI/18/067	13380	07/08/2018	Level 1	**05/10/2018**	**91**
BHSCT/SAI/18/071	13526	04/09/2018	Level 1	**30/10/2018**	**87**
BHSCT/SAI/18/072	13525	04/09/2018	Level 1	**30/10/2018**	**87**
BHSCT/SAI/18/078	13692	02/10/2018	Level 1	**27/11/2018**	**83**
BHSCT/SAI/18/082	13805	15/10/2018	Level 1	**11/12/2018**	**81**
BHSCT/SAI/18/093	14055	29/11/2018	Level 1	**24/01/2019**	**75**
BHSCT/SAI/17/075	11870	04/12/2017	Level 1	**11/02/2019**	**72**
BHSCT/SAI/18/069	13410	10/08/2018	Level 1	**22/03/2019**	**67**
BHSCT/SAI/19/013	14506	14/02/2019	Level 1	**11/04/2019**	**64**
BHSCT/SAI/19/014	14577	25/02/2019	Level 1	**22/04/2019**	**62**
BHSCT/SAI/19/017	14599	01/03/2019	Level 1	**26/04/2019**	**62**
BHSCT/SAI/19/018	14661	13/03/2019	Level 1	**08/05/2019**	**60**
BHSCT/SAI/19/019	14663	13/03/2019	Level 1	**08/05/2019**	**60**
BHSCT/SAI/19/029	14902	17/04/2019	Level 1	**12/06/2019**	**55**
BHSCT/SAI/19/030	14908	18/04/2019	Level 1	**13/06/2019**	**55**
BHSCT/SAI/19/034	14931	25/04/2019	Level 1	**20/06/2019**	**54**
BHSCT/SAI/19/038	14986	03/05/2019	Level 1	**28/06/2019**	**53**
BHSCT/SAI/19/028	14833	10/04/2019	Level 1	**09/07/2019**	**51**
BHSCT/SAI/19/044	15299	07/06/2019	Level 1	**02/08/2019**	**48**
BHSCT/SAI/19/046	15303	07/06/2019	Level 1	**02/08/2019**	**48**
BHSCT/SAI/19/047	15311	11/06/2019	Level 1	**06/08/2019**	**47**
BHSCT/SAI/19/049	15361	21/06/2019	Level 1	**16/08/2019**	**46**
BHSCT/SAI/19/051	15382	25/06/2019	Level 1	**20/08/2019**	**45**
BHSCT/SAI/19/053	15386	25/06/2019	Level 1	**20/08/2019**	**45**
BHSCT/SAI/19/067	15644	30/07/2019	Level 1	**24/08/2019**	**44**
BHSCT/SAI/19/058	15433	03/07/2019	Level 1	**28/08/2019**	**44**
BHSCT/SAI/19/059	15434	03/07/2019	Level 1	**28/08/2019**	**44**

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HSC Trust Reference	HSCB Ref	Reported date	Current Level of Review	SEA/LSR/RCA Report due	Number of weeks overdue
BHSCT/SAI/19/064	15593	25/07/2019	Level 1	19/09/2019	41
BHSCT/SAI/19/068	15649	31/07/2019	Level 1	25/09/2019	40
BHSCT/SAI/19/069	15647	31/07/2019	Level 1	25/09/2019	40
BHSCT/SAI/19/073	15691	06/08/2019	Level 1	02/10/2019	39
BHSCT/SAI/19/077	15778	15/08/2019	Level 1	10/10/2019	38
BHSCT/SAI/19/078	15784	16/08/2019	Level 1	11/10/2019	38
BHSCT/SAI/19/079	15786	19/08/2019	Level 1	14/10/2019	37
BHSCT/SAI/19/080	15788	19/08/2019	Level 1	14/10/2019	37
BHSCT/SAI/19/083	15877	28/08/2019	Level 1	23/10/2019	36
BHSCT/SAI/19/084	15879	29/08/2019	Level 1	24/10/2019	36
BHSCT/SAI/19/087	15965	06/09/2019	Level 1	01/11/2019	35
BHSCT/SAI/19/088	15975	10/09/2019	Level 1	05/11/2019	34
BHSCT/SAI/19/094	16120	02/10/2019	Level 1	28/11/2019	31
BHSCT/SAI/19/097	16254	18/10/2019	Level 1	13/12/2019	29
BHSCT/SAI/19/098	16300	24/10/2019	Level 1	19/12/2019	28
BHSCT/SAI/19/099	16302	25/10/2019	Level 1	20/12/2019	28
BHSCT/SAI/19/103	16357	01/11/2019	Level 1	27/12/2019	27
BHSCT/SAI/19/105	16402	07/11/2019	Level 1	02/01/2020	26
BHSCT/SAI/19/109	16495	20/11/2019	Level 1	15/01/2020	24
BHSCT/SAI/19/110	16528	21/11/2019	Level 1	16/01/2020	24
BHSCT/SAI/19/111	16535	22/11/2019	Level 1	17/01/2020	24
BHSCT/SAI/19/112	16566	26/11/2019	Level 1	21/01/2020	23
BHSCT/SAI/19/113	16570	26/11/2019	Level 1	21/01/2020	23
BHSCT/SAI/19/114	16609	29/11/2019	Level 1	27/01/2020	22
BHSCT/SAI/19/117	16674	10/12/2019	Level 1	04/02/2020	21
BHSCT/SAI/19/118	16671	11/12/2019	Level 1	05/02/2020	21
BHSCT/SAI/19/121	16720	20/12/2019	Level 1	07/02/2020	21
BHSCT/SAI/19/124	16737	24/12/2019	Level 1	18/02/2020	19
BHSCT/SAI/19/125	16741	27/12/2019	Level 1	21/02/2020	19
BHSCT/SAI/20/001	16828	08/01/2020	Level 1	04/03/2020	17
BHSCT/SAI/20/002	16834	08/01/2020	Level 1	04/03/2020	17
BHSCT/SAI/20/003	16849	13/01/2020	Level 1	09/03/2020	16
BHSCT/SAI/20/004	16850	13/01/2020	Level 1	09/03/2020	16
BHSCT/SAI/20/005	16986	30/01/2020	Level 1	26/03/2020	14
BHSCT/SAI/20/006	16992	31/01/2020	Level 1	27/03/2020	14
BHSCT/SAI/20/007	17044	06/02/2020	Level 1	02/04/2020	13
BHSCT/SAI/20/010	17082	13/02/2020	Level 1	09/04/2020	12
BHSCT/SAI/20/012	17087	14/02/2020	Level 1	10/04/2020	12
BHSCT/SAI/20/014	17136	21/02/2020	Level 1	17/04/2020	11
BHSCT/SAI/19/115	16641	05/12/2019	Level 1	23/04/2020	10
BHSCT/SAI/20/015	17168	27/02/2020	Level 1	23/04/2020	10
BHSCT/SAI/20/017	17184	28/02/2020	Level 1	24/04/2020	10
BHSCT/SAI/20/018	17185	28/02/2020	Level 1	24/04/2020	10
BHSCT/SAI/20/019	17210	04/03/2020	Level 1	29/04/2020	9
RCA LEVEL TWO					
BHSCT/SAI/16/082	9230	22/09/2016	Level 2	12/06/2017	159
BHSCT/SAI/17/054	11224	25/08/2017	Level 2	17/11/2017	137
BHSCT/SAI/18/010	12172	25/01/2018	Level 2	19/04/2018	115

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HSC Trust Reference	HSCB Ref	Reported date	Current Level of Review	SEA/LSR/RCA Report due	Number of weeks overdue
BHSCT/SAI/18/049	13013	18/06/2018	Level 2	06/11/2018	86
BHSCT/SAI/18/074	13559	12/09/2018	Level 2	05/12/2018	82
BHSCT/SAI/18/085	13831	18/10/2018	Level 2	10/01/2019	77
BHSCT/SAI/18/064	13255	27/07/2018	Level 2	17/01/2019	76
BHSCT/SAI/18/087	13901	29/10/2018	Level 2	21/01/2019	75
BHSCT/SAI/18/013	12237	05/02/2018	Level 2	11/03/2019	68
BHSCT/SAI/19/008	14404	29/01/2019	Level 2	23/04/2019	62
BHSCT/SAI/17/040	10729	22/06/2017	Level 2	30/04/2019	61
BHSCT/SAI/18/016	12254	06/02/2018	Level 2	10/05/2019	60
BHSCT/SAI/19/022	14694	19/03/2019	Level 2	11/06/2019	55
BHSCT/SAI/19/027	14757	29/03/2019	Level 2	21/06/2019	54
BHSCT/SAI/19/025	14732	25/03/2019	Level 2	24/06/2019	53
BHSCT/SAI/19/035	14932	25/04/2019	Level 2	18/07/2019	50
BHSCT/SAI/19/039	14989	03/05/2019	Level 2	26/07/2019	49
BHSCT/SAI/19/041	15175	22/05/2019	Level 2	14/08/2019	46
BHSCT/SAI/19/042	15238	29/05/2019	Level 2	21/08/2019	45
BHSCT/SAI/18/096	14170	21/12/2018	Level 2	23/08/2019	45
BHSCT/SAI/19/040	15088	17/05/2019	Level 2	30/08/2019	44
BHSCT/SAI/19/060	15437	04/07/2019	Level 2	26/09/2019	40
BHSCT/SAI/19/061	15449	05/07/2019	Level 2	27/09/2019	40
BHSCT/SAI/19/076	15712	09/08/2019	Level 2	01/10/2019	39
BHSCT/SAI/19/086	15961	06/09/2019	Level 2	29/11/2019	31
BHSCT/SAI/19/090	15984	10/09/2019	Level 2	03/12/2019	30
BHSCT/SAI/19/096	16157	09/10/2019	Level 2	01/01/2020	26
BHSCT/SAI/19/101	16341	31/10/2019	Level 2	23/01/2020	23
BHSCT/SAI/19/102	16342	31/10/2019	Level 2	23/01/2020	23
BHSCT/SAI/19/106	16410	12/11/2019	Level 2	04/02/2020	21
BHSCT/SAI/19/120	16679	12/12/2019	Level 2	05/03/2020	17
BHSCT/SAI/19/036	14969	01/05/2019	Level 2	06/03/2020	17
BHSCT/SAI/19/122	16723	20/12/2019	Level 2	02/04/2020	13
BHSCT/SAI/20/008	17074	12/02/2020	Level 2	06/05/2020	8
BHSCT/SAI/20/009	17079	13/02/2020	Level 2	07/05/2020	8
BHSCT/SAI/20/011	17084	13/02/2020	Level 2	07/05/2020	8
RCA LEVEL THREE					
BHSCT/SAI/19/048	15331	14/06/2019	Level 3	25/05/2020	5

Level of review has changed since initial notification

Review Report due date has been revised, this includes those extended due to Interim COVID arrangements

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BHSCT Outstanding / Overdue Terms of Reference & Team Membership

HSC Trust Reference	HSCB Ref	Reported date	Notification	Level 2 TOR Due	Number of weeks overdue
BHSCT/SAI/19/040	15088	17/05/2019	Level 2	**05/07/2019**	**52**
BHSCT/SAI/19/086	15961	06/09/2019	Level 2	**04/10/2019**	**39**
BHSCT/SAI/19/090	15984	10/09/2019	Level 2	**08/10/2019**	**38**
BHSCT/SAI/19/036	14969	01/05/2019	Level 2	**10/01/2020**	**25**
BHSCT/SAI/19/122	16723	20/12/2019	Level 2	**06/02/2020**	**21**
BHSCT/SAI/20/009	17079	13/02/2020	Level 2	**12/03/2020**	**16**

In addition to the above, the completion of the following SAI review report has been deferred pending the outcome of other HSC investigation/review processes or another statutory agency/external body review

HSC Trust Reference	HSCB Ref	Reported date	Current Level of Review
BHSCT/SAI/17/076	11872	04/12/2017	Level 1
BHSCT/SAI/18/028	12501	29/03/2018	Level 1
BHSCT/SAI/18/036	12660	27/04/2018	Level 1

Safety and Quality Improvement Plan - Performance Report as at 28/02/22

Activity Report

Overview of Notifications reported by Year

Classification	2018	2019	2020	2021	2022	Total	% increase from 2018 to 2021
Serious Adverse Incident	369	459	497	594	77	**1996**	61%
SAI Never Event	11	13	21	20	2	**67**	82%
Early Alert	173	278	467	554	86	**1558**	220%
Total	**553**	**750**	**985**	**1168**	**165**	**3621**	

Overview of Open SAI Records

Current Position	Total No. of records
Final Report Received (<8 weeks)	51
Final Report Received (>8 weeks)	64
SAIs Deferred	41
Report overdue (waiting submission by Reporting Organisation)	594
In Process (Final Report not yet due)	97
Total	**847**

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Internal Performance Measures

1. Learning to be issued

Breakdown of learning to be issued following identification that sits outside the timeframe (6 weeks) as outlined in the Safety & Quality Improvement Plan.

Letters

Programme of Care	6-12 months	12 months+	No. of SAIs linked to learning	Total Letters to be issued
Reminder of Best Practice Letter	2	2	4	2
Learning Letter	3	1	4	3
Total			**8**	**5**
Comparison to previous data as at 30.09.21				4
Comparison to previous data as at 28.01.21				19

Note :

- Two letters included in the above figures have been retracted and are currently being amended for reissue
- Two letters have been excluded from the above figures as they have been put on hold (one on hold awaiting amendment to guidance before development of letter / one awaiting approval from DoH re issuing of learning)
- It is anticipated that all letters, including the two on hold, will be disseminated before the end of March 2022.

Articles

Programme of Care	< 3 months	3-6 months	6-12 months	12 months+	24 months+	Total no. of SAIs linked to learning	Total Articles to be issued
SAIs to be Incorporated into Integrated Care Articles	0	2	3	1	0	**6**	**6**
SAIs to be Incorporated into Learning Matters Articles	3	11	8	17	16	**55**	**33**
Comparison to previous data as at 30.09.21							29

Integrated Care Articles were not included in previous data, therefore a comparison is not available.

Note: 8 articles are currently with Page Setup Design for completion and will be issued within the next two weeks. Further editions incorporating 23 articles are in production to be issued before the end of March 2022.

2. Assurances re Safety & Quality Alerts to be reviewed by Professional Lead

Number of Assurances received awaiting review by Professional Lead outside of agreed timeframe (Level 2 SQAs to be assessed within 5 working days / Level 3 SQAs - within 15 working days).

Nil Return – all assurances are within timeframe as outlined above.

3. Final Reports with HSCB/PHA for review

Final Review Reports with HSCB/PHA awaiting identification of learning/closure that sit outside the timeframe (8 weeks) as outlined in the Safety & Quality Improvement Plan:

Programme of Care	Awaiting HSCB / PHA Action			Total no. of Review Reports for consideration by Professional Group	No. of Review Reports awaiting Action from Rep. Org following initial review	Total no. of Review Reports Received
	Level 1	Level 2	Level 3			
Acute Services (Primary Care) Level	8	6		**14**	12	26
Elderly	6	1		**7**	2	9
Family and Childcare (inc CAMHS)	3	1		**4**	1	5
Learning Disability					1	1
Maternity and Child Health	2	4		**6**	5	11
Mental Health	1	2	2	**5**	7	12
Total as at 28.02.22	**20**	**14**	**2**	**36**	**28**	**64***
Comparison to data as at 30.09.21	**23**	**5**	**2**	**30**	**25**	**55**
Comparison to data as at 28.01.21	**55**	**18**	**6**	**79**	**13**	**92**

Breakdown by timescale:

Programme of Care	8wks - 3 months	3-6 months	6-12 months	12 months+	24 months+	Total
Acute Services	5	13	6	2		**26**
Elderly	3	2	4			**9**
Family and Childcare (inc CAMHS)	2	1	2			**5**
Learning Disability		1				**1**
Maternity and Child Health		4	6	1		**11**
Mental Health	3	6	1	1	1	**12**
Total	**13**	**27**	**19**	**4**	**1**	**64**

***Note** - The above data does not include 3 SAIs on internal pause – 2 are awaiting the dissemination of a PSA Alert to ascertain if Regional Learning is required / 1 Covid related SAIs due to the scale of family engagement involved.

4. ToRs with HSCB/PHA Awaiting Approval

ToRs with HSCB/PHA awaiting approval that sit outside the timeframe (2 weeks for Level 2 Reviews and 4 weeks for Level 3 Reviews) as outlined in the Safety & Quality Improvement Plan:

Programme of Care	Awaiting HSCB / PHA Action	Awaiting Trust Action	Total
Acute Services	1		1
Elderly		1	1
Learning Disability	1		1
Total as at 10.02.22	**2**	**1**	**3**

Comparison to previous data as at 30.09.21	**5**	**3**	**8**
Comparison to previous data as at 28.01.21	**2**	**0**	**2**

ToR awaiting approval by timescale

Programme of Care	< 3 months	3-6 months	6-12 months	12 months+	Total
Acute Services	1				**0**
Elderly	1				**0**
Learning Disability	1				**0**
Total	**3**	**0**	**0**	**0**	**0**

5. Deferred SAIs

Number of SAI records currently deferred, this may be due to ongoing Police Investigation or consideration by SBNI of a Case Management Review.

Programme of Care	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total
Acute Services	2			10*		**12**
Elderly	2		1	3		**6**
Family and Childcare (inc CAMHS)	3		5			**8**
Learning Disability	5					**5**
Mental Health	1	3	4		2	**10**
Total	**13**	**3**	**10**	**13**	**2**	**41**

- Note: Urology

6. Overdue Review Reports from Reporting Organisation

Number of Overdue Review Reports by Reporting Organisation / Programme of Care:

Programme of Care	BHSCT	BSO	HSCB	NHSCT	NIAS	PCARE	PHA	SEHSCT	SHSCT	WHSCT	Total
Acute Services	117			21	20		1	15	26	28	**228**
Corporate Business / Other	10	1		1						1	**13**
Elderly	14			3				2	5	3	**27**
Family and Childcare (inc CAMHS)	47			12				16	4	5	**84**
Learning Disability	21			7				2	4	1	**35**
Maternity and Child Health	32		1	7					15	4	**59**
Mental Health	28			63				9	27	14	**141**
Physical Disability and Sensory Impairment								1			**1**
Primary Health and Adult Community (includes GP's)	1					2		2	1		**6**
Total	**270**	**1**	**1**	**114**	**20**	**2**	**1**	**47**	**82**	**56**	**594**

Comparison to data as at 30.09.21	247	1	1	100	12	10	2	38	67	47	**525**
Comparison to data as at 28.01.21	200	0	3	68	26	6	2	44	74	52	**496**

Breakdown by Level of Review:

Level of Review	BHSCT	BSO	HSCB	NHSCT	NIAS	PCARE	PHA	SEHSCT	SHSCT	WHSCT	Total
Level 1	221	1	1	98	20	2		45	49	42	**479**
Level 2	42			14			1	2	30	14	**103**
Level 3	7			2					3		**12**
Total	**270**	**1**	**1**	**114**	**20**	**2**	**1**	**47**	**82**	**56**	**594**

Breakdown by timescale:

	0 - 3 months	3-6 months	6-12 months	12 months+	24 months+	36 months+	Total
Report overdue	157	122	173	104	29	9	**594**

7. Overdue Terms of Reference and Team Membership from Reporting Organisation

Number of overdue Terms of Reference and Team Membership by Reporting Organisation / Programme of Care:

Programme of Care	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	PCARE	Total
Acute Services	4	1		1	2		**8**
Elderly	3						**3**
Learning Disability	8			1			**9**
Maternity and Child Health	3		1	4	1		**9**
Mental Health	1	3	1				**5**
Total	**19**	**4**	**2**	**6**	**3**	**0**	**34**

Comparison to data as at 30.09.21	4			4	4		**12**
Comparison to data as at 28.01.21	5	2	1	23	4	**1**	**36**

Breakdown by timescale:

	0 - 3 months	3-6 months	6-12 months	Total
ToR overdue	21	9	4	**34**

8. Outstanding Assurances from Reporting Organisation

Number of outstanding assurances in relation to Safety & Quality Alerts by Reporting Organisation / Type of Learning:

Type of Learning	BHSCT	NHSCT	NIAS	SEHSCT	SHSCT	WHSCT	Total
DoH SQSD Circular	3	3	1	1			8
Learning Letter	2			2	2		6
Learning Reminder	2					1	3
Professional Letter	2	1		1		1	5
Total as at 28.02.22	9	4	1	4	2	2	22
Comparison to previous data as at 30.09.21	6	7	1	4	3	5	26

Breakdown by timescale:

	0 - 3 months	**3-6 months**	**6-12 months**	**12 months+**	**24 months+**	**Total**
Number of outstanding Assurances	9	3	4	4	2	**22**

MAHI - STM - 097 - 10441

FROM: Rodney Morton PHA/ Patricia Crossan HSCB

DATE: 15th December 2020

TO: HSCB SMT

ISSUE:	Update on SAI position both internal and from HSC Trusts
TIMING:	15th December 2020
PRESENTATIONAL ISSUES	n/a
FOI IMPLICATIONS	n/a
FINANCIAL IMPLICATIONS	n/a
LEGISLATION/POLICY IMPLICATIONS	n/a
EQUALITY/HUMAN RIGHTS/RURAL NEEDS IMPLICATIONS	n/a
RECOMMENDATION	SMT are asked to note this update and actions taken

1. INTRODUCTION/BACKGROUND

On 17th November 2020 a paper titled 'an Overview of Safety and Quality process in relation to SAIs, Early Alerts and SQAs' was discussed at SMT. The paper highlighted that **219** reports were currently open with the HSCB/PHA and 445 outstanding from the HSC Trusts, therefore colleagues were requested to provide SMT with an update/further information on these, including issues and solutions to address the backlog.

2. Summary of Backlog

Table 1

	HSCB /PHA	HSC Trusts
Current Position	**219**	**445**
% Level 1	**70%**	**74%**
% Level 2	**24%**	**24%**
%Level 3	**6%**	**2%**
Top three POC		

Acute	**15%**	**35%**
Mental Health	**16%**	**10%**
Family and Child Care	**53%**	**33%**
Delay timings		
0-6	**40%**	**47%**
>6	**60%**	**53%**

3. Reasons Underpinning Backlog

There are numerous reasons for this backlog the main ones are listed below

- Capacity within DRO's
- Sourcing panel members
- Delays in responses from Trusts to DRO queries
- Delays due to Covid
- Other processes e.g. PSNI, CMR

4. Summary of improvements/ actions PHA/HSCB:

1. DRO's have been asked to conclude all reports by March 2021
2. Mental Health Group DRO's are reviewing all their open reports to progress to closure by December 2020. If this is not progressed a separate group will be established to take this forward.
3. Additional capacity has been sought from the Leadership Centre to assist children and young people's team this will be in place by January 2021
4. New backlogs will be prevented by March 2021

Further detail in attached paper 1

5. Updated position HSC Trusts:

While the *Procedure for the Reporting and Follow up of Serious Adverse Incidents (2016)* outlines timescales for the submission of SAI reports from Trusts following notification it is rare that reports are submitted within these timescales. As outlined in paper 2 Trusts note a number of reasons for this mainly difficulty with securing panels to carry out the review.

Despite longstanding communication and engagement from the HSCB on outstanding reports there has been no improvement in this position in fact despite a letter in June 2020 to all Trusts asking for an action plan to deal with backlogs delays have in fact extended (370 delayed in June 2020 and 445 in October 2020) see updated position below (table 2)

Table 2

Reporting Organisation	Number when Cx letter sent 30th June 2020	Number as of 30th October 2020	Percentage
SHSCT	56	68	16%
NHSCT	48	66	15%
NIAS	46	27	6%
SEHSCT	32	35	8%
PCARE	11	8	2%
WHSCT	65	74	17%
BHSCT	112	161	36%
Other		6	1%
Total	**370**	**445**	**100%**

The Governance and Safety and Quality Nursing team will liaise with each individual Trust regarding their backlog and the development of a time bound improvement plan and provide an update to SMT regarding issues and concerns. This will include an oversight team who will oversee progress towards this. A performance improvement template (to include timescales for improvement) individual to each Trust will be developed and should be included in discussions at Trusts accountability meetings.

Further detail outlined in paper 2

6. Summary

All of the above delays outline the need for the development of a Standard Operating Procedure for the management of the SAI timescales to include times when the process needs to be deferred due to some of the reasons above and the timescales readjusted accordingly while ensuring that any immediate learning is disseminated in a robust and timely way.

RECOMMENDATION

SMT is asked to note this paper and the actions to be taken forward

Name of Directors: Rodney Morton PHA (363505)

Patricia Crossan HSCB (363293)

Appended: Paper 1- update on HSCB/ PHA position
Paper 2- update on actions re HSC Trusts position

Safety and Quality Improvement Plan: **MAHI - STM - 097 - 10444**

The improvement plan aims to put in place an effective safety and quality structure across the HSCB and PHA supported by a culture of quality improvement. The plan focuses on the development of a robust performance management framework with a particular emphasis on the management of Serious Adverse Incidents (SAI), Early Alerts and Safety and Quality Alerts (SQA). The plan will be further enhanced by the development of detailed action plans to support the achievement of strategic requirements.

No.	Aim (Primary Driver)	Secondary Driver	Strategic Requirements	Measurement / Performance Indicators/Timescales	
Internal Performance Measures					
1	**Review the Safety and Quality structures within the HSCB/PHA that provide assurance to SMT / AMT, Governance & Audit Committees / Boards of HSCB / PHA that effective Safety and Quality processes are in place.**	Establish an effective safety framework for the HSCB/PHA. Establish robust and effective Safety and Quality processes that support the Safety Framework to ensure smooth migration of Safety and Quality functions to DoH.	Review the current processes in place for the role, remit and function of the Quality, Safety and Experience Group and the Safety Quality Alerts Team and other associated Safety and Quality Groups.	Complete	Internal
2	**A dedicated resource within the HSCB responsible for the managing and reporting of SAIs in line with the HSCBs Regional Procedure for the Reporting and Follow up of SAIs issued in 2016.**		Lisa McWilliams, Director of PMSI assigned HSCB Lead Officer responsible for the management of SAIs.	Complete	Internal
			Establish a Professional Directors Forum to support the responsible Officer for the management of SAIs.	Monthly meetings to be arranged commencing February 2021	

No.	Aim (Primary Driver)	Secondary Drivers	Strategic Requirements	Measurement / Performance Indicators/Timescales	
3	**Establish an improvement team within the HSCB who will work:** **• Across HSCB and the PHA professional groups** **• Collaboratively with each Trust**	Improvement Team to secure an understanding of organisational positions, assess risk and agree timescales for recovery action.	Identify a HSCB/PHA Lead(s) to put in place an effective team to ensure a process of continuous improvement.	Complete	Internal
			Identify a Project Manager who is familiar with the systems and processes in relation to SAIs.	To be completed	
4	**Regional Leaning is issued within the agreed timescales.**	Learning identified to be disseminated in the form of a Learning letter, Reminder of Best Practice Letter to be finalised / circulated within 6 weeks. Learning identified to be included in a Learning Matters Newsletter within 8	Address the current backlog of Regional Learning to be issued.	The number of learning letters, currently open on the system, that have not been issued within 6 weeks of identification. **Current Status = See Table 1** The number of Learning Matters Articles that have not been issued within a Learning Matters Newsletter within 8 weeks of identification. To be monitored	Internal
			Ensure there is a lean process in place going forward to issue Regional Learning within agreed timescales.		
5	**Ensure there is an effective and robust process in place to performance manage HSCB/PHA internal processes from the submission of final review report to the identification of learning and closure of SAIs.**	All SAIs to be managed by a SAI Professional Group. SAIs should be closed within 13 weeks following receipt of the SAI Review Report. To include	Ensure there is a lean process in place going forward whereby SAIs are reviewed, learning identified and records closed within agreed timescales.	The number of weeks taken to close SAIs following receipt of the Review Report. **Current Status = See table 2**	Internal

No.	Aim (Primary Driver)	Secondary Driver	Strategic Requirements	Measurement / Performance Indicators/Timescales	
		• 4 week check point			
6	**An effective process is in place to approve ToR received within agreed timescales.**	ToRs to be approved by DROs within 2 weeks of receipt.	Address the current backlog of ToRs Ensure there is a lean process in place going forward whereby ToRs are approved within agreed timescales.	The number of ToRs that have not been approved within 2 weeks of submission. **Current Status = see table 3** **To be monitored**	Internal
7	**An effective system in place for the management of Level 3 Reviews in line with the HSCB's Regional Procedure for the Reporting and Follow Up of SAIs.**	Level 3 reviews should be monitored to ensure realistic timescales for individual SAIs are being established and achieved.	Establish an oversight team to monitor Level 3 SAI Reviews and ensure individual timescales have been established. To develop improvement indicators.	TBC	Internal
External Performance Measures					
1	**To put in place a performance management framework to ensure the timely submission of:** • **SAI Review Reports** • **Terms of Reference** • **Assurances on Safety & Quality**	Review Reports should be submitted within timeframes: • Level 1 – within 8 weeks of notification • Level 2 - within 12 weeks of notification • Level 3 - to be submitted within a	Work with HSC Trusts to develop a time bound improvement plan for the current backlog and any deferred SAIs: • Letter to be sent to all Reporting Organisations • Arrange follow up meetings	The number of SAIs where the Review Report is overdue. **Current Status = see table 4** The number of SAIs	External

No.	Aim (Primary Driver)	Secondary Driver	Strategic Requirements	Measurement / Performance Indicators/Timescales	
	Alerts	realistic timescale agreed by HSCB/PHA and Reporting Organisation.	Develop accountability protocols to hold Reporting Organisations to account for delays through their accountability meetings. Consider amending timescale for submission.	where the ToR is overdue. **Current Status = see table 5** The number of assurances overdue by the response due date. Meetings arranged for February 2021 with Trusts	

HEALTH AND SOCIAL CARE BOARD/PUBLIC HEALTH AGENCY
TERMS OF REFERENCE
QUALITY SAFETY AND EXPERIENCE GROUP (QSE)

1.0 Introduction

The Health and Social Care Board (HSCB) and the Public Health Agency (PHA) receive information and intelligence from a wide range of sources in relation to safety, quality and patient experience of services commissioned.

The purpose of the Quality, Safety and Experience Group is to identify themes, patterns and areas of concern emerging from all existing sources; and agree the actions to be taken to address these in order to improve the safety and quality of services commissioned. A diagrammatic overview of the Quality, Safety Experience Internal co-ordination arrangements for the PHA/HSCB is attached in appendix 1.

2.0 Objectives of the QSE Group

2.1 To streamline and further enhance current arrangements in relation to Safety, Quality and Patient Experience;

2.2 To consider learning, patterns, themes or areas of concern from all sources of information and to agree appropriate actions to be taken, and follow up of agreed actions;

2.3 To provide an assurance to the Senior Management Team of the HSCB, the Agency Management Team of the PHA and the Governance Committees and Boards of both organisations that the QSE Group has an overview of all sources of information in relation to the safety, quality and patient experience of services and is co-ordinating appropriate action in response.

3.0 Working Arrangements between Existing Groups/Information Flow to QSE

3.1 The Regional Serious Adverse Incident Review Group (SAI) and the Regional Complaints Group (RCG) will be reconstituted as a Serious Adverse Incident Sub Group and a Regional Complaints Sub Group of the QSE Group.

3.2 The Complaints and SAI Sub Groups, which will be multi-disciplinary groups, will meet on a monthly basis, prior to each QSE group, to consider in detail issues emerging from SAIs and complaints and agree issues which require to be referred to the QSE, together with a recommendation for consideration.

3.3 Other existing groups relating to the Patient Experience, Medicines Management, SQAT, Safeguarding Board and Case Management Reviews and Quality 2020 will refer matters on an agreed basis to the QSE Group with an appropriate recommendation for consideration.

4.0 Membership of the QSE

Joint Chairs: **Director of Nursing, Midwifery and Allied Health Professionals;**

Director of Public Health/Medical Director;

Director of Performance and Corporate Services;

Director of Social Care;

Assistant Director of Social Care (Safety and Quality Lead);

Representative for General Medical Services/Safety and Quality;

Head of Pharmacy and Medicines Management;

Assistant Director of Nursing and Allied Health Professionals;

Assistant Director of Public Health Medicine (Safety and Quality)

Clinical Director, Safety Forum;

Governance Manager;

Head of Nursing, Quality and Patient Safety;

Pharmacy Lead – Medicines Governance and Public Health;

Complaints/Litigation Manager;

Head of Dental Services (co-opt as required);

Head of Optometry (co-opt as required);

Assistant Director of Allied Health Professionals (co-opt as required);

In Attendance:

Deputy Complaints Manager

Assistant Governance Manager

Senior Nurse (Safety, Quality and Patient Experience)

5.0 Frequency of Meetings

Meetings of the Group will be monthly

6.0 Administrative Support to the QSE Group

6.1 The Action log shall be taken by the Director of Nursing Midwifery and Allied Health Professionals (or her nominated deputy).

6.2 The agenda and papers will be developed and circulated by Corporate Services staff.

6.3 Agreed actions will be followed up by Corporate Services staff.

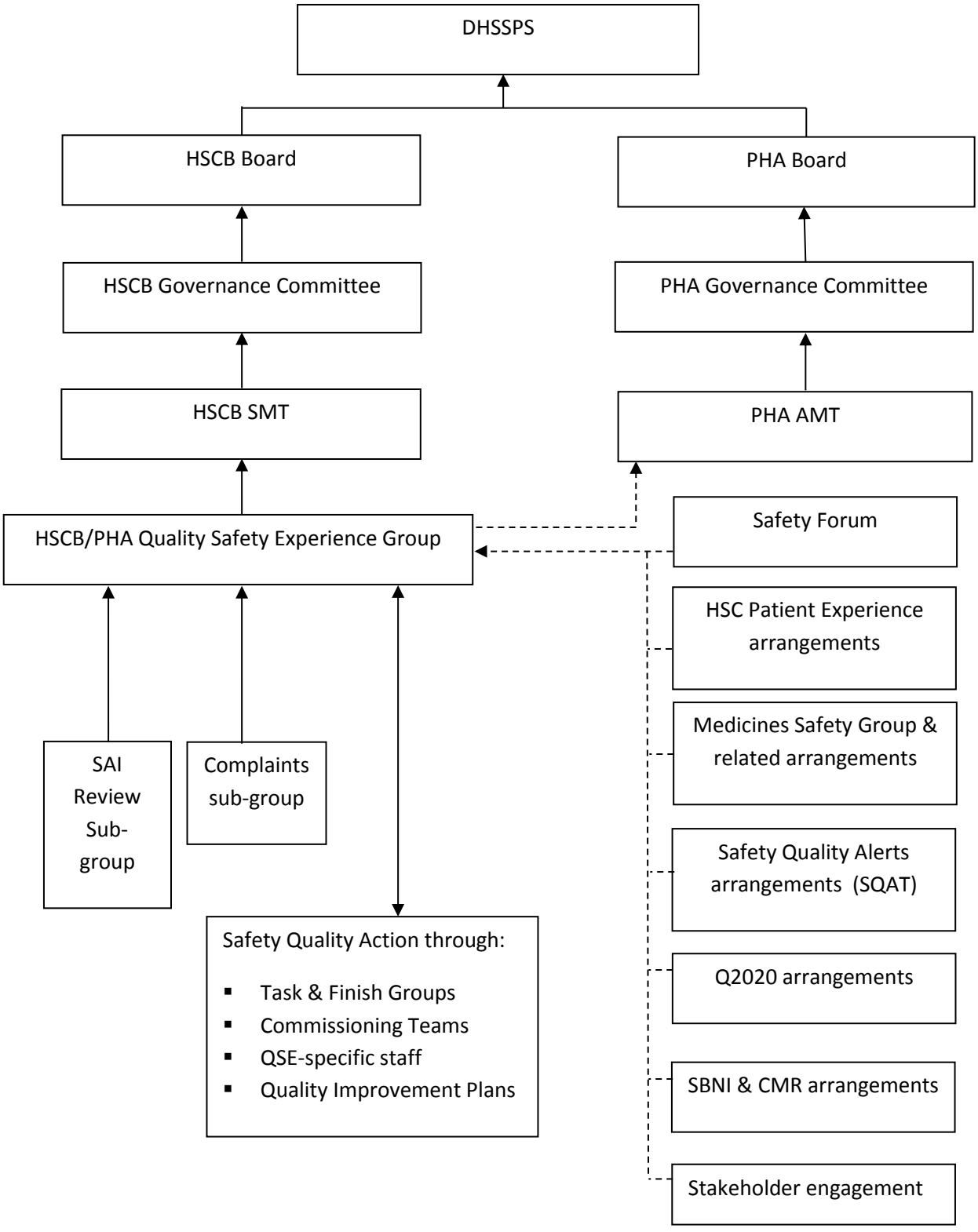
6.4 Agenda items and papers should be forwarded to qse.team@hscni.net

7.0 Review of Terms of Reference

These Terms of Reference will be reviewed in 12 months.

Appendix 1

Diagrammatic Overview of Quality Safety Experience Internal Coordination Arrangements – HSCB/PHA



MAHI - STM - 097 - 10452

HEALTH AND SOCIAL CARE BOARD / PUBLIC HEALTH AGENCY

SERIOUS ADVERSE INCIDENT LEARNING SUB-GROUP

TERMS OF REFERENCE

1. INTRODUCTION

The purpose of the Serious Adverse Incident Learning Sub Group (SAILSG) is to provide assurances that appropriate structures, systems and processes are in place within the Health and Social Care Board (HSCB) and Public Health Agency (PHA) for the management and follow up of serious adverse incidents arising during the course of the business of an HSC organisation/Special Agency or commissioned service.

The SAILSG has oversight across all professional groups and has responsibility to ensure that themes and trends, best practice and learning is identified and disseminated in a timely manner, in conjunction with the HSCB/PHA Quality and Safety Experience Group (QSE) and Safety and Quality Alert Team (SQAT).

2. ACCOUNTABILITY OF THE GROUP

The SAILSG will report to the HSCB/PHA QSE Group.

3. OBJECTIVES OF THE GROUP

3.1 Examine themes and trends from SAIs and where appropriate ensure that any regional learning/ practice issues arising from SAIs are shared with the QSE group in a timely manner

3.2 Make recommendations to the QSE Group on the commissioning of:

- 3.2.1 Thematic Reviews
- 3.2.2 Independent reviews in respect of specific SAIs;

3.3 Escalate, issues of concern and importance, in respect of SAIs to the QSE Group, as appropriate;

3.4 Provide a bi-annual SAI Learning Report to the Board of the HSCB and PHA and their respective Governance committees;

3.5 Provide assurances to SMT, AMT and the Boards of the HSCB and PHA and respective Governance Committees that SAIs are managed and followed up in line with the SAI procedure

3.6 Have oversight of updates to the policy and procedure for the Reporting and Follow up of SAIs

4. MEMBERSHIP OF THE GROUP

Core membership of the SAILSG will consist of the following officers, or their nominated representative, from the HSCB and the PHA:

- **Co-Chairs**
  - HSCB Governance Manager
  - PHA Quality and Safety Lead

- **Members**
  - HSCB Assistant Governance Manager
  - Acute SAI Professional Group Representative
  - Maternity SAI Professional Group Representative
  - Paediatric & Child Health SAI Professional Group Representative
  - Older Peoples SAI Professional Group Representative
  - Primary Care SAI Professional Group Representative
  - Corporate Services SAI Group Representative *
  - Mental Health SAI Group Representative
  - Children's Services SAI Group Representative

**Governance Manager will represent Corporate Services; the Chair will be invited to attend where specific agenda items require discussion*

In Attendance:

- RQIA representatives (*for items of mutual interest to both RQIA and HSCB/PHA*)
  - Assistant Director Nursing and Pharmacy
  - Assistant Director Mental Health and Learning Disability

- HSCB Complaints Manager *(for items of mutual interest relating to complaints issues)*

(Refer to attached addendum for current membership listing)

The SAILSG may also invite, as appropriate, the relevant HSCB/PHA Officers from the service area in which a serious adverse incident has arisen, to attend meetings where that incident is being considered. Equally, where the SAIRSG considers that it requires other specialist knowledge it is at liberty to invite/co-opt any relevant specialist to provide advice.

5. QUORUM

The SAILSG shall be quorate by the attendance of four members of the Group, to include the Chair and/or Co Chair and representation of two professional areas.

In exceptional circumstances, meetings can proceed without relevant professionals present this can be endorsed at the next meeting.

6. ADMINISTRATION

The SAILSG will be supported by the Governance Team who will ensure:

- agreement of the agenda with Chairperson;
- collate and circulate all associated papers at least 3 working days in advance of each meeting (*representatives in attendance for items of mutual interest will only to be circulated related papers*);
- keep a record of matters arising and log of actions;
- take forward the work of the SAIRSG, in conjunction with group members, to ensure actions, learning and outcomes from each meeting are progressed.

The action log from each meeting shall be approved and considered at the following meeting.

7. RELATIONSHIP / LINKS WITH OTHER GROUPS

There are a range of other quality and safety or improvement groups across the HSCB/PHA where learning and best practice can be identified and shared. To ensure continuity of learning the SAIRSG will work in conjunction with these groups.

8. FREQUENCY OF MEETING

The SAILG meetings will take place bi-monthly

9. REVISION OF TERMS OF REFERENCE

The SAILSG will review its Terms of Reference after six months (initially and then annually) or earlier as required.

MAHI - STM - 097 - 10456

ADDENDUM

Membership of Group – September 2018

- **Co-Chairs**

- HSCB Governance Manager - Anne Kane
- PHA Quality and Safety Lead - Christine Armstrong

- **Members**

- HSCB Assistant Governance Manager - Jacqui Burns
- Acute SAI Professional Group Representative - TBA
- Maternity SAI Professional Group Representative - TBA
- Paediatric & Child Health SAI Professional Group Representative -TBA
- Older Peoples SAI Professional Group Representative -TBA
- Primary Care SAI Professional Group Representative - TBA
- Corporate Services SAI Group Representative * - Anne Kane
- Mental Health SAI Group Representative - TBA
- Children's Services SAI Group Representative - TBA

**Governance Manager will represent Corporate Services; the Chair will be invited to attend where specific agenda items require discussion*

MAHI - STM - 097 - 10457

SAI Professional Group

Terms of Reference

1. Purpose of the Group

To ensure collective, multidisciplinary decision making on the management of SAI Reviews and the identification of regional learning in line with the 'Procedure for the Reporting and Follow up of Serious Adverse Incidents (November 2016)'.

SAI Professional Groups provide a systematic process for reviewing incidents to identify and agree on potential regional learning to be disseminated across the wider service to improve patient safety and reduce the risk of recurrence, not only within the reporting organisation, but across Health and Social Care as a whole.

2. Objectives of the Group

Level 1 Reviews

Members of the SAI Professional Group must:

- Ensure review reports have been signed off by the relevant professional or operational director within the reporting organisation given that the process assigns reporting organisations the responsibility for quality assuring Level 1 SEA reviews, ensuring the robustness of the report and identifying learning prior to submission to the SPPG;
- Establish if regional learning identified by the reporting organisation should be shared with the wider service and consider the most appropriate method of dissemination.

Level 2/3 Reviews

Members of the SAI Professional Group must:

- Consider and approve Terms of Reference and Team Membership for Level 2 and Level 3 reviews, as required;
- Consider Root Cause Analysis (RCA) Reports to ensure a robust review has been conducted. If there are concerns, SAI Professional Group members should liaise with the reporting organisation and/or other professionals /officers, including RQIA (*where relevant*) until a satisfactory response is received;
- Consider all recommendations of suggested / proposed learning documented within the review report. In addition, identify any related learning to be communicated across the HSC and consider the most appropriate method of dissemination;
- Review Action plans ensuring they clearly set out how/when each recommendation will be implemented, with named leads responsible for each action point. As required, SPPG/PHA to follow up with the reporting organisation to ensure successful delivery of the action plan;
- Identify any immediate/medium/long term strategic issues which contributed to the incident and need to be addressed, communicate these to the relevant commissioning service.

All Levels of Review

Members of the SAI Professional Group must:

- Agree on appropriate closure of the incident;
- Ensure the timely development of regional learning for approval by the Weekly Incident and Learning Review Group and onward referral to Safety Brief;
- Ensure timely and appropriate level of engagement afforded to service users/families/carers by the reporting organisation throughout the review;
- Liaise with other Professional Colleagues as required;
- Escalate areas of concern as appropriate to Safety Brief for guidance;
- Record any local learning identified following a SAI Review;
- Surveillance of SAIs to identify patterns/clusters/trends;
- Verify regional codes, as assigned upon notification, to be used in conjunction with CCS2 Coding to identify regional recurring themes / trends;
- Ensure all communication between SPPG/PHA and reporting organisation is conveyed between the SPPG Governance department and Governance departments in respective reporting organisations. This will ensure all communication both written and verbal relating to the SAI, is recorded on the SPPG DATIX risk management system.

3. Accountability of the Group

Each SAI Professional Group provides assurance to safety brief that any urgent action is taken following the receipt of SAI Review Reports and that any areas of concern are promptly escalated.

4. Frequency of Meeting

SAI Professional Groups reviewing Level 1 SAIs meet on a fortnightly basis however Groups considering Level 2/3 reviews meet on a monthly basis.

Meetings will be held more frequently, as required, in line with the number SAI review reports within the system to ensure a timely review and identification of learning.

5. Quorum

Each SAI Professional shall be quorate by the attendance of three members of the Group. Expertise / advice can be sought from SPPG/PHA colleagues as required.

6. Revision of Terms of Reference

The Terms of Reference will be reviewed in twelve months (March 2023) or earlier as required.

MAHI - STM - 097 - 10459
Safety Brief - Terms of Reference

June 2022

1. Purpose of the Group

The purpose of the joint SPPG/PHA Safety Brief meeting is to provide Directorate oversight of all safety and quality issues and is uniquely placed to connect issues and triangulate learning arising from SAIs, complaints, confidential enquiries, RQIA recommendations, NCEPOD reports etc. The group is jointly chaired by the Director of Strategic Performance and the Director of Nursing, however other relevant Directors or appropriate representation are invited to attend as required.

The group aims to provide a systematic oversight of Safety and Quality issues and enforce a proactive approach to manage patient safety across all areas.

2. Objectives of the Group

- Provide a platform for discussion of Safety and Quality issues and agree actions to be taken
- Escalate appropriately any urgent action required or areas of concerns, such as identified themes / trends arising from the weekly Incident Review Group and agree next steps
- Review / sign off professional, learning and reminder of best practice letters prior to dissemination.
- Put in place mechanisms to ensure continued improvements across all safety and quality processes.
- Escalate any Safety and Quality issues requiring oversight by all Directors to the fortnightly Directors meeting or monthly Group Head meeting as required.
- Each Director to escalate non-compliance to any of the Safety & Quality processes and seek resolution within their organisational construct.

3. Accountability of the Group

The Lead Directors for SPPG/PHA are individually responsible for providing assurance to their respective Boards/Senior Management Team/NEDs (PHA only) ensuring they are appraised on all Safety and Quality issues and matters arising.

4. Frequency of Meeting

The group will meet weekly.

5. Quorum

Safety Brief shall be quorate by the attendance one Director and Senior representation from both PHA and SPPG.

6. Revision of Terms of Reference

The Terms of Reference will be reviewed in twelve months (June 2023) or earlier as required

BW/203

HSC Health and Social Care

QUALITY 2020

LEARNING FROM... STROKE

A REVIEW OF SERIOUS ADVERSE INCIDENTS, COMPLAINTS AND EXPERIENCE

EDITION 01
JULY 2022

Stroke Symptoms 1
The Impact of Stroke 2
Specialist Stroke Teams 3
Visual Changes 3
Dizziness 4
Headache 5
Reduced Concious Level 6
Thrombectomy Transfer Delay 6
Quality Improvement 7

Lessons and key learning points in relation to stroke care have been identified from complaints, Serious Adverse Incidents and patient experience of stroke shared with Care Opinion.

Strokes are a serious life-threatening condition that occur when the blood supply to the brain is disrupted. Strokes are a medical emergency and prompt recognition and treatment is critical.

Around 2,800 people are admitted to hospitals in Northern Ireland due to stroke. It is essential that healthcare professionals recognise the signs and symptoms.

A review of serious adverse incidents and complaints has identified a number of themes for the improvement of recognition of patients with stroke.

The main stroke symptoms can be remembered with the word **FAST:**

> I woke up and was listening to the radio so I tried to get out of bed and my legs left me. I crawled round to the other side of bed to get the phone and rang my son. I thought it was a stroke.

FAST is designed to recognise the main, common symptoms of stroke. However, not all stroke patients describe the common symptoms. This is particularly true for those who have a posterior circulation stroke.

Other symptoms of stoke include:

- Dizziness
- Headache
- Seizures
- Confusion
- Difficulty understanding what others are saying (aphasia)
- Reduced consciousness
- Visual changes
- Problems with balance or gait
- Difficulty swallowing (dysphagia)

> I was in the kitchen having a coffee with my sister when she started complaining of a weird sensation in her head and then collapsed. She had a brain aneurysm and a major stroke.

LEARNING FROM...
STROKE

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The Impact of Stroke

Stroke can have a devasting impact on people's lives; both patients and their loved ones. It is the fourth largest cause of death, and two thirds of those who survive stroke have a life changing disability. It is key to listen to experiences that patients and families have had to learn how we can improve.

> I had a stroke… I was terrified/unsure on what my future would be.

> I'm frustrated due to the loss of my independence, though I am coming to terms with this.

The number of complaints related to stroke are increasing. Common themes are concerns about **care and treatment** and **communication** from healthcare professionals.

Health and Social Care Trust	April 2020 - March 2021	April 2021 - March 2022
Belfast	2	5
Northern	1	5
South Eastern	2	3
Southern	1	4
Western	2	3
NIAS	0	8
Total number of stroke-related complaints	**8**	**28**

Complaints case study: At around 9pm Patient X experienced dizziness, double vision and vomiting. Family members called 999 and paramedics arrived within 15 minutes. Patient X was FAST negative when assessed and the working diagnosis was felt to be vertigo. Patient X arrived at ED at around 10pm, however, as they were not pre-alerted or triaged as a possible stoke patient, they waited until 4am to be seen. At this stage CT imaging was performed and the patient was subsequently diagnosed with a Posterior Inferior Cerebellar Artery Stroke and was admitted to the stroke unit.

Key learning:

- FAST test does not include vertigo as a possible indicator of posterior stroke
- Improving the recognition of posterior strokes has been highlighted as a learning need nationally

> My husband had took a stroke and I rushed him in to hospital… but when I got him in to A&E we still had to wait in a long queue to speak to the receptionist, especially when a stroke is an illness which must be treated as soon as possible.

LEARNING FROM...
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Specialist Stroke Teams

The stroke team are a specialist team with expertise in the diagnosis and management of stroke. Early involvement can help identify patients who are suitable for thrombolysis and thrombectomy. The stroke team can also support patients to receive prompt brain imaging and advise where further imaging is appropriate.

Key Learning:

- Patients with suspected stroke should be seen immediately on arrival to hospital by a specialist stroke team for structured assessment.

> The staff here are excellent. Their quick action and diagnosis have saved my life. I am so lucky to be here.

Visual Changes

SAI Case study: Patient A presented to the emergency department reporting blurred vision for 90 minutes and neck pain radiating down into the shoulder. The patient was triaged as priority 3 and, due to pressures in the department, waited three hours to be seen by a doctor. On assessment, the patient was found to have a right sided hemianopia (visual loss) and CT imaging showed an occipital lobe stroke. At this stage, Patient A was referred to the stroke team. In view of the established stroke on the CT scan, patient A was not felt to be a suitable candidate for thrombolysis. Following further imaging, a diagnosis of vertebral artery occlusion secondary to dissection was made. Whilst an inpatient, Patient A suffered a further stoke, deteriorated and sadly died in intensive care.

Key Learning:

- Patients presenting with new changes in vision should have a Recognition of Stroke In the Emergency Room (ROSIER) score completed at triage.

LEARNING FROM...
STROKE

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Dizziness

SAI case study: Patient B presented to the Emergency Department with confusion, dizziness and slurred speech. The initial impression was that this was not stroke and patient B was treated for meningitis and encephalitis. A CT scan was performed which reported a possible meningioma and recommended an MRI scan. Patient B deteriorated over the next 12 hours with fluctuating consciousness so had repeat imaging. Further scans showed a basilar artery thrombus. Despite undergoing clot retrieval, Patient B sustained a catastrophic stroke and sadly died.

Complaint case study: Patient Y presented to the Emergency Department with dizziness, vomiting and neck pain. Due to pressures in the department, the patient waited six hours to be seen and was assessed in a non-clinical area. Following medical assessment, the patient was discharged with a diagnosis of vertigo.

The dizziness persisted for five days and patient Y contacted their GP who prescribed medication for vertigo. This did not help and, following contact with an out-of-hours GP, an ambulance was arranged to take patient Y to hospital.

A CT imaging was performed on arrival and confirmed a vertebral artery dissection. Patient Y was admitted under the neurosurgical team.

Key Learning:

- The assessment of patients with dizziness or unsteadiness should be structured to look for red flags symptoms of stroke.
- Timing, Triggers and Targeted Examinations (TiTrATE) is a methodical approach to the dizzy patient.

LEARNING FROM...
STROKE

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Headache

SAI Case study: Patient C attended the Emergency Department with a four-day history of headache and dizziness. Patient C also experienced vomiting, neck stiffness and photophobia. After medical review, Patient C was diagnosed with migraine and discharged home. Five days later, following contact with GP, the patient was referred to the assessment unit with ongoing headache. On this occasion, Patient C was discharged with a diagnosis of sinusitis. Two days after the second attendance, Patient C experienced their worst headache to date and visited the optician due to developing double vision. The optician referred to the emergency department and, on assessment, Patient C was also found to be unsteady. A CT brain showed an acute bleed. Following advice from the neurosurgeons, the patient was managed conservatively.

Key Learning:

- Vomiting, neck stiffness and patients reporting 'worst headache ever' are red flags for headache and further investigation should be considered.
- It is good practice for patients presenting on a second occasion at hospital with the same complaint to be seen and assessed by a senior doctor.
- Patients presenting with headaches should have Central Nervous System observations performed and recorded to identify any changes or deterioration.

Complaints case study: Patient Z presented to the Emergency Department with a severe occipital headache, vomiting and dizziness. Patient Z was reviewed by the stroke team and subsequently had a CT and CT angiogram which were reported as normal. The stroke team felt that this was unlikely to be stroke and advised admission under the acute medical team with a working diagnosis of subarachnoid haemorrhage. A lumbar puncture was performed and was negative for subarachnoid haemorrhage. Following neurology review, a CT venogram was performed to rule out venous sinus thrombosis. This was reported as negative and Patient Z was discharged home with a diagnosis of thunderclap headache.

Six months later, Patient Z was admitted with speech disturbance. A CT was performed and showed an old infarction in the left cerebellar hemisphere and an MRI showed multiple small acute infarcts. Following a review, it was concluded that the initial admission was probably due to the left sided cerebellar infarct. The initial imaging was reviewed and a new left sided cerebellar infarct could be seen on the CT venogram which was not reported at the time.

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Reduced Conscious Level

SAI case study: Patient D was brought to the emergency department via ambulance following a collapse in the community. The patient had a reduced conscious level (GCS 8) and left sided weakness. The patient was pre-alerted due to the low consciousness but the left sided weakness was not communicated. The patient was not initially triaged as stroke and the stroke team were not alerted. Patient D was reviewed on arrival and the anaesthetic team was in attendance. There was a delay in obtaining a CT brain; when performed it showed a stroke in the right frontal lobe and early changes on the left side of the brain. Patient D had a stroke affecting both hemispheres which was the cause of the reduced consciousness. The stroke team were contacted and the patient received thrombolysis. Patient D deteriorated following thrombolysis and a repeat CT showed stroke progression in both hemispheres. The patient was admitted to the intensive care unit where they sadly died.

Key Learning:

- Stroke can cause patients to present with reduced consciousness.
- Handover and communication about changes in neurology and concern of stroke is essential.
- Patients with suspected stroke and reduced level of consciousness (GCS <13) should have CT brain imaging within an hour.

Thrombectomy Transfer Delay

SAI Case study: Patient E arrived at the emergency department at 15:19. They had been pre-alerted due to a new neurological deficit (FAST+). A CT brain was ordered at 15.43 and performed at 16.15. A CT angiogram was performed at 16.40. Patient E was discussed with a senior stroke physician and a diagnosis of Left Total Anterior Circulation Stroke was made. The patient was deemed outside the window for thrombolysis but a potential candidate for thrombectomy. The patient was accepted for transfer for potential clot retrieval. NIAS were contacted at 17.15 and a '999 blue light ambulance for urgent transfer' was requested. The patient did not leave the Emergency Department until 19.00 and arrived at RVH Stroke Unit at 20.05. Thrombectomy treatment was unable to proceed as the service was unavailable at the time of the patient's arrival. The patient was transferred back to the original hospital the following day.

Key Learning:

- Ambulance transfers for urgent thrombectomy are time critical. When phoning to request an urgent transfer, the phrase **'Immediate Time Critical Blue Light Transfer'** should specifically be used.
- If thrombectomy might be indicated, imaging with contrast angiography (CTA) should be performed promptly after the initial CT brain.

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Quality Improvement

Learning from complaints, SAIs and patient experience is important to ensure patients receive the right care at the right time. These case studies highlight the different ways that patients with stroke can present and identify the key learning points.

KING'S College LONDON SSNAP Sentinel Stroke National Audit Programme

All stroke cases in Northern Ireland are entered into the Sentinel Stroke National Audit Programme (SSNAP). This is a quality improvement programme that looks at how well stroke care is being delivered. Case entries, pre COVID, have shown improvements in the audits from all five Trusts.

Further information on results of the audit are available at SSNAP - Home (strokeaudit.org)

Care Opinion
What's your story?

Recently, the Department of Health have completed a consultation on Reshaping Stroke Care in Northern Ireland to seek views on how to make stroke care better in Northern Ireland.

Care Opinion is an online user feedback platform whereby service users, families & carers can share their experience of services across Health & Social Care Northern Ireland.

Care Opinion is a public platform which can be accessed at www.careopinion.org.uk.

If you have any comments or questions related to this Edition of Learning From please get in contact by email at learningmatters@hscni.net

Editorial Team

Strategic Planning and Performance Group

Fiona Quigg
Geraldine McArdle
Liz Fitzpatrick
Michael Cruickshanks

Public Health Agency

Anne-Marie Phillips
Denise Boulter
Brid Farrell
Dr Maeve Middleton
Grainne Cushley
Linda Craig

HSS(F)2/2004

Chief Executives of
HSS Boards/Trusts/Agencies

Directors of Finance
HSS Boards/Trusts/Agencies

February 2004

Dear Sir/Madam

STATEMENT ON INTERNAL CONTROL: FULL IMPLEMENTATION FOR 2003/04

The purpose of this circular is to advise HPSS bodies of the wording of a model Statement on Internal Control for 2003/04.

HSS (FAU) 19/2003, issued on May 2 2003, advised all HSS bodies of the requirement to implement a full Statement of Internal Control by 2003/04.

HPSS bodies must develop the model wording provided to suit their own circumstances and explain what has been done to date, anything that remains to be done and the action planned for the coming year with a proposed timetable.

System of Internal Control

The statement on the system on internal control summarises the process that has been applied in reviewing the effectiveness of the system of internal control as appropriate to the circumstances of the reporting body.

The review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the organisation who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports. The statement should specify the work undertaken during the year. It should also record details of actions taken or proposed to deal with material internal control aspects of any significant problems disclosed in the annual report and accounts.

Risk Management

HSS bodies should have risk management, control and review processes in place, appropriate to the circumstances and activities of the body. The details of these processes will vary from one body to another depending on circumstances such as the size of the body and the complexity of the risks which it faces. It is important however that HPSS bodies adhere to the principles of the AS/NZS 4360:1999, which is the common model of risk management adopted by the Department for itself and all of its associate bodies.

Examples of the high level elements which would assist bodies to consider the completeness of the processes that have been put in place are:

- Leadership and strategy
- Context for risk management

- Risk Identification and Evaluation
- Criteria for evaluation of risk

- Risk Control Mechanisms
- Review and Assurance Mechanisms

HPSS bodies are referred to Circular HSS(PPM) 5/2003, issued on 11 April 2003 which required all HPSS bodies to have a functioning risk register in place by September 2003.

HPSS bodies are also referred to DAO (DFP) 25/03, issued by DFP to Accounting Officers in July 2003 which is available, along with other guidance on the area of governance, on the DHSSPS website: http://www.dhsspsni.gov.uk/hss/governance.

Statement on Internal Control

The Statement on Internal Control should be developed in accordance with the proforma at Appendix 1 to this Circular.

The wording of the proforma in italics is an example of wording which should be developed by individual organisations to suit their particular circumstances and should provide a brief but comprehensive summary of the actual processes in place, including a description of how current initiatives are being taken forward. The statement should provide an honest appraisal of the state of internal controls currently in operation which is capable of substantiation. The narrative description of the processes in place should be used for reporting on progress or compliance with central initiatives.

In particular the revised proforma for 2003/04 includes:

- Confirmation that the results of the Accounting officer review of the effectiveness of internal control has been discussed with the Board, Audit Committee (and the Risk Committee, where applicable)
- An expectation for a reference in the Statement on Internal Control to ongoing maintenance and development of risk management and review processes.

The Statement on Internal Control should be presented along with the annual accounts. It should be signed by the Accountable Officer and passed to the external auditors for review and will form part of the audited annual financial statements.

Any enquiries concerning the content of this circular should be addressed in the first instance to Deborah Crudden [redacted].

Yours faithfully

WENDY THOMPSON
Financial Accounting Unit

Appendix 1

The wording which is not in italic script in this proforma is compulsory.

Suggested wording for a Statement on Internal Control for the Financial Year 2003/04

Scope of Responsibility

The Board of [HPSS body] is accountable for internal control. As Accountable Officer and Chief Executive of the Board of [HPSS body], I have responsibility for maintaining a sound system of internal control that supports the achievement of the policies, aims and objectives of the organisation, and for reviewing the effectiveness of the system.

Purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of organisational policies, aims and objectives, and to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in [HPSS body] for the year ended 31 March 2004, and up to the date of approval of the annual report and accounts, and accords with Department of Finance and Personnel guidance.

Example wording:

The Board exercises strategic control over the operation of the organisation through a system of corporate governance which includes:-

- *a schedule of matters reserved for Board decisions;*
- *a scheme of delegation, which delegates decision making authority within set parameters to the Chief Executive and other officers;*
- *standing orders and standing financial instructions, the establishment of an audit committee.*

Example wording:

The system of internal financial control is based on a framework of regular financial information, administrative procedures including the segregation of duties and a system of delegation and accountability. In particular it includes:-

- *comprehensive budgeting systems with an annual budget which is reviewed and agreed by the board;*
- *regular reviews by the board of periodic annual financial reports which indicate financial performance against the forecast;*
- *setting targets to measure financial and other performances;*
- *clearly defined capital investment control guidelines;*
- *as appropriate, formal budget management disciplines.*

The [HPSS body] has an internal audit function which operates to defined standards and whose work is informed by an analysis of risk to which the body is exposed and annual audit plans are based on this analysis. In 2003-04 Internal Audit reviewed the following systems [specify the systems]. In his annual report, the Internal Auditor reported that the [HPSS body] system of internal control was adequate and effective [or otherwise as concluded by auditors]. However, [as appropriate] weaknesses in control were identified in a [small] number [be specific] of areas. Recommendations to address these control weaknesses have been or are being implemented.

With regard to the wider control environment the [HPSS body] has in place a range of organisational controls, commensurate with the current assessment of risk, designed to ensure the efficient and effective discharge of its business in accordance with the law and departmental direction. Every effort is made to ensure that the objectives of the [HPSS body] are pursued in accordance with the recognised and accepted standards of public administration.

For example: [bodies should provide specific examples], the [HPSS body's] recruitment and selection policies are based on the principle of equality of opportunity and controls are in place to ensure that all such decisions are taken in accordance with the relevant legislation. [Details of compliance or lack of it with management action to address weaknesses could be given].

Capacity to handle risk

Provide details of the key ways in which

- *leadership is given to the risk management process*
- *staff are trained or equipped to manage risk in a way appropriate to their authority and duties. Include comment on guidance provided to then and ways in which you seek to learn from good practice.*

The risk and control framework

The [HPSS body] has developed a risk management strategy, which has identified the organisation's objectives and risks and sets out a control strategy for each of the significant risks. Procedures have been put in place for verifying that aspects of risk management and internal control are regularly reviewed and reported and that risk management has been incorporated fully into the corporate planning and decision making processes of the organisation.

[Add further detail as necessary, referring to the continuing development of risk management and the introduction of controls assurance standards in accordance with departmental guidance].

In addition to these factors the actions outlined below are planned in the coming year [include a brief description of planned actions in the current year]. Include too the conclusion of any recent independent review, for example by internal audit or consultants, of the current situation.

Review of Effectiveness

As Accountable Officer, I have responsibility for the review of effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the [*HPSS body]* who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the

Board and Audit Committee and a plan to address weaknesses and ensure continuous improvement to the system is in place.

Significant internal control problems (if applicable)

If there are significant internal control problems, record here an outline of the actions taken, or proposed , to deal with them. The wording should be tailored to reflect the circumstances of the case.

Signature of Accountable Officer and date of signature

MAHI - STM - 097 - 10472

SB 15/06

SOUTHERN HEALTH AND SOCIAL SERVICES BOARD

GOVERNANCE

FRAMEWORK

March 2006

MAHI - STM - 097 - 10473

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Governance Framework for Southern Health And Social Services Board

Background

Circular DAO (DFP) 5/2001 introduced the requirement for a wider Statement of Internal Control (SIC) in the accounts of the DHSSPS and of HPSS bodies. The circular referred to the Turnbull Report conclusion that a sound system of internal control must be based on a thorough and regular evaluation of the extent and nature of risks to which an organisation is exposed. The HRRI Review (1999) into risk management in the HPSS, concluded that, while good work was being done, the approach across the HPSS and within individual bodies tended to be fragmented and inconsistent.

Circular HSS (PPM) 6/2002 announced that the DHSSPS, in recognition of the importance of a sound system of risk management, had entered into a license agreement with Standards Australia for the use of their internationally recognised risk management standard AS/NZS 4360:1999 (now updated to 2004 model). The application of this internationally recognised approach to risk management would be seen as an important piece of evidence in support of a Statement of Internal Control.

The application of Controls Assurance standards within the HPSS, was announced in Circular HSS (PPM) 8/2002. This process would enable individual HPSS organisations to provide evidence that they are doing their reasonable best to protect users, staff, the public and other stakeholders against risk of all kinds. It is a means by which Chief Executives as Accountable Officers can discharge their responsibilities and provide assurances to the Department, the Assembly and the Public.

In January 2003 the DHSS&PS issued guidance under Circular HSS (PPM) 10/2002, specific to clinical and social care governance. The guidance was to enable HPSS organisations to formally begin the process of developing and implementing clinical and social care governance arrangements within their respective organisations and set a framework for action which highlighted the roles, responsibilities, reporting and monitoring mechanisms that are necessary to ensure delivery of high quality health and social care.

The circular also stipulated the requirement that this new guidance should be read in the context of previous guidance already issued on the implementation of a common system of risk management and the development of controls assurance standards for financial and organisational aspects of governance.

The Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003 imposed a 'statutory duty of quality' on HPSS Boards and Trusts. To support this legal responsibility, the Quality Standards for Health and Social Care have been issued by DHSSPS. They will be used by the new Regulation, Quality Improvement Authority (RQIA) to assess the quality of care provided by the HPSS.

The Southern Health and Social Services Board recognises that it is moving the Governance agenda forward in an environment of limited resources and that Governance issues which arise, will have to be tested and prioritised against other service pressures. Collaborative working is particularly important so that duplication can be avoided and we can learn from each other's approaches.

Introduction

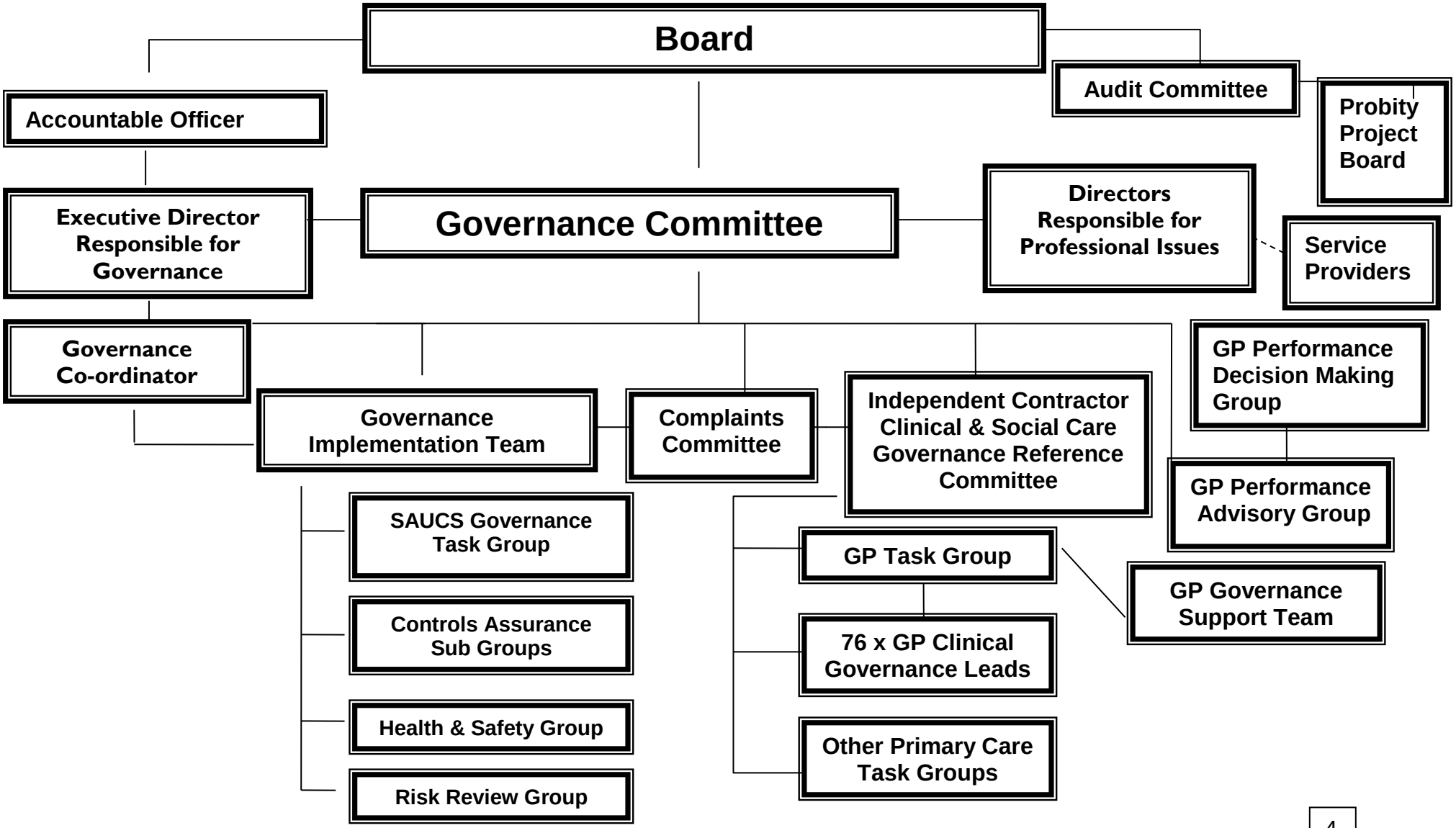
The core activity of the Southern Health and Social Services Board (Board, (SHSSB) is the effective commissioning and provision of health and social care within available resources, in order to improve the health and social well being of its population. This is a task which is central to the priorities of all staff regardless of profession or grade.

The Board has developed a framework in order to ensure it discharges its functions in a way which ensures that risks are managed as effectively and efficiently as possible and to acceptable standards of quality. The specific objective is to protect the organisation against loss, the threat of loss and the consequences of loss, whilst at the same time having a framework in place that highlights the roles, responsibilities, reporting and monitoring mechanisms that are necessary to ensure commissioning and delivery of high quality health and social care.

The Board has a duty to protect users, carers, staff and others in the planning and delivery of services. Reducing risk is not just about financial or management probity it is about improving the quality of services and user experience of those services. This means that equal priority needs to be given to the obligations of governance across all aspects of the organization. There is a need to cover financial, organizational and clinical and social care and a need for these to be truly integrated within the organisation's culture. Good governance hinges on having clear objectives, sound practices, a clear understanding of the risks run by the organization and effective monitoring arrangements. Therefore, any strategy seeking to 'continuously improve the quality of services and safeguarding high standards of care' must put in place an accountability framework which permeates all levels of responsibility within the organisation.

In the Southern Health and Social Services Board, this will be achieved by the adoption of a multi-level Governance Framework.

Governance in SHSSB



Roles and Responsibilities

The Board

To set strategic direction and to ensure that there are proper and independent assurances given on the soundness and effectiveness of the systems and processes in place for meeting corporate objectives and delivery of appropriate outcomes. The Board defines governance as, the structures, processes, roles and responsibilities which secure arrangements in respect of financial, organisational and clinical and social care governance, all of which are underpinned by a sound system of risk management.

The Chief Executive

The Chief Executive as Accountable Officer is responsible for ensuring the implementation of governance throughout the organisation and for signing the Annual Statement of Internal Control

The Governance Committee

To oversee the implementation of Governance and report to the Board on a regular basis to ensure it is kept fully aware of progress. It will also provide assurances to the Board that reporting mechanisms are in place to ensure risk is being identified and managed through the operation of effective controls, in all aspects of the Board's business.

The Audit Committee

The Audit Committee will seek independent assurances from both internal and external audit and the HPSS Regulation, Quality Improvement Authority and report to the Board in respect of internal financial and organisational controls systems and clinical and social care governance by:

- Reviewing audit reports on the effectiveness of the system for internal financial control, organisational controls, clinical and social care governance and risk management.
- Assessing the scope and effectiveness of the organisational systems established by management to identify, assess, manage and monitor risks.

Governance Implementation Team

The Governance Implementation Team is a multi-disciplinary group made up of governance leads from each directorate/programme of care within the Board. The Chair of the group is directly accountable to the Chief Executive for the operational implementation of risk management processes in conjunction with the Board's 'duty of quality', controls assurance and clinical and social care governance arrangements.

Groups reporting to the Governance Implementation Team are:

- **Southern Area Urgent Care Service (SAUCS) Governance Task Group**
  Responsible for the development and implementation of Governance within SAUCS, including the monitoring of relevant controls assurance standards

- **Sub groups for each of the Controls Assurance Standards formally issued by DHSSPS**
  Responsible for the annual assessment and review of individual controls assurance standards as issued by DHSSPS

- **Health and Safety Committee**
  The promotion and co-operation between the Board and staff in investigating and carrying out measures to ensure the health, safety and welfare at work of all employees.

- **Risk Review Group**
  To screen incidents, complaints and claims received by the Board, identify trends/risks and where necessary undertake investigations.

Complaints Committee

Monitor and seek to improve the Board's operation of the complaints procedure by identifying changes in practice in respect of findings and recommendations from Independent Review Panels.

Independent Contractor Clinical & Social Care Governance Reference Committee

To report to the Governance Committee on the implementation and development of governance across Family Practitioner Services within the Board's area.

Prevention, Detection & Management of Under-Performance in General Practice

To screen and where necessary undertake investigations on any concerns about practitioners received by the Board and when required advise on interventions to address any problems identified. In line with the GP Performance Decision Making Group advise the Governance Committee on any necessary referrals or possible disciplinary actions.

Director Responsible for Governance

The Executive Director with responsibility for Governance will report through the Chief Executive to the Board on all operational governance issues. He will also chair the Governance Implementation Team and manage the Governance Co-ordinator.

Directors Responsible for Professional Issues

Each Executive Director will be responsible for the implementation of Governance within their area of professional responsibility.

Governance Co-ordinator

The Governance Co-ordinator will support the Director responsible for Governance and take the lead role in the development and implementation of Governance arrangements within the Board. He/She will be responsible for developing systems and procedures for the effective promotion and maintenance of a governance and risk management culture within the Board. He/She will also lead the work of the Governance Implementation Team and report to the Governance Committee on current Governance arrangements within the Board and relevant guidance issued by DHSSPS.

Staff

All staff regardless of grade and profession are expected to be risk aware at all times and to report any adverse events. Crucial to this will be the Board's policy and procedure on incident/near miss reporting which promotes a non-punitive approach to the reporting of such incidents.

Individual members of staff or groups of staff will be actively encouraged not only to report incidents but also suggest ways of improving services or reducing perceived risks. Depending on their nature or their scope, these suggestions will be considered by either the Governance Implementation Team or relevant specialist committee

Building a Governance and Assurance Framework

The SHSSB governance and assurance framework provides a simple but comprehensive method for effectively managing the principal risks to meeting the Board's corporate objectives. It also provides a structure for the evidence to support the Statement of Internal Control. This simplifies board reporting and the prioritisation of action plans, which in turn, allow for more effective performance management.

The key stages in this cyclical process are illustrated in ***Figure 1;*** below:

Figure 1

The Management of Risk

Managing risk is a key component of the Governance Framework and it is therefore essential that systems and processes are in place to identify and manage all risks as far as reasonably possible.

All organisations engaged in the provision of health and social care carry a significant number of risks which have the potential to cause harm to service users, patients, visitors or staff and loss to the organisation. The purpose of risk management is not to remove all risk but to ensure that risks are recognised and their potential to cause loss fully understood. Based on this information, action can be taken to direct appropriate levels of resource at controlling the risk or minimising the effect of potential loss.

The Board has recognised the need to adopt such an approach and has put in place a systematic and unified process to ensure the management of risks across all areas of the Board's activity. This has led to the implementation of a fully functioning board wide risk register at both directorate and corporate levels. This process illustrated in ***Figure 2*****;** is based on the Australian/New Zealand (AS/NZS) 4360:1999 standard, which has been adopted by the DHSSPS and which all HPSS organisation must comply with. **Appendix 1 – Process for the Management of Board Wide Risks** gives a more detailed description of this process.

Figure 2

Categorisation of Risk

All risks do not carry the same likelihood of occurrence or degree of consequence in terms of actual or potential impact on service users, patients, staff, visitors, the organisation , or its reputation or assets.

Once an understanding of the organisation's objectives has been gained and a consensus on principal risks reached it is important to ensure a consistent and uniform approach is taken in categorizing risks in terms of their level of priority in order that appropriate action is taken at the appropriate level of the organisation.

The Board has adopted a 'five by five' risk grading matrix. This matrix which is used to categorise potential risks, incidents, complaints and claims, facilitates the prioritisation of risk in terms of likelihood and consequence. In doing so, this will help identify the nature and degree of action required and levels of accountability for ensuring such action is taken.

Appendix 2 - Risk Analysis Matrix

Acceptable Risk

The Board recognises that it is impossible and not always desirable to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources in order to achieve health and social care benefits for the local population.

From time to time the Board may be willing to accept a certain level of risk. For example, promoting independence for individuals; or in order to take advantage of a new and innovative service; or due to the high costs of eliminating a risk in comparison with the potential threat. In these circumstances the risk will continue to remain on the risk register and will be monitored and reviewed at regular intervals.

However, as a general principle the Board will seek to eliminate and control all risks which have the potential to: harm staff, service users, patients, visitors and other stakeholders; have a high potential for incidents to occur; would result in loss of public confidence in the Board and/or its partner agencies; would have severe financial consequences which would prevent the Board from carrying out its functions on behalf of the local population.

Independent Assurances

The process for gaining assurance about the effectiveness of the key controls is fundamentally about looking at all the relevant evidence together and arriving at informed conclusions. The most objective assurances are derived from independent reviews which will include RQIA (when fully operational), departmental special inquiries or reviews, internal and external audit. These assurances will be supplemented from non-independent sources eg. multi-professional audit, internal management representation, performance management, self-assessment reports etc.

Board Reporting

The SHSSB's governance framework maintains an explicit structure for reporting key information to the Board. It provides the mechanism to ensure the Board are kept informed if the organisation's objectives are at risk because of inadequacies in the operation of controls or where the organisation has insufficient assurance about them. At the same time, it provides structured assurances about where risks are being managed effectively and objectives being delivered.

Both the Governance Committee and Audit Committee will provide the Board with regular reports about the assurances on the management of principal risks in order that the Board can be proactive in addressing issues that arise. These reports will provide details of:

- Positive assurance on principal risks where controls are effective and objectives being met;
- Where the achievement of meeting corporate objectives are at risk through significant gaps in control
- Where there are gaps in assurances about the organisations's ability to achieve it principal objectives

This will lead to a Board Action Plan to improve the key controls to manage the Board's principal risks and gain assurances where required and also provide the evidence to support the Annual Statement of Internal Control.

Reviewing the Governance Framework

The Governance Framework will continue to be kept under review in light of changing structures under the Review of Public Administration.

Southern Health & Social Services Board

Process for the Management of Board Wide Risks

Introduction

A Risk Register is a management tool that enables an organisation to understand its comprehensive risk profile. It is simply a repository for all risk information. This repository is the hub of the internal control system, given that it should contain the objectives, risks and controls for the whole organisation. It therefore makes sense for the organisation's review of the system of internal control to centre around the Risk Register.

The Controls Assurance Standard for Risk Management requires all HPSS organisations to maintain a risk register. The Southern Health & Social Services Board (Board) has identified the need for a fully functioning risk register across all areas of activity throughout the organisation.

Aim of the Risk Register

The aim of the Risk Register is to maintain a recognised process whereby The Board is kept informed, and has access to the major risks which face the Board and the actions being taken to resolve or reduce these risks.

The register will be a live document, consisting of the following departmental registers and an overall Corporate Register.

- Executive Register
  A register which embraces those risks which emanate from the Board's overall Corporate Objectives and which straddle across all directorates.
- Chief Executive's Office Register
- Finance & Internal Audit's Register
- Public Health's Register
- Social Services Register
- Primary Care's Register
- SAUCS Register
- Planning & Performance Management's Register
- Local Health & Social Care Groups' Register

The following explains the process from the initial identification of a risk, how the risk should be managed and demonstrates the progression for the identification and management of corporate risks.

Assessing the Risk

Having identified an actual or potential risk, each directorate must evaluate the risk through the risk assessment process, using the Board's Risk Grading Matrix. All risks will be graded in terms of likelihood and impact ie. how likely it is that the risk becomes a reality and if it does the impact or consequence to the Board.

Managing the Risk

Each risk identified will be managed according to its risk severity.

The following indicates the five levels of severity which dictate how the risk will be managed:

Insignificant Risks

Risks assessed at this level will be accepted at directorate level. Additional controls may be applied where deemed appropriate. The risk will continue to be monitored by a nominated member of staff and will be quarterly reviewed.

Minor Risks

Risks at this level may not be fully manageable at directorate level as they fall outside the direct control of the director who has initially identified the risk. In this instance these risks will be forwarded to the Senior Management Team for them to validate, agree to accept or treat the risk and assign responsibility to the relevant directorate/s.

Minor risks which can be managed within a directorate will have a treatment plan put in place, will be monitored by a nominated member of staff and will be quarterly reviewed.

Moderate/Major Risks

Risks at this level which are regarded as being outside the direct control of the relevant director will be forwarded to the Senior Management Team for them to validate. If the Senior Management Team agrees the risk is outside the direct control of a directorate/s they will refer the risk to the Governance Committee for inclusion on the corporate risk register. *The Governance Committee will agree to accept or treat the risk and will assign responsibility to a nominated person to manage/monitor the risk which will be reviewed quarterly.*

Risks at this level which can be managed within a directorate will have a treatment plan put in place, will be monitored by a nominated member of staff and will be quarterly reviewed.

Catastrophic Risks

All risks at this level will be forwarded to the Senior Management Team for them to validate and forward to the Governance Committee for inclusion on the Corporate Register.

If the Senior Management Team agrees the risk is outside the direct control of a director, the risk will be forwarded to the Governance Committee for them to decide to treat/accept the risk and assign responsibility to a nominated person to manage/monitor the risk. .

If the risk is manageable within the directorate, the treatment plan will be forwarded to the Governance Committee for inclusion on the Corporate Register which will be quarterly reviewed.

When a catastrophic risk has been identified, the Chief Executive will inform the Senior Executive Team who will manage the risk until a Board meeting and/or Governance meeting has been convened.

Risk Review Process

The following steps indicate the Board's fully rotational risk review process:

Step 1

A review of each Directorate's register will be carried out on a rolling quarterly basis; the mechanism supporting this process will be via the Governance Implementation Team. The governance lead from each Directorate will update the team on their current register, highlighting newly identified risks and progress in relation to action plans. An additional benefit of this process is the sharing of risk information across directorates.

Step 2

These reviews will be forwarded to the Senior Management Team who will forward them to the Governance Committee highlighting those risks which should be included on the Corporate Register.

The Executive Register will be reviewed quarterly by the Senior Management Team who will forward those risks to be included on the Corporate Register to the Governance Committee

Step 3

The Corporate Register will be reviewed by the Governance Committee at each quarterly meeting.

Step 4

An annual risk register review will be carried out, reflecting the above.

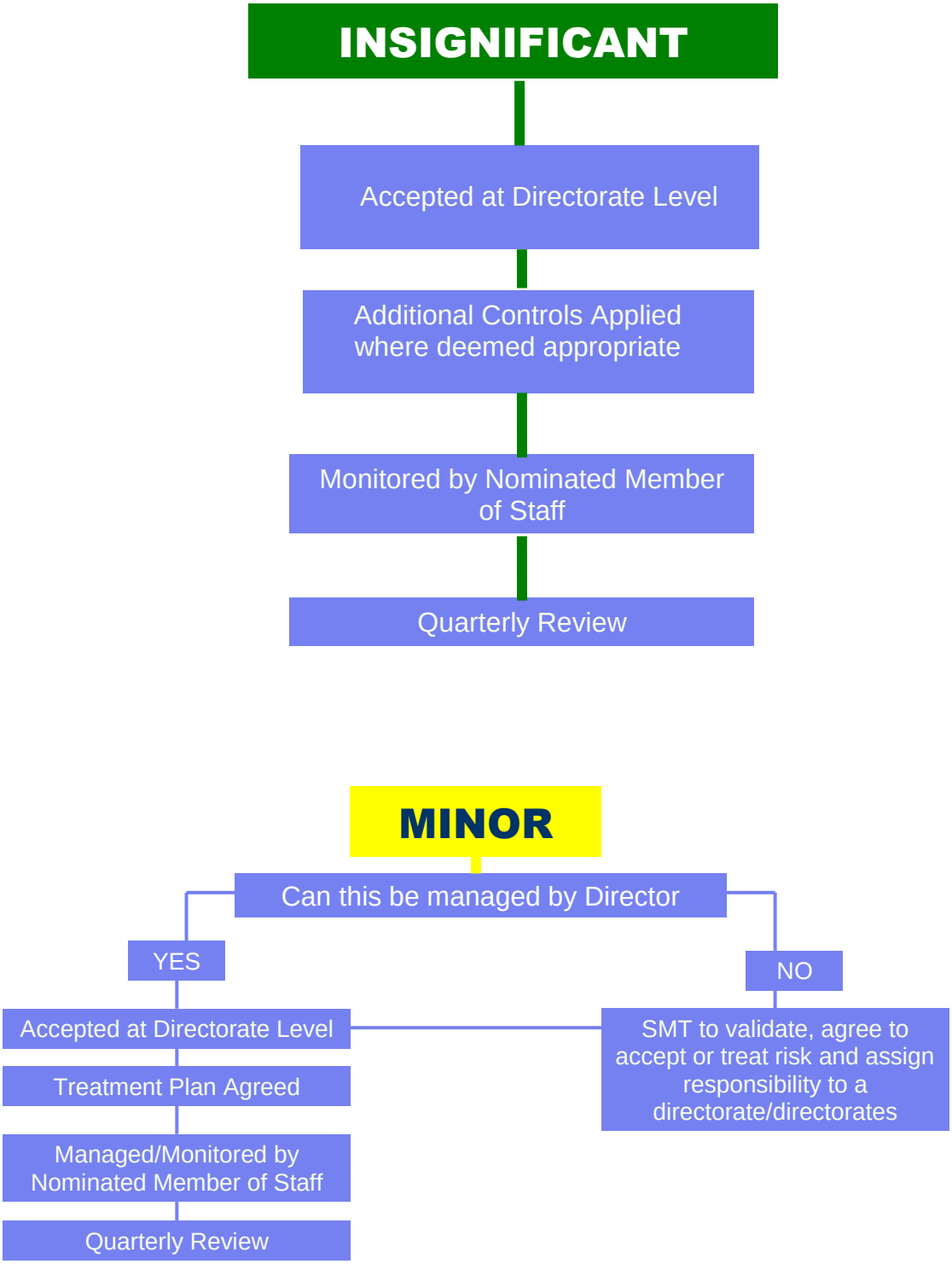
Step 5

The annual review will be considered before setting corporate objectives and subsequent directorate objectives.

Step 6

Refer back to Step 1; all directorate registers and the strategic register will be reviewed taking account of newly set objectives.

Levels of Risk Severity



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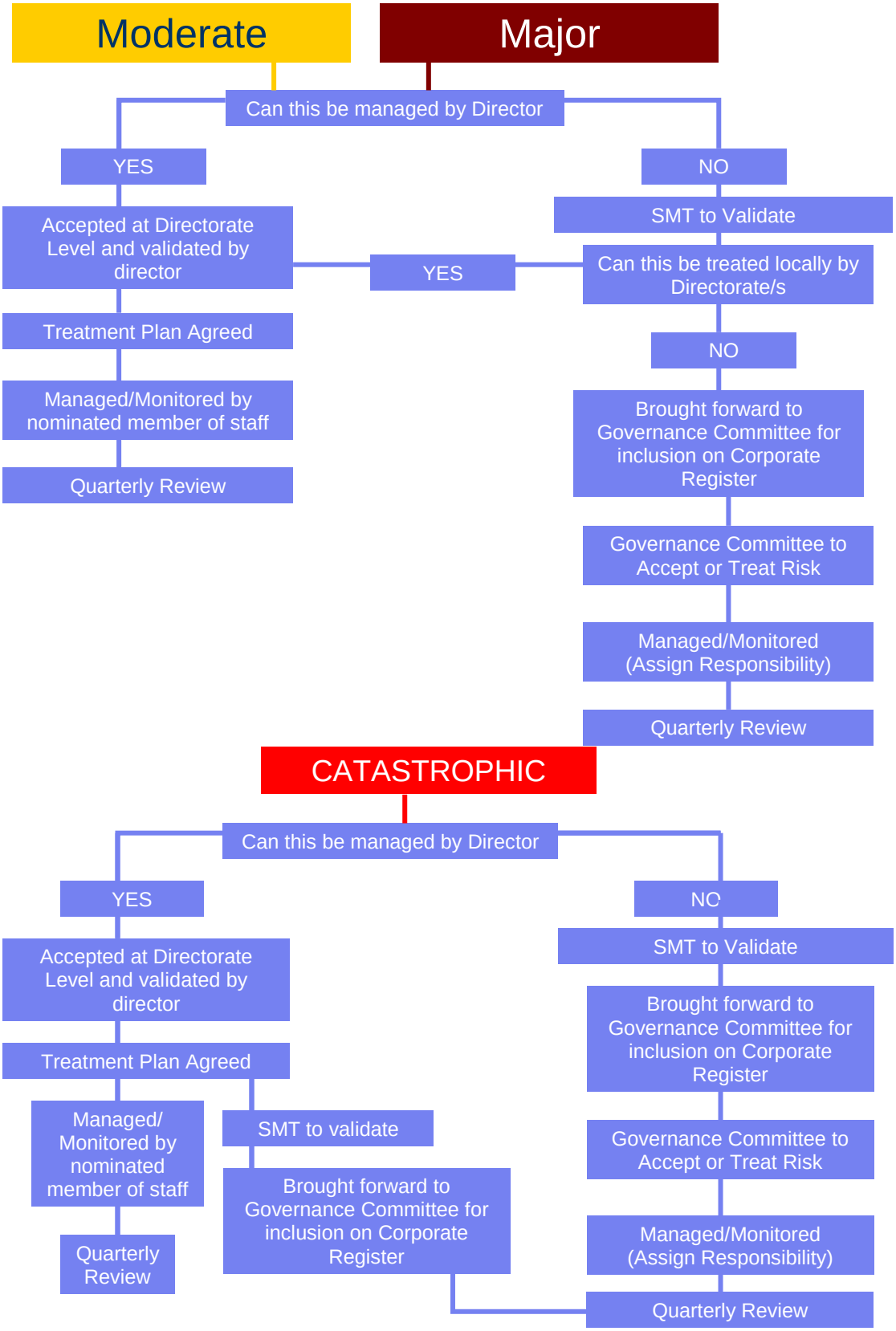
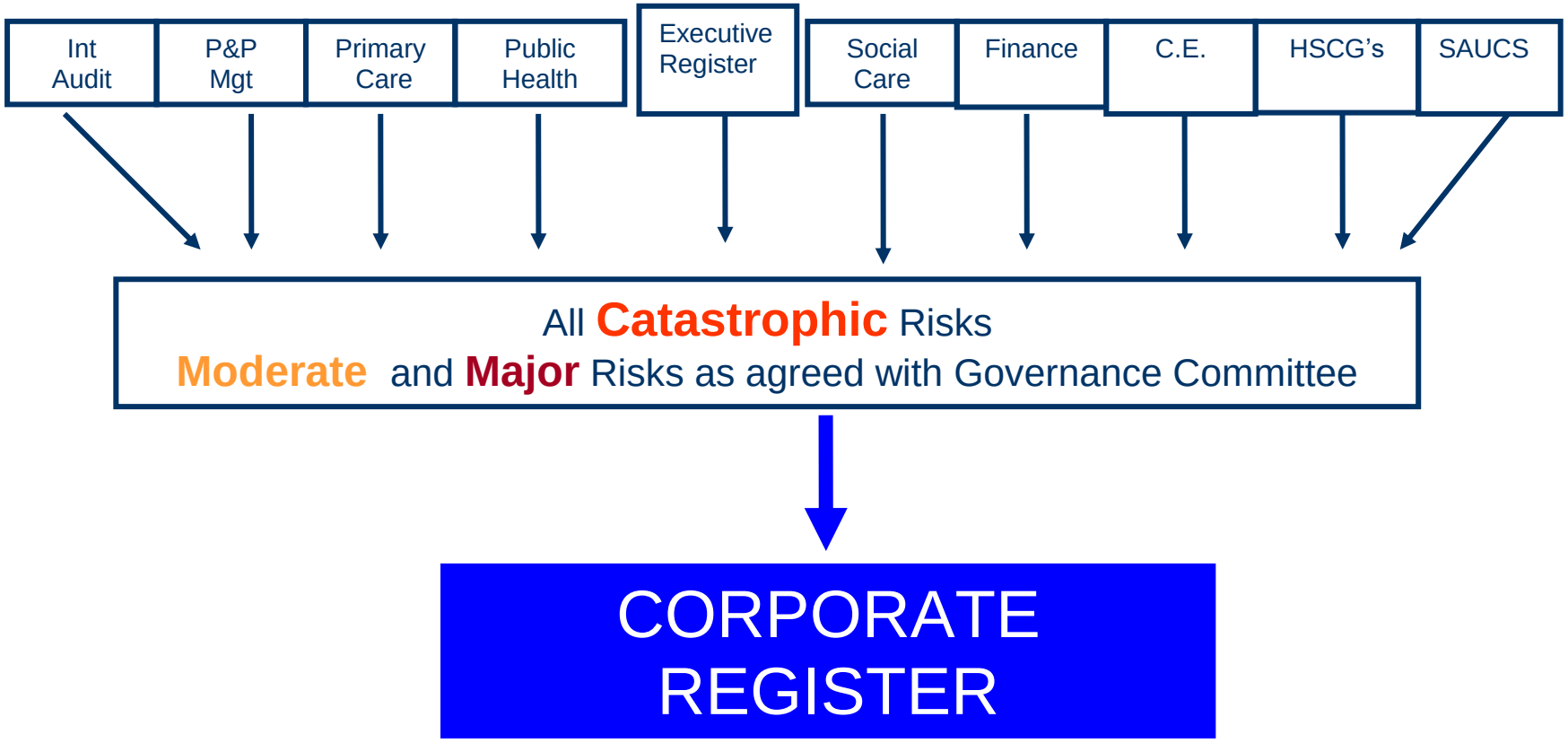


CORPORATE RISK REGISTER



RISK ANALYSIS MATRIX

APPENDIX 2

SHSSB RISK IMPACT ASSESSMENT TABLE

Category Of Risk / Impact On Organisation	Safeguard service users and community	Safeguard Staff/Visitors/ Contractors	Quality and Professional Standards	Govt Priorities, Targets, Policies. Board Objectives re Service provision	Safeguard Public confidence and SHSSB reputation	Legal/Statutory	Protect assets and avoid financial loss
Very Low	No impact on public health or social care. Minimal disruption to routine activities of staff and organisation. No long term consequences.	Minor incident. First aid administered.	Minor non-compliance	Negligible non compliance Negligible service deficit	Issue of no public/political concern.	Legal Challenge Minor out-of-court settlement	Less than 5K
Low	No impact on public health or social care. Impact on staff, service delivery and organisation, rapidly absorbed. No long term consequences.	Incident requiring medical treatment. < 3 day absence. Emotional distress.	Single failure to meet internal standards or follow protocol	Failure to meet national target for 1 quarter. 5% off Board service provision target	Local press interest. Local public/political concern.	Civil action – no Defence Improvement notice	£5K -£50K
Medium	Minimal impact on public health and social care. Impact on staff, service delivery and organisation absorbed with significant level of intervention. Minimal long term consequences.	Hospital Admission >/= 3 day absence Semi-permanent injury / emotional trauma.	Repeated failures to meet internal standards or follow protocols	Failure to meet national target for 2 quarters 5% – 20% off Board service provision target	Limited damage to reputation Extended local press interest/regional press interest. Regional public/political concern.	Class action Criminal prosecution Prohibition Notice	£50K- £250K

High	Significant impact on public health and social care. Impact on staff, service delivery and organisation absorbed with some formal intervention with other organisations. Significant long term consequences.	Fatality. Permanent disability / emotional injury	Failure to meet national/professional standards	Failure to meet national target >2 quarters Visible failure in service provision area(s) >20%	Loss of credibility and confidence in Board/ Service. National press interest. Independent external enquiry. Significant public/political concern.	Criminal prosecution – no defence Executive officer dismissed	£250K – £1.0M
Very High	Major impact on public health and social care. Impact on staff, service delivery and organisation absorbed with significant formal intervention with other organisations. Major long term consequences	Multiple fatalities. Multiple permanent disabilities / emotional injuries.	Gross failure to meet professional/ national standards	Failure to meet National Targets >2 quarters by significant margin. Significant failure >35% in service provision	Full Public Enquiry. PAC Hearing Major public/political concern.	Criminal prosecution – no defence Executive officer fined or imprisoned	More than £1.0M

RISK LIKELIHOOD ASSESSMENT TABLE

LEVEL	DESCRIPTION
ALMOST CERTAIN	LIKELY TO RECUR IN MOST CIRCUMSTANCES
LIKELY	WILL PROBABLY RECUR BUT IS NOT PERSISTENT ISSUE
POSSIBLE	MAY OCCUR OCCASIONALLY
UNLIKELY	DO NOT EXPECT TO HAPPEN AGAIN BUT IS POSSIBLE
RARE	DO NOT BELIEVE WILL EVER HAPPEN AGAIN

RISK GRADING MATRIX

LIKELIHOOD	IMPACT / CONSEQUENCE				
	Very Low	Low	Medium	High	Very High
Almost Certain	Minor	Minor	Moderate	Catastrophic	Catastrophic
Likely	Insignificant	Minor	Moderate	Major	Catastrophic
Possible	Insignificant	Minor	Minor	Major	Major
Unlikely	Insignificant	Insignificant	Minor	Moderate	Moderate
Rare	Insignificant	Insignificant	Insignificant	Minor	Minor

Appendix 3

Glossary of Terms

Term	Definition
Assurance	Confidence, based on sufficient evidence, that internal controls are in place, operating effectively and objectives are being achieved
Audit Committee	The function of an Audit Committee is to support the accounting officer (or board) by monitoring and reviewing both the risk, control and governance processes which have been established in the organisation and the associated assurance processes (which are mainly internal and external audit assurances). In some organisations, this role is amalgamated with the relevant assurance committee.
Assurance Committee	A board level committee with overarching responsibility for ensuring appropriate assurance is gained on the management of all principal risks. This may be an existing committee such as a governance, or risk management committee
Governance and Assurance Framework	A structure within which boards identify the principal risks to the organisation meeting its principal objectives and map out both the key controls in place to manage them and also how they have gained sufficient assurance about their effectiveness
Board Assurance Action Plan	An action plan approved by the board to improve its key controls to manage its principal risks, and gain assurances where required
Board Assurance Reports	Key information reported to the board on the assurance framework, providing details of positive assurances and significant gaps in internal controls and assurances relating to principal risks. In addition to providing information leading to a board assurance action plan this will also provide evidence to support the annual Statement on Internal Control
Controls Assurance	A holistic concept based on best governance practice. It is a process designed to provide evidence that HPSS organisations are doing their 'reasonable best' to manage themselves so as to meet their objectives and protect patients, staff, the public and other stakeholders against risks of all kinds

Term	Definition
Core Controls Assurance Standards	Three self-assessment standards which underpin the annual Statement on Internal Control, these being: Governance Standard; Risk Management Standard; Financial Management Standard
Directorate Level Objective	How the organisation translates an overall goal into deliverables at directorate (or equivalent) level
Effective Control	A control that is properly designed, and delivers the intended objective
External Assurance	Assurances provided by reviewers, auditors and inspectors from outside the organisation, such as External Audit, HPSS Regulation and Improvement Authority or Royal Colleges for example
Gap in Assurance	Failure to gain sufficient evidence that policies, procedures, practices or organisational structures on which reliance is placed are operating effectively
Gap in Control	Failure to put in place sufficient effective policies, procedures, practices or organisational structures to manage risks and achieve objectives
Head of Internal Audit Opinion	An annual opinion provided to inform the board in completing their Statement on Internal Control. This provides opinions on (a) the overall assurance framework and (b) the effectiveness of that part of the system of internal control reviewed by Internal Audit during the year
Independent Assurance	Assurances provided by (a) reviewers external to the organisation and (b) internal reviewers working to government standards, such as Internal Audit
Internal Assurance	Assurances provided by reviewers, auditors and inspectors who are part of the organisation, such as Clinical or Multi-Professional Audit or management peer review
Internal Control	The ongoing policies, procedures, practices and organisational structures designed to provide reasonable assurance that objectives will be achieved and that undesired events will be prevented or detected and corrected
Key Control	A control to manage one or more principal risks

Term	Definition
Mapping of Assurance	A process, providing a clear management trail, that links • principal objectives to principal risks • principal risks to key controls • key controls to assurances
Organisation (or Strategic) Objective	An overall goal of the organisation
Organisational Controls Assurance Standards	Self-assessment standards (excluding the core standards) which provide a framework to improve internal controls across a wide, but not all encompassing, range of organisational areas
Positive Assurance	Evidence that shows risks are being reasonably managed and objectives are being achieved
Principal Objectives	Objectives set at organisation and directorate (or equivalent) level
Principal Risk	A risk which threatens the achievement of Principal Objectives
Prioritisation of Risk	A process by which risks are graded in order based on the likelihood of their occurrence and the impact of their consequences
Reasonable Best	A decision or course of action, agreed by the board, that is based on sufficient evidence
Risk	The possibility of suffering some form of loss or damage. The possibility that objectives will not be achieved
Risk Assessment	The identification and analysis of relevant risks to the achievement of objectives
Risk Management	A systematic process by which potential risks are identified, assessed, managed and monitored
Sources of Assurance	The various reviewers, auditors and inspectors, both internal and external, who carry out work at HPSS organisations (see Internal Assurance and External Assurance). Boards will have to determine which sources of assurance are relevant to principal risks and to what extent they are sufficient

Term	Definition
Statement on Internal Control (SIC)	An annual statement signed by the Accountable Officer on behalf of the board that forms part of the Annual Financial Statements for the year. The SIC provides public assurances about the effectiveness of the organisation's system of internal control
System of Internal Control	A system, maintained by the board, that supports the achievement of the organisation's objectives. This should be based on an ongoing risk management process that is designed to identify the principal risks to the organisation's objectives, to evaluate the nature and extent of those risks, and to manage them efficiently, effectively and economically

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PROMOTING HEALTH
SECURING CARE
Northern Health and Social Services Board

RISK MANAGEMENT STRATEGY

APRIL 2004

RISK MANAGEMENT STRATEGY

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1. BACKGROUND

In March 2000, HRRI/St Paul were commissioned to:

- Develop a comprehensive Risk Management Strategy document for use by Boards;
- Prepare an overall model Action Plan through which to implement the Strategy in each Board;
- Devise a model Education and Training Programme by which to launch the Strategy in each Board.

The original Risk Management Strategy (*February 2002*) was based on the work carried out by HRRI and outlined a practical framework to be used by Health and Social Services Boards, in taking forward the Risk Management agenda. It was also a central theme of HRRI's work that each Board would build on the document and would work in collaboration, with the other Boards and health and social care organisations, to secure effective Risk Management and Controls Assurance.

In June 2002, the Department issued guidance setting out details in relation to the expansion of the Statement of Internal Control. Also included, was guidance on the Controls Assurance process which essentially provides evidence that HPSS organisations are doing their reasonable best to manage themselves so as to meet their objectives and protect patients, staff, the public and other stakeholders, against risk of all kinds. The Department took advantage of work already done within the NHS Controls Assurance Project and in the first instance identified 6 key areas to be focused on, with Risk Management being one of the core standards, to be implemented with immediate effect.

In July 2002, the Department of Health, Social Services and Public Safety (DHSS&PS) advised that it had decided to adopt a common Risk Management model, for itself and all of its associated bodies. In order to take advantage of the pioneering work already underway in England, the Department chose the same internationally recognised Standard, AS/NZS 4360:1999, already in use by the NHS. This is the same standard that the Board had decided to adopt and had been incorporated in the Board's original Risk Management Strategy (*February 2002*).

In January 2003, the Department issued guidance to enable the process of developing and implementing Clinical and Social Care Governance arrangements, within Health and Social Services organisations. One element of the guidance advised that HPSS organisations must designate a Committee, to be responsible for the oversight of the Clinical and Social Care Governance of the organisation. This could be an entirely new Committee, or the function could be taken on by an existing Committee e.g. The Risk Management Committee.

The Northern Health and Social Services Board recognises that it is moving the Risk Management agenda forward in an environment of limited resources and that issues, which arise from Risk Management, will have to be tested and prioritised against other service pressures. Collaborative working is particularly important so that duplication can be avoided and we can learn from other's approaches.

The Risk Management Strategy does not purport to highlight all risk areas but sets out a framework designed to enable the Northern Health and Social Services Board to assess risk and to identify treatments in a structured way.

2. INTRODUCTION

The Northern Health and Social Services Board is responsible for commissioning high quality patient and client care for the community it serves.

This Risk Management Strategy has been developed in order to ensure the Northern Health and Social Services Board discharges its functions in a way, which ensures that risks are managed as effectively and efficiently as possible and to acceptable standards of quality. The aim of the Strategy is to ensure that the organisation's objectives are met and to protect the organisation against loss, the threat of loss and the consequences of loss. In this context, loss can take many forms including loss of life or quality of life, loss of opportunity and financial and reputational loss. It is recognised that there are four main areas of risk for the Board, which this framework is designed to address:

- the Board's **strategic** functions (for example, health surveillance, population needs assessment, social care strategic functions and risk analysis of policy creation in the light of Equality and Human Rights legislation);

- the Board's internal **operational responsibilities** (for example, resource allocation to programmes of care, systems for corporate governance, financial and workplace safety);

- the adequacy of Risk Management within services **commissioned** by Boards (for example, robust professional recruitment procedures in Trusts and care homes; patient and client access to information in provider organisations);

- The adequacy of Risk Management in **collaborative/ partnership working** within the HPSS family and with other organisations.

This Strategy recognises, and seeks to build upon, the work that already has been done within the Board to put in place a robust Risk Management Structure and process, with a holistic approach, embracing **financial, organisational** and **professional** risk throughout the board.

This document defines the Board's strategy for Risk Management. The strategy has been **endorsed** by the Board and applies to **all**

employees of the Board, and highlights that risk issues and the management of these risks, are a key responsibility of every line manager and the concern of every employee.

Risk Management is now viewed as an essential Quality System and one which is a fundamental part of the total management approach to quality improvement, corporate and professional governance and the controls assurance programme.

The Northern Health and Social Services Board have significant legal and statutory obligations and, in particular, it remains liable for the actions of its staff. Similarly, the Board and its officers are subject to potential criminal prosecution for breaches of legislative duties established to protect employees and the public from actions carried out in the normal course of the organisation's activities. Of particular importance is the need to establish and maintain robust compliance and monitoring structures in relation to the Equality legislation vis-à-vis Section 75 of the Northern Ireland Act 1998.

Accordingly, the Northern Health and Social Services Board believes that by approaching the control of such risks in a strategic and organised manner and assigning appropriate levels of accountability, the risks can be reduced to a more acceptable level. This will result in better quality of commissioning care for patients, clients and residents, a safer environment for staff and a reduction in unnecessary expenditure whilst promoting a reputation for commissioning of high quality health and social care.

3. NHSSB RISK MANAGEMENT POLICY STATEMENT

The Risk Management Policy Statement, outlined below, represents the Northern Health and Social Services Board's corporate philosophy towards Risk Management and forms part of the Board's Internal Control and Corporate Governance arrangements. The purpose of this Policy Statement is to ensure that all staff and other interested parties are aware of their ongoing responsibilities for managing risk.

Risk Management Policy Statement for the Staff of the Northern Health and Social Services Board

NHSSB Mission Statement:
"*To promote the health and well-being of the Board's resident population and secure a balanced range of health and social care services to the highest standards within available resources to meet the specific needs of the population. The Board will, in taking this forward, inform and involve local people so that their views can be taken into account when making policy and planning decisions."*

The Northern Health and Social Services Board recognises that the implementation of the Risk Management Strategy is an ongoing process, which is aimed at supporting the above Mission Statement.

The continuing development of the Northern Health and Social Services Board's Risk Management programme will ensure that its organisational objectives are realised in a safe environment. The Northern Health and Social Services Board will provide staff with a workplace that is safe and development oriented.

Systematic identification, analysis and control of risks, which may threaten achievement of Board objectives, will be afforded a high priority within the Northern Health and Social Services Board. An educational process and the establishment of a supportive, open and learning culture that encourages staff to report mistakes and raise concerns through the appropriate channels will underpin this process.

All managers and staff need to acknowledge that the risks within the Northern Health and Social Services Board will be reduced if

everyone adopts an attitude of ***openness***. All necessary efforts must be made to encourage reporting of adverse incidents, mistakes and events where no actual harm has occurred and the overall approach within the organisation should be one of ***help and support*** to each other, rather than recrimination and blame. The Northern Health and Social Services Board is committed to this approach.

In line with the desire to create a culture of openness, no disciplinary action will result from reporting incidents, mistakes, including events where no actual harm has occurred, except where there have been criminal or malicious activities, professional malpractice, acts of gross misconduct, repeated mistakes, or where the "incident" is the non- reporting of other errors or violations.

A ***positive approach*** to Risk Management will assist in turning what appear to be overwhelming difficulties and threats into opportunities for improvement. Every adverse incident, which is reported, presents a chance to learn about, understand and improve the services in the future.

Managers at all levels have a fundamental part to play in risk management by ensuring that they ***respond quickly and decisively*** to any reports of adverse incidents or complaints by staff, or indeed by patients, clients or the general public. It is vital the person reporting an incident is given ***feedback*** on any action taken, or otherwise, on the reported incident, with some clear indication as to how that particular risk situation has been addressed. By taking such an approach all ***staff will be encouraged to report*** incidents more readily in the future. The benefits of retrospective analysis and action are crucial in risk prevention.

Adequate and effective communication is recognised as a fundamental prerequisite to the management of risk. Lack of information can lead to low staff morale and subsequent under-performance of staff. It can also lead to misunderstanding between service personnel, a failure to pass on vital information, or the incorrect information being cascaded to staff.

The Northern Health and Social Services Board will further develop its internal and external communication strategies, which clearly define how information flows throughout the Northern Health and Social Services Board and with external agencies.

4. NHSSB SYSTEMATIC APPROACH TO RISK MANAGEMENT

The Northern Health and Social Services Board recognises that one of the key components of an effective system for managing risk is a robust structure and process for Governance and Controls Assurance. The process of Governance and Risk Management are both focused upon identifying actual or potential risk areas, analysing the impact the likelihood that such risks might have upon the organisation and implementing effective risk control mechanisms where deemed appropriate. The development of clear Governance management structures is critical in enabling the Northern Health and Social Services Board to:

- effectively manage the risks inherent within its own operational environment;

- monitor the effectiveness of the Risk Management programmes in place within the Northern Health and Social Services Board by requiring provider health and social care organisations to have Risk Management programmes in place.

In the Autumn 2002, the Board secured a Risk Management training partner, with the intention of implementing the Board's Risk Management Strategy, supported by a training and development programme. In order to tailor the training, to the specific needs of the Board, the initial task was to review the Board's Corporate Plan 2002/03 and gain an understanding of the Board's objectives. The next step was to identify and categorise the types of risk which could impede the achievement of those objectives.

The following **Risk Management Objectives** were agreed:

- Manage risk of harm to the population in relation to the services secured by the board;

- Minimise failure to secure services according to the balance of prioritized need and manage the risk should this occur;

- Manage risks to quality of service and best practice;

- Manage risks to the Board's resources (*human, financial, information and other assets*);

- Manage risks to reputation;

- Avoid risk of inequity or inequality;

- Manage risks of failing to meet statutory and regulatory requirements;

- Manage risk of failing to respond to community expectations;

- Promote partnership in risk management with independent contractors, providers and other related groups.

A Risk Management Operational Group was established, to co-ordinate and support directorates with implementation at an operational level. This team provides a focus on risk and brings together the relevant expertise, which already exists, and pools information and knowledge providing an organization-wide approach.

By June 2003, the majority of directorates had established their Risk Registers and Treatment Plans, using their directorate plans as a reference point. Work is currently underway to develop the format for the Corporate Risk Register and Treatment Plan and after assessment, significant risks identified, at Directorate level, will form the basis of the Corporate Risk Register and treatment plan. The Corporate Risk Register will be monitored by the Risk Management and Clinical and Social Care Governance Committee. By incorporating appropriate review dates, the risks will be regularly reassessed and control measures reappraised for adequacy.

The post of Board Risk Management Co-ordinator was advertised in early 2003 and interviews held in March 2003. No appointment was made. The post was re-advertised and interviews held in June 2003. The position was filled and the successful applicant took up post within NHSSB at the beginning of August 2003.

4.1 Governance and Controls Assurance

The Northern Health and Social Services Board has established appropriate structures for Governance and Controls Assurance, in order to:

- maintain a comprehensive overview of the standards expected of the range of clinical and social services provided by Trusts and primary care organisations;
- identify, promulgate and build upon areas of good practice;
- assess and minimise the risk of untoward events; investigate specific problems as they arise;
- investigate specific problems as they arise;
- ensure that the relevant lessons are learnt and effectively communicated to all relevant organizations;
- provide the necessary reassurance to the general public that the appropriate checks and balances are *in situ* to ensure the maintenance of the highest possible standards of care.

An appropriate structure, within the Board, has been established to fulfill these requirements as detailed in **Appendix A.**

More recently the Board, in response to HSS (PPM) 5/2003, has undertaken a Controls Assurance self assessment relating to the Risk Management Standard, this will assist in the development of the Corporate Risk Register and Treatment Plan. As compliance with the Controls Assurance standards (*i.e. Governance, Finance and Risk Management*), will be measured by a system of self-assessment, these will provide a useful platform to drive the Risk Management process forward. The Controls Assurance approach will ensure the Risk Management process is kept live and will improve the quality of Risk Registers, which will reflect the risks to achieving objectives.

4.2 Collaboration with other HPSS organisations

A key goal of the Risk Management Strategy is to foster collaboration between the four Health and Social Services Boards and other relevant agencies. In doing so, the potential for duplication of effort and utilisation of scarce resources, will be minimised and an opportunity will arise to share the workload and learn from each other's experiences and areas of outstanding practice.

The Board is accountable to the Department of Health, Social Services and Public Safety and the assessment of the risks facing the Board has to be taken in the context of guidance and direction issued by the Department. The Department is accountable for the actions of provider Trusts and within this context certain actions pertaining to the reduction of risk will lie between the Department and the Trusts. Within this context, the Board will endeavour to ensure that systems and processes are in place to minimise risk. Responsibility for monitoring and compliance will, however, remain with the Department.

The Northern Board is also mindful of the requirement on provider organisations to introduce a system of Clinical and Social Care Governance, underpinned by a statutory duty of quality and backed by continuous professional development and other training programmes.

For this Strategy to be truly effective and to co-ordinate specific Risk Management activity, there will be a need for explicit direction and guidance of the expectations that are to be placed upon Health and Social Services Boards from the DHSSPS. There will also be a need for clear guidelines relating to what may be expected by the Health and Social Services Boards of its provider organisations. The development and communication of clear frameworks will be crucial in order to manage the work that needs to be undertaken and to reduce the potential for conflict or disagreement between the Northern Health and Social Services Board and its provider organisations. The Northern Board is fully committed to working with the DHSSPS and other HPSS organisations to shape this direction. The NHSSB recognises the management of risk is important to both commissioner and provider and can be best achieved by close collaboration and a spirit of openness between parties.

5. RISK MANAGEMENT STRUCTURE AND RESPONSIBILITIES

It is a fundamental tenet of this Strategy that, whilst overall accountability and responsibility for Risk Management lies with the Chief Executive, all Managers and Heads of Department must accept that the management of risks, in their service areas and departments, is one of their key operational and day-to-day responsibilities.

It is also important managers at all levels stimulate the interest of their staff in the identification and reporting of hazards and risks which exist and that Managers address these proactively. Additionally, all Managers are expected to ensure that any adverse incidents and near misses (i.e., a situation which could develop into a major incident or which could be overlooked), which occur in their areas of responsibility, are reported immediately, through the agreed reporting systems and responded to positively.

5.1 Risk Management Training and Education Requirements

The effective establishment of a genuine Risk Management process within the Northern Health and Social Services Board requires an element of culture change, education for all staff and to varying degrees, specific, technical and practical training for those involved at differing levels within the Risk Management framework.

The Risk Management Strategy will be supported by an ongoing education and development programme. The training programme will enable and empower all relevant employees and stakeholders to identify and manage risks. Training will be carried across the organisation and will be targeted so that it is appropriate for the degree of involvement and responsibility of employees.

The education and development programme has been designed to educate staff as to the reason for Risk Management, how they can contribute and what the benefits will be to themselves and the Board as a whole.

The training will provide:

- raised awareness of the general principles and objectives of risk management;
- a definition of the employee's role in the risk management process;
- specialist Risk Management training in Risk Management techniques - purpose of risk registers, techniques for risk identification and sources of information;
- NHSSB system for risk evaluation and the preparation of treatment options and action plans.

An overview of Risk Management training carried out to date by NHSSB is contained in **Appendix B.**

The education and development training is provided to ensure the organisation is well placed to manage existing risks to the Northern Health and Social Services Board, but also to be able to identify new risks, for example, through the introduction of new legislation and develop appropriate risk control responses. The Northern Health and Social Services Board must be able to implement effective risk control measures promptly.

All staff will be given appropriate Risk Awareness education upon commencement of employment and updated annually thereafter.

5.2. Accountability and reporting structures

The Department's Controls Assurance Standard for Risk Management, April 2003 confirms that the Chief Executive has overall responsibility for Risk Management within the Board. The overall organisational responsibilities for Risk Management are detailed below and take into account, the requirements of the Controls Assurance Standard for Risk Management.

5.2.1. The Board:

- considers for approval the Board's Risk Management Strategy;
- nominates members to the Risk Management and Clinical and Social Care Governance (RM & CSCG) Committee and approves Terms of Reference for the Committee;
- reviews reports from the Committee;
- communicates significant risks to the Department, and other partners/stakeholders when appropriate;
- annually reviews the Board's approach to Risk Management and approves changes or improvements to Risk Management policy and strategy.

5.2.2. Risk Management and Clinical and Social Care Governance Committee:

- ensures organisation wide systems are in place for the co-ordination and prioritisation of Risk Management and Clinical and Social Care Governance issues, which should also identify relationships with provider organisations in managing risk and promoting Clinical and Social Care Governance;
- ensures that processes are in place to enable the Board to communicate and consider all significant risks;
- ensures that the Board has a system for Clinical and Social Care Governance that identifies and addresses Clinical and Social Care Governance priorities and integrates Clinical and Social Care Governance activities with Risk Management and related areas;

- annually reviews and recommends to the Board, for approval, a Risk Management Strategy;
- annually reviews and recommends to the Board, for approval, a Clinical and Social Care Governance Action Plan;
- reviews the results of an annual baseline assessment of Clinical and Social Care Governance arrangements;
- ensures the development and implementation of the Risk Management Strategy;
- ensures that processes are in place to manage less significant risks and that appropriate controls are in place and working effectively;
- oversees the work of the Risk Management and Clinical and Social Care Governance Operational Groups.

(Further details relating to this Committee are shown at **Appendix C**).

5.2.3. Chief Executive and Senior Management Team

- the Chief Executive has overall responsibility for Risk Management and Controls Assurance within the Board;
- designates an Executive Director with responsibility for Risk Management;
- approves the resources required to implement Risk Management initiatives;
- considers and agrees the risk assessments and treatment plans outlined in the Board's Corporate Risk Register;
- ensures Risk Management processes are consistent with the Board's corporate objectives, functions, powers and duties;
- identifies a designated Risk Management Lead for each Directorate and ensure that each LHSCG has a designated RM Lead.

5.2.4. Designated Executive Director

- oversees the implementation of the Risk Management Strategy, Policy and Procedures within the Board;
- oversees the development and maintenance of an organisation-wide up-to-date Corporate Risk Register and treatment plan;
- advises Risk Management Co-Coordinator and Directorate Risk Management Leads;
- advises the Chief Executive and Senior Management Team members in all key aspects of Risk Management within the organisation.

5.2.5. Heads of Department, Managers and LHSCG Chairs supported by Designated Risk Management Lead for each Directorate or LHSCG

- implement the Risk Management plan within their Directorate or LHSCG, including risk assessment and incident reporting;
- develop appropriate triggers for incident recording;
- ensure staff are aware of and adhere to appropriate Risk Management plan, including continual risk self assessment;
- ensure the availability of Risk Management procedures and information for all staff within their area of responsibility;
- facilitate the training of staff to support the implementation of Risk Management procedures;
- stimulate the interest of their staff to participate in the Risk Management processes by responding positively to the reporting of adverse incidents or general risk related concerns;
- develop, review and update local Risk Register and ensure action is taken to reduce unacceptable risk to an acceptable level by implementing Risk Treatment and Action Plans.

5.2.6. Designated Risk Management Lead for Each Directorate or LHSCG

This function will support the Heads of Department, Managers and LHSCG chairs operationalising the Department or LHSCG Risk Management Plan by:

- co-ordinate the risk assessment activity within each service/ department ensuring the completion of assessments and review of incident records in line with the Board's Risk Management Strategy and other policy requirements;
- facilitate the flow of incident reports through the service/ department in line with Board policy;
- enable respective directorate and LHSCG staff to contribute to the development of a local Risk Register;
- develop and maintain an up to date register of risks specific to their Directorate or LHSCG;
- communicate risks which cannot be managed locally to the Risk Management Operational Group for validation and prioritisation on Corporate Risk Register;
- advise Department Heads, Managers and LHSCG Chairs on appropriate means for ensuring less significant risks are actively managed at Directorate level, with appropriate controls in place and working.

5.2.7. Board Risk Management Co-ordinator

- Advising on development of Risk Management methodologies;
- coordinating and reporting activity on risk assessments and the status of risk and controls;
- compiling Corporate Board Risk Register in conjunction with Risk Management Operational Group;

- demonstrating compliance with standards as required through internal and external assessments;

- liaise with Directorates to ensure the risk management plan is being adhered to;

- liaise with Directorates to ensure that procedures are in place and regularly updated;

- education and training on Risk Management;

- support to the Risk Management Committee and other related groups, if appropriate;

- liaison with Risk Managers in other Boards and provider organisations;

- liaison with other quality and safety-related initiatives across the organisation.

The Risk Management Co-ordinator will be accountable to the Designated Director.

5.2.8. Risk Management Operational Group

- supports the Designated Executive Director in the operational implementation of Risk Management Systems across the Directorates and functions within the Board;

- assists the Designated Executive Director in the identification of areas of shared risk across the Directorates and functions within the Board;

- assists the Risk Management Co-ordinator to ensure that there is a consistent approach to the application of Risk Management procedures to identify, evaluate and control risks;

- assists the Risk Management Co-ordinator with the compilation of the Corporate Risk Register and Treatment Plan;

- assists the Risk Management Co-ordinator in the compilation of regular Risk Management Reports, Action Plans and updates, for consideration by the Risk Management Committee.

5.2.9 All Other Staff

- Have an awareness of risk at all times;

- notify line managers of any identified risks;

- report all incidents, near misses, and accidents using the appropriate reporting procedures. The Board recognises that the development of a culture, which accepts that the reporting of such incidents is largely based on help and support (*See policy statement*);

- Be familiar with the Board's and Departmental policies and procedures and comply with the same;

- acceptance of personal responsibilities for maintaining a safe environment.

6. RISK MANAGEMENT AND CONTROL MODEL

Diagram 1 below represents the Risk Management model as outlined within the Australia/New Zealand Risk Management Standards AS/NZS 4360. The Heath and Social Services Board will be utilising this approach to manage risk within the organisation.

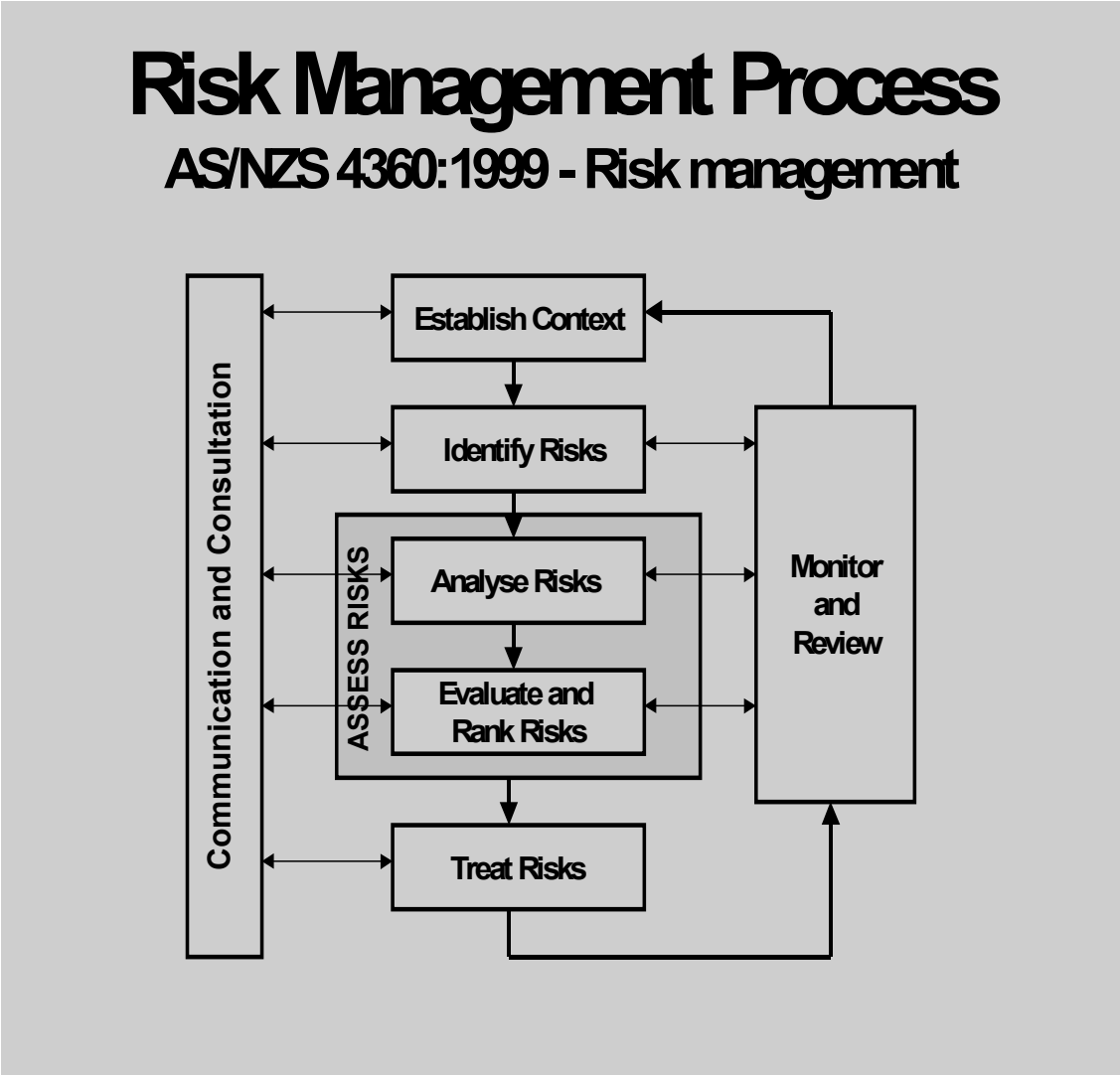

Diagram 1 ***Source: AS/NZS 4360.1999***

Risk Management is recognised as an integral part of good management practice. It is an iterative process consisting of steps, which, when undertaken in sequence, enables continual improvement in decision-making.

Risk Management is the term applied to a logical and systematic method of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risks designed to ensure that:

- the Board's objectives are defined and agreed;
- the risks threatening these objectives are identified, analysed and evaluated;
- decisions to control those risks are identified, implemented and monitored;
- the risk management process is effectively communicated within and externally to the organisation;
- the risk management process is embedded in the Board's business planning cycle.

The key stages of Risk Management will comprise of the following:

6.1. Establish the Context

The Board needs, firstly, to set a context for the risk management framework by establishing what the key influences upon its organisational objectives are.

6.2. Identify Risks

Effective and co-ordinated risk identification systems are vital to the success of the Northern Health and Social Services Board risk management process.

The Risk Management and Clinical and Social Care Governance Committee, whose Terms of Reference and Committee Membership are outlined in **Appendix C**, will ensure there is an ongoing programme of risk identification. It will also ensure a risk audit is carried out at least annually, in every part of the Northern Health and Social Services Board.

The process of risk identification entails the review of pertinent organisational documents, consultation with staff to identify specific risks within their area of work, site tours and inspections and a review of past incidents, audit information, claims and complaints.

6.3. Analyse the Risks

The formal assessment reports will be reviewed by the Risk Management Co-ordinator. An organisation-wide Corporate Risk Register will then be compiled by the Risk Management Co-ordinator to ensure that significant risks are recorded, actions identified and implementation tracked.

Risk analysis involves the assignment of severity and frequency "scores". The Board will work to develop a methodology for prioritising risks, based on severity and frequency. The Risk Register can be completed by applying this methodology to identified risks. (NHSSB Risk Matrix is shown at **Appendix D**).

6.4. Evaluate the Risks

This will allow all the risks identified to be prioritised (risk evaluation), in order to create a manageable programme of risk management targets.

6.5. "Treat" Risks

Where it is not possible to avoid a risk entirely, it is important that all necessary steps are taken to control the frequency and severity of the risk. Risk Treatments take the form of controls. It is likely that risk treatments chosen will be of two main types: those designed to *prevent* risks (and, therefore, to reduce likelihood or frequency of occurrence), and those designed to *mitigate* loss, should a risk materialise (and, therefore, reduce the impact of risk). Within these two types, the treatment of risk may take several forms, for example, training and education, development and dissemination of protocols or guidelines and physical controls.

The Risk Management Co-ordinator will also provide expert advice and assistance to the manager(s) in identifying appropriate remedial actions.

6.6. Monitor and Review

The Risk Management structure in the Northern Health and Social Services Board will consider all activity of the Board, including statutory and other functions.

The Northern Health and Social Services Board's progress in the assessment and control of risk will be reviewed annually by the Risk Management and Clinical and Social Care Governance Committee, which reports to the Board. This will enable the Chief Executive and Board to assess the effectiveness of the systems and the changes which need to be made. Each year a detailed Risk Management Action Plan will be prepared. See **Appendix E** for Action Plan 2003-4.

The Board will receive annual reports, which will provide assurances of the effectiveness of overall NHSSB Risk Management System and that it is complementing existing roles and management and executive professional responsibilities already in place. Reports will be in the form of:

- Compliance Assessment with Risk Management Controls Assurance Standard;
- Quarterly Update of the Corporate Risk Management Action Plan;
- Annual review of Risk Management Strategy.

Risk Management is a continuous process and full implementation will be an evolving development.

6.6.1 Key Performance Indicators

Key performance indicators will require to be developed over time following monitoring and review of the Risk Management System.

In the interim period, it is proposed to measure improvements in Risk Management performance, by monitoring compliance with the Risk Management Controls Assurance Standard.

The effectiveness of the Risk Management and associated control measures will be monitored through the structures described in this Strategy. Independent assessment of these measures will be carried out by Internal Audit, as agreed with the Designated Director.

6.7 Communicate and Consult

The Board will identify the appropriate structures and processes to ensure that it communicates effectively with its staff and stakeholders at each stage of this. For example, it will need to ensure Board members are committed to the Risk Management methodologies adopted, that staff are aware of the mechanisms for reporting concerns and issues, and that stakeholders understand the objectives of the Board.

7. APPROVAL AND REVIEW

This Risk Management Strategy has been prepared for the attention of **ALL** staff within the NHSSB to provide a clear vision and practical framework to assist the control of risk within the NHSSB. The strategy will be communicated by means of training and will be made available to all staff via the NHSSB intranet.

The Risk Management Strategy will be reviewed annually by RM & CSCG Committee, but may be subject to change consistent with any new guidance, legislation or corporate change being introduced.

This Strategy was **approved** by NHSSB Board of Directors at their

meeting on ___ / ___ / ___ and

becomes effective on ___ / ___ / ___

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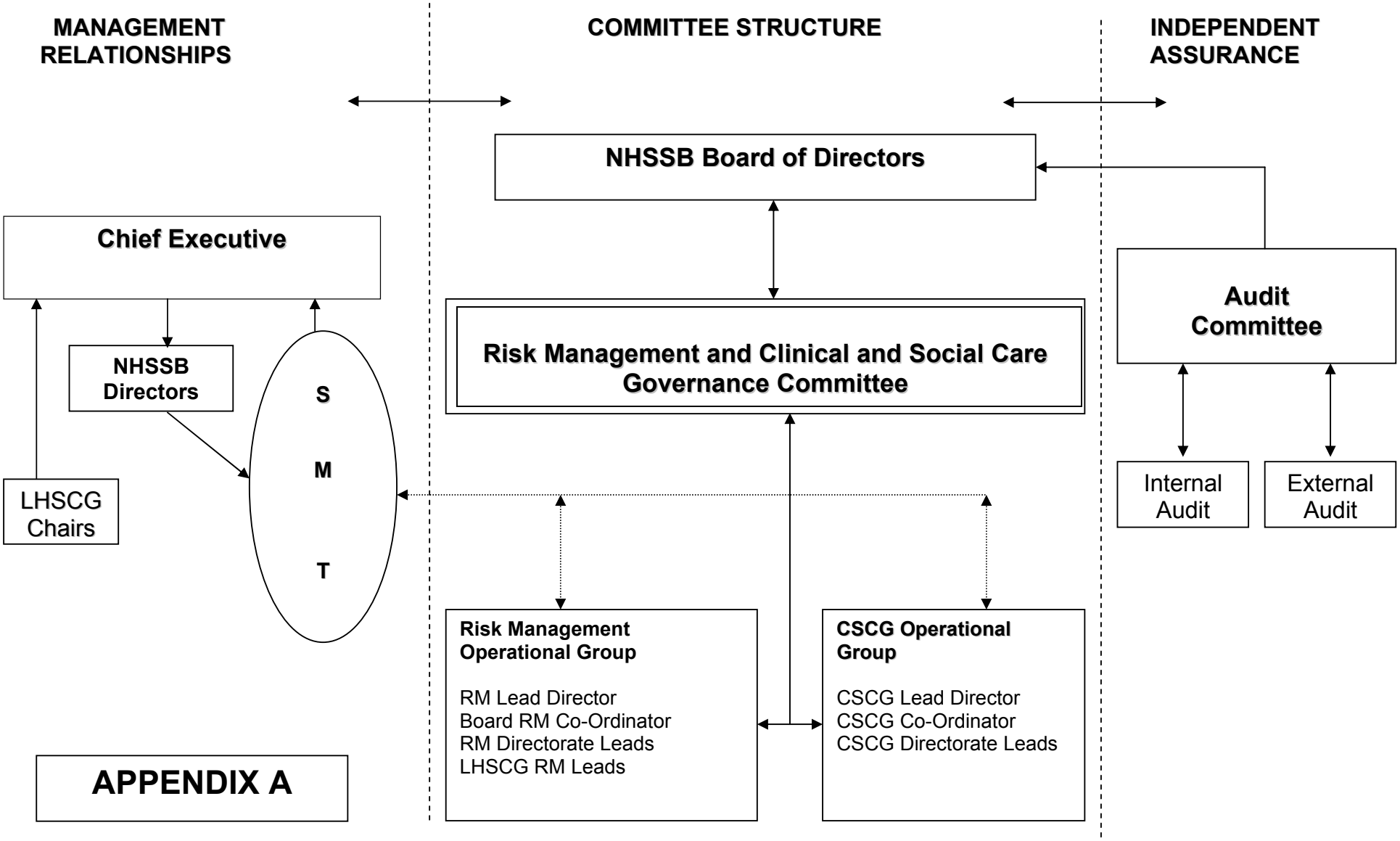
NHSSB RISK MANAGEMENT AND CLINICAL AND SOCIAL CARE GOVERNANCE STRUCTURE



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APPENDIX B

NHSSB RISK MANAGEMENT TRAINING OVERVIEW

In the Autumn 2002 the Board secured a Risk Management training partner, with the intention of implementing the Board's Risk Management Strategy, supported by a training and development programme.

During November and December 2002, General Awareness Training sessions were held for **all** staff and in-depth training for the Risk Management Leads from each Directorate, with a sweep up session in early January 2003, for those staff who had been unable to attend any of the previous sessions.

In June 2003, Awareness Training was provided for LHSCG staff and in-depth training has been held for LHSCG Risk Management Leads during October 2003, where delegates will be given instruction on the tools and techniques required to establish and maintain Risk Registers and Treatment Plans, which will facilitate LHSCGs in populating their respective Risk Registers and Treatment Plans.

In November 2003, Risk Management Training will be incorporated into the Board's Induction Programme, which is mandatory for all new employees.

APPENDIX C

RISK MANAGEMENT AND CLINICAL AND SOCIAL CARE GOVERNANCE COMMITTEE

TERMS OF REFERENCE:

The Risk Management and Clinical and Social Care Governance Committee is a committee of the Board with the following Terms of Reference*:*

1. Agree and recommend for Board adoption the Board's Risk Management and Clinical and Social Care Governance Strategies.

2. Scrutinise and recommend to Board for ratification, all major Risk Management and Clinical and Social Care Governance Policies and Procedures.

3. Provide assurance to the Board that appropriate processes exist within the Board in all areas of its work, to take forward Risk Management and Clinical and Social Care Governance.

4. Determine, on behalf of the Board, appropriate channels for monitoring Risk Management and Clinical and Social Care Governance systems

Membership:

Membership of the Committee should comprise of at least three non-executive Members, with one acting as Chairman.

The Directors with lead responsibilities for Risk Management and Clinical and Social Care Governance will be in attendance at all Committee meetings.

Other Directors will attend the Committee as and when required.

The secretarial support to the Committee will be provided by the Board Secretary or his/her nominee.

Quorum: Two

Frequency of Meetings: Tri-annually

Reports to: The Board

Links to: The Board

Roles of Risk Management and Clinical and Social Governance Committee:

- ensures organisation wide systems are in place for the co-ordination and prioritisation of Risk Management and Clinical and Social Care Governance issues, which should also identify relationships with provider organisations in managing risk and promoting Clinical and Social Care Governance;
- ensures that processes are in place to enable the Board to communicate and consider all significant risks;
- ensures that the Board has a system for Clinical and Social Care Governance that identifies and addresses Clinical and Social Care Governance priorities and integrates Clinical and Social Care Governance activities with Risk Management and related areas;
- annually reviews and recommends to the Board, for approval, a Risk Management Strategy;
- annually reviews and recommends to the Board, for approval, a Clinical and Social Care Governance Action Plan;
- reviews the results of an annual baseline assessment of Clinical and Social Care Governance arrangements;
- ensures the development and implementation of the Risk Management Strategy;
- ensures that processes are in place to manage less significant risks and that appropriate controls are in place and working effectively;
- oversees the work of the Risk Management and Clinical and Social Care Governance Operational Groups.

APPENDIX D

RISK MANAGEMENT MATRIX

IMPACT	LIKELIHOOD					
		VL	L	M	H	VH
	VH	Medium	High	High	Very High	Very High
	H	Low	Medium	Medium	High	Very High
	M	Low	Medium	Medium	Medium	High
	L	Very Low	Low	Medium	Medium	High
	VL	Very Low	Very Low	Low	Low	Medium

APPENDIX E

	ACTION	ESTIMATED RESOURCES (DAYS)					TIMESCALES											PRODUCT
		Lead Director	Project Manager	Each Co-ordinator	Each SMT Member	Each Staff Member	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
1	**Initial QA of Draft Directorate Risk Registers & Treatment Plans**																		Quality Assured Directorate Risk Registers and Treatment Plans
	Consider Consistency of Identification, Scoring, Treatment	1	3	1			■	■	■										
	Identify Significant Areas of Shared Risk	1	3	1			■	■	■										
	Reconcile Treatment Plans for Shared Areas of Risk	1	3	1			■	■	■										
	Functioning Registers Established	1	3	1			■	■	■										
2	**Consolidation of Directorate Risk Registers and Treatment Plans into Corporate Register and Plan**																		
	Organise Workshop for SMT to Consider High Level/Strategic Risks	2	4	2	1				■	■									
	Match Relevant Risks to Corporate Plan Products	1	2	1						■	■	■							
	Identify Common Risks and Treatment Plans	1	2	1						■	■	■							1st "Cut" Corporate Risk Register and Treatment Plan
	Treatment Plan priorities in Corporate and Directorate actions and internal decision-making processes.	2	30	2	1	1							■	■	■				3rd "Cut" Corporate Risk Register and Treatment Plan
3	**Involvement of LHSCG's**																		LHSCG Risk Register and Prioritised Treatment Plan
	Organise Awareness and Specific Training	1	2	1		3	■	■											
	Produce Draft Risk Registers and Treatment Plans	1	8	3		3			■	■									

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	ACTION	ESTIMATED RESOURCES (DAYS)					TIMESCALES	PRODUCT
4	**QA LHSCGs Risk Registers and Treatment Plans**	4	20	4		12		Quality Assured LHSCG Risk Registers and Treatment Plans
5	**Consolidation of LHSCGs Risk Registers and Treatment Plans into Corporate Register and Plan**	4	8	4				2nd "Cut" Corporate Risk Register and Treatment Plan
6	**Assessment of Compliance Against Depts. Key Areas**							Self Assessment of Compliance
	Financial Management (Core)	1	2	1	0.5	1		
	Governance (Core)	1	2	1	0.5	1		
	Risk Management (Core)	1	2	1	0.5	1		
	Human Resources	1	2	1	0.5	1		
	Medical Equipment and Devices	1	2	1	0.5	1		
	Medicines Management	1	2	1	0.5	1		
7	**Draw up Prioritised Action Plan to Meet Required Level of Compliance**							Prioritised Action Plan
	Financial Management - Full Compliance	0.5	1	1	0.5	1		
	Governance "	0.5	1	1	0.5	1		
	Risk Management "	0.5	1	1	0.5	1		
	Medicines Management (Degree of Compliance to be confirmed)	0.5	1	1	0.5	1		
	Human Resources "	0.5	1	1	0.5	1		
	Medical Equipment and Devices "	0.5	1	1	0.5	1		

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	ACTION	ESTIMATED RESOURCES (DAYS)					TIMESCALES	PRODUCT
8	**Appoint and Induct Board Risk Management Co-ordinator**	2	10					Appointment of Board Risk Management Co-ordinator
9	**Respond to Self Assessment of NIAO Risk Areas**							Implementation of Action Plan
	Implement Action Plan						As stated in NIAO Action Plan	
10	**Participate in 4 Board Governance Group**							Standard CSCG and Risk Management Processes
	Lead Role in Development of Standard Training and Awareness Packs	5	15					
	Lead Role in Quality Improvement /Clinical and Social Care G overnance Group	5	15					
11	**Prepare Statement of Internal Control for Annual Accounts 2003/04**	2	3	0.5				Statement of Internal Control
12	**Prepare Risk Management Action Plan for 2004**	2	4	1	0.5			Risk Management Action Plan for 2004/05
13	**Consider Interface with Main Providers**	4	10	2	1			Updates via Quarterly Reporting
14	**Report on Progress**							
	Quarterly Report to Governance Committee	3	6	2	0.5			Quarterly Report
15	**Prepare Section for Annual Report**	2	4	1	0.5			Annual Report
16	**Revise Board Risk Management Strategy to Reflect Linkage with Clinical and Social Care Governance**	3	6	2	1			Revised Risk Management Strategy

WESTERN
HEALTH AND SOCIAL SERVICES BOARD

A RISK MANAGEMENT STRATEGY

FOR THE

WESTERN HEALTH AND SOCIAL SERVICES BOARD

March 2004

1.0 INTRODUCTION

1.1 The Western Health and Social Services Board is responsible for commissioning high quality health and social care for the community it serves. This Risk Management Strategy has been developed in order to ensure the Western Health and Social Services Board discharges its functions so as to ensure that risks are managed as effectively and as efficiently as possible and to acceptable standards of quality.

1.2 Risk management is recognised as an integral part of good management practice. It is about having in place a corporate and systematic process for evaluating and addressing the impact of risk in a cost effective way and having staff with the appropriate skills to identify and assess the potential for risk to arise. Risk management is as much about identifying opportunities as avoiding or mitigating losses.

1.3 This strategy recognises, and seeks to build upon, the work that has already been done within the Board to put in place a robust risk management structure and process. A holistic approach has been adopted to embrace financial, organisational and professional risk throughout the Board.

2.0 MAIN AREAS OF RISK

It is recognised that there are four main areas of risk for the Board.

- **the Board's strategic** functions (for example, population needs assessment, statutory functions, and risk analysis of policy creation in the light of Equality and Human Rights legislation);
- the Board's **internal operational responsibilities** (for example, resource allocation to Programmes of Care, systems for corporate governance, financial and workplace safety);
- the adequacy of risk management within **services commissioned** by the Board (for example, robust professional recruitment procedures in Trusts and private sector providers, patient and client access to information in provider organisation and infection control programme);
- the adequacy of risk management in **collaborative/partnership working** within the HPSS family and with other organisations.

3.0 RISK MANAGEMENT POLICY STATEMENT

The Western Health and Social Services Board follows and adopts best practice in the identification, evaluation and control of risks to ensure, as far as is reasonably practical, that risks are managed or reduced to an acceptable level. The Board accepts that some risks exist and can never be eliminated. It is, however, important that all staff are aware of the nature of risk and the types of risk associated with their areas of work. Senior staff must accept responsibility for dealing with risks in their service areas. Senior management will provide support and assistance in the risk assessment and evaluation process.

4.0 OBJECTIVES IN RELATION TO RISK MANAGEMENT

The Board's objectives in relation to the management of risks are to:

- integrate risk management into the culture of the Board;
- manage risk in accordance with best practice;
- consider legal compliance and statutory duties as a minimum standard;
- anticipate and respond, wherever possible, to changing social, environmental and legislative requirement;
- raise awareness of the need for risk management.

5.0 RISK MANAGEMENT PROCESS

In line with the Australia/New Zealand Risk Management standard [redacted] AS/NZS4360:1999 the key stages of the Board's risk management process comprise:

5.1 Establishing the context

The Board will establish a strategic, organisational and risk management context in order to define the basic parameters within which risks must be managed and to provide guidance for decisions within more detailed risk management studies. The Board has agreed the criteria (see Appendix 3) against which risk is to be evaluated and has defined the structure for risk management.

5.2 Identifying risks

The Board will continue to ensure that the risks to be managed are identified using a comprehensive, well-structured, systematic process. The Board's Governance & Risk Management Committee will ensure that there is an ongoing programme of risk identification and that a rolling risk audit programme is developed. The approach used to identify risks will depend on the nature of the activities under review and the type of risk involved.

5.3 Analysing the risks

All identified risks will be analysed to separate minor acceptable risks from the major risks and to provide data to assist in the evaluation and treatment of risks. Risk analysis will involve consideration of the sources of risk, their consequences and the likelihood that those consequences may occur. Factors which effect consequences and likelihood will be identified and risk will be analysed by combining estimates of consequences and likelihood in the context of existing control measures. Formal assessment reports will be reviewed by the Governance & Risk Management Committee.

Initial Directorate risk registers are currently being developed. These will be used to populate an organisation-wide risk register to ensure that significant risks are recorded, actions identified and implementation tracked. The Board will work to develop a methodology for prioritising risks based on severity, frequency and existing controls.

5.4 Evaluating the risks

Risk evaluation will involve comparing the level of risk found during the analysis process with the previously established risk criteria. The output of the risk evaluation will be a prioritised list of risks for further action. If the resulting risks fall into the low or acceptable risk category, they will be accepted with minimal further treatment. Low and accepted risks will be monitored and periodically reviewed to ensure they remain acceptable. If risks do not fall into the low or acceptable risk category, they will be treated as described below.

5.5 Treating risks

Where it is not practicable to avoid a risk entirely, all necessary steps will be taken to control the frequency and severity of the risk. Controls will be established to prevent risks (and therefore reduce likelihood or frequency of occurrence) and/or to mitigate loss should a risk materialise (and therefore reduce the impact of the risk). The Risk Management Co-ordinator will provide expert assistance and advice to Board officers in identifying appropriate actions to treat risks.

During the next 12 months the Board will aim to develop a system for identifying and categorising risks which clearly states under what circumstance and at what level the Board would be willing to carry risk.

5.6 Monitoring and reviewing

The Board will monitor risks, the effectiveness of the risk treatment plan and strategies and the management system set up to control implementation. Risks and the effectiveness of control measures will be monitored to ensure changing circumstances do not alter risk priorities, as few risks remain static.

Ongoing review will take place to ensure that the management plan remains relevant.

5.7 Communication and consultation

Communication and consultation with stakeholders will be an important consideration at each step of the risk management process.

6.0 CONTROLS ASSURANCE [redacted]

6.1 Controls Assurance is a holistic concept based on best governance practice. It is a process designed to provide evidence that the Board is doing its "reasonable best" to manage ourselves so as to meet our objectives, protect patients, staff, the public and other stakeholders against risks of all kinds. Controls Assurance is a process of self-assessment against a number of standards. Compliance with the following standards is currently being assessed together with associated action plans:

- Financial Management (core standard)
- Governance (core standard)
- Risk Management (core standard)
- Human Resources
- Medical Equipment & Devices
- Medicines Management

6.2 There are further standards in draft format, which will be introduced in 2004/05 (see www.dhsspsni.gov.uk/hss/governance/index.html for more details).

7.0 CLINICAL & SOCIAL CARE GOVERNANCE

7.1 Clinical and Social Care Governance is defined as a framework within which HPSS organisations are accountable for continuously improving the quality of services and safeguarding high standards of care and treatment. Clinical and Social Care Governance arrangements within organisations, which provide or commission services, are now underpinned by a statutory duty of quality.

7.2 The Board is committed to the principles of Clinical and Social Care Governance and has compiled an initial baseline assessment of current practice. Feedback sessions are being arranged on the assessment by the DHSSPS and will result in a prioritised action plans to take the process forward.

8.0 RISK MANAGEMENT STRUCTURES AND RESPONSIBILITIES

8.1 It is a fundamental tenet of this Strategy that, whilst overall accountability and responsibility for risk management lies with the Chief Executive as accountable officer and the Board, all managers and Heads of Department must accept that the management of risk in their service areas and Departments is one of their key operational and day-to-day responsibilities.

The overall risk management structures and responsibilities of managers and staff are described in Appendices 1 & 2.

8.2 The risk management structure in the Western Health and Social Services Board will include consideration of the risks associated with the maintenance of our statutory functions, which are exercised through the role of the Director of Public Health, the Director of Social Care and the Chief Nurse. These statutory functions are established through legislation and up-to-date details of the relevant legislation are maintained by the Directors and are covered by Directorate Risk Management procedures.

9.0 ASSOCIATED POLCIES & PROCEDURES

Accident / Incident Reporting Policy
Claims Handling Policy
Complaints Policy
Whistle Blowing Policy
Standing Orders / Standing Financial Instructions
Emergency Plan

10.0 TRAINING

Risk management education and training of all staff is an essential element of the Risk Management Strategy. A programme of awareness training sessions has been held and induction for new staff will include risk management. An ongoing risk management training programme should be developed based on a training needs analysis. Raising general awareness amongst staff will also be undertaken through staff briefings and inclusion of relevant documents on the intranet.

11.0 ACTION PLAN 2004-2005 *

- Quality assure draft directorate risk registers and treatment plans
- Consolidate directorate risk registers and treatment plans in corporate register and plan
- Agree a systematic process for reviewing directorate & corporate registers and treatment plans
- Develop a system for identifying and categorising risks, which clearly states under what circumstance and at what level the Board would be willing to carry risk
- Assess compliance with controls assurance standards and develop action plans
- Update and prioritise action plans for the implementation of Clinical & Social Care Governance arrangements
- Review and implement training needs analysis
- Prepare a risk management action plan for 2004/05
- Review our arrangements for Governance and Risk Management in light of proposed SCTs
- Finalise Corporate Risk Register

DATE OF REVIEW **DECEMBER 2004**

APPENDIX 1

WESTERN HEALTH & SOCIAL SERVICES BOARD

GOVERNANCE
ROLES & RESPONSIBILITIES

1 THE BOARD

The Board is accountable for internal control within the organisation. It exercises strategic control over the operation of the organisation through a system of governance. Governance in this context is taken to mean the whole system of risk management, clinical and social care governance and controls assurance. The role of the Board is to set strategic direction and ensure the delivery of corporate objectives through the implementation of appropriate governance structures and processes.

2 CHIEF EXECUTIVE

The Chief Executive as Accountable Officer is responsible for ensuring the implementation of governance structures and processes throughout the organisation and for the organisation's effectiveness in achieving corporate objectives. The Chief Executive signs the Annual Statement of Internal Control on behalf of the Board.

3 GOVERNANCE & RISK MANAGEMENT COMMITTEE

The role of the Committee is to oversee the implementation of governance and report to the Board on a regular basis to ensure it is kept fully aware of progress. It will also provide assurances to the Board that reporting mechanisms are in place to ensure risk is being identified and managed through the operation of effective controls, in all aspects of the Board's business.

Membership

- Chair (Non Executive Director)
- 2 Further Non Executive Directors

In addition, others asked to attend may include:

- WHSSC Chief Officer
- Chief Executive
- Directors
- Risk Management Lead
- Clinical & Social Care Governance Lead
- Northern & Southern LHSCG Governance Leads
- Chief Internal Auditor
- Risk Management Co-ordinator

4 THE GOVERNANCE & RISK MANAGEMENT OFFICERS GROUP

The prime task of the Governance & Risk Management Officers Group is to co-ordinate and communicate Risk Management and Clinical & Social Care Governance activity across the Board and to facilitate the process of integration and prioritisation across the specific areas of governance. This multi-disciplinary group is directly accountable to the Chief Executive for the operational implementation of the Board's strategies for Governance.

Membership

- Risk Management Lead (Chair)
- Clinical & Social Care Lead
- Lead from each Directorate
- Northern & Southern LHSCG Governance Leads
- Risk Management Co-ordinator

5 RISK MANAGEMENT LEAD

The Risk Management Lead is the designated person with overall responsibility for ensuring the implementation of Risk Management and compliance with Controls Assurance Standards. The Risk Management Lead reports, through the Chief Executive, to the Governance and Risk Management Committee on Risk Management issues.

6 CLINICAL & SOCIAL CARE GOVERNANCE LEAD

The Clinical & Social Care Governance Lead is the designated person with overall responsibility for ensuring the implementation of Clinical & Social Care Governance and reporting, through the Chief Executive, to the Governance & Risk Management Committee on Clinical and Social Care Governance issues.

7 LOCAL HEALTH & SOCIAL CARE GROUPS

Clinical & Social Care Governance Leads are accountable, via the Chair of the LHSCG, to the WHSSB Chief Executive for ensuring the implementation of Governance and Risk Management within LHSCG's. They chair Clinical & Social Care Governance sub-groups, which report to the LHSCGs. Northern and Southern LHSCG Leads are members of the Board's Governance and Risk Management Officers Group and attend meetings of the Governance and Risk Management Committee as required.

8 GOVERNANCE & RISK MANAGEMENT CO-ORDINATOR

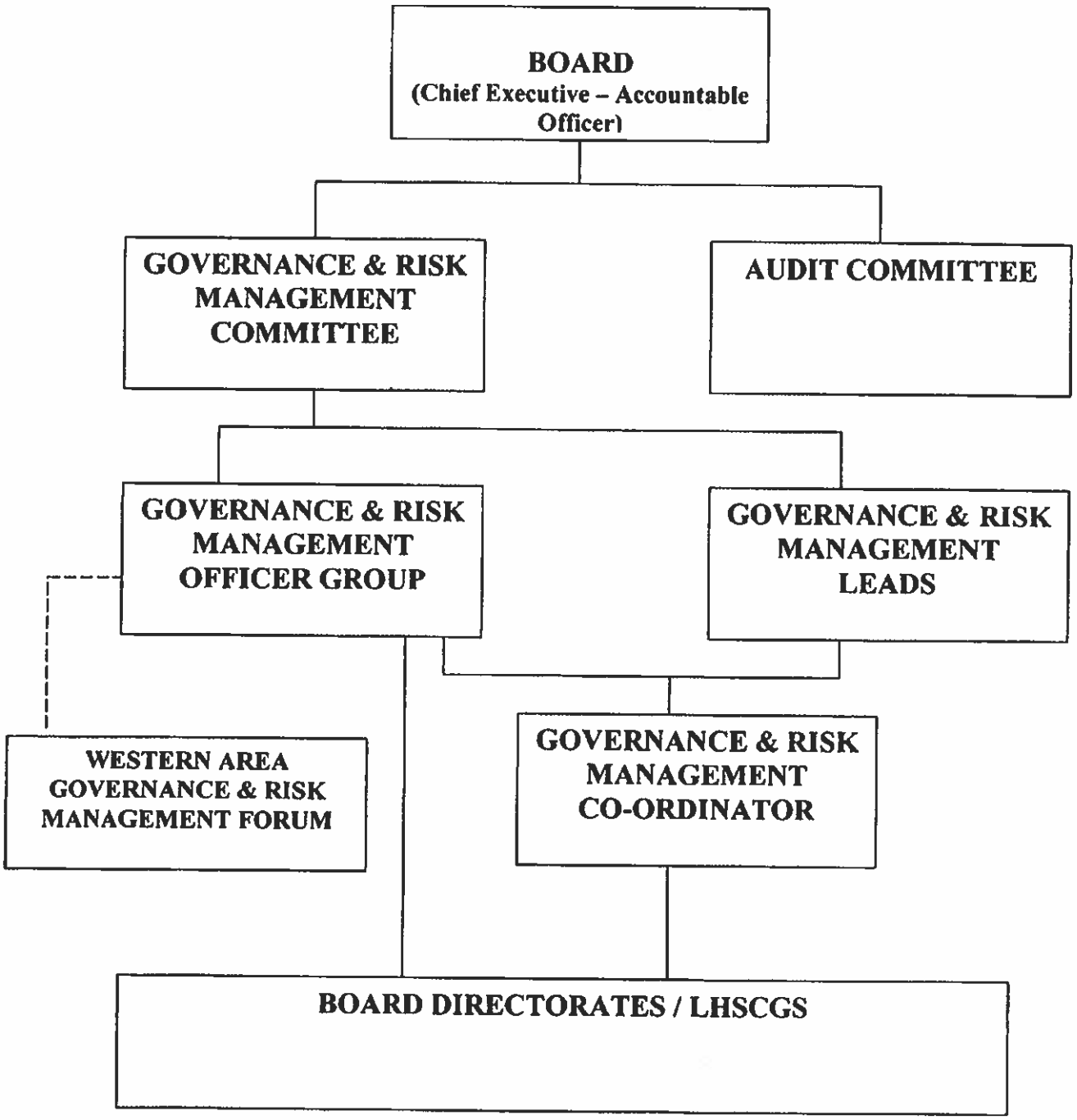
The Governance & Risk Management Co-ordinator is responsible for co-ordinating the risk management and clinical & social care governance programmes and ensuring appropriate processes are in place to implement controls assurance. The Co-ordinator reports to the Risk Management Lead. He/She also works with other Board Risk Management Co-ordinators and the Regional Governance & Risk Management Advisor.

9 ALL STAFF

All WHSSB staff have a responsibility to ensure that appropriate Risk Management and Clinical & Social Care Governance processes are in place and adhered to in their respective areas of business. Staff at all levels can support their line managers by raising risk and control concerns as soon as they arise.

APPENDIX 2

WHSSB GOVERNANCE & RISK MANAGEMENT ORGANISATION CHART



APPENDIX 3

RISK IMPACT ASSESSMENT TABLE

Category Impact	Safeguard service users, community and staff	Quality and Professional Standards	Govt Priorities, Targets, Policies. Board Objectives re Service provision	Safeguard Public confidence and WHSSB reputation	Legal/Statutory	Protect assets and avoid financial loss
Insignificant	Minor injury	Minor non-compliance	Negligible non compliance Negligible service deficit	Negligible interest or consequences	Legal Challenge Minor out-of-court settlement	Less than 5K
Minor	Cuts/bruises < 3 days absence < 2 days extended hospital stay Emotional distress	Single failure to meet internal standards or follow protocol	Failure to meet national target for 1 quarter. 5% off Board service provision target	Minor public embarrassment Local press interest 1 day	Civil action – no Defence Improvement notice	£5K -£50K
Moderate	3 days absence 3-8 days extended hospital stay Semi permanent physical harm/ emotional trauma	Repeated failures to meet internal standards or follow protocols	Failure to meet national target for 2 quarters 5% – 20% off Board service provision target	Some public embarrassment, Limited damage to reputation Extended local press interest	Class action Criminal prosecution Prohibition Notice	£5K-£250K
Major	9 days extended hospital stay Fatality Permanent disability/ emotional trauma	Failure to meet national/professional standards	Failure to meet national target >2 quarters Visible failure in service provision area(s) >20%	Loss of credibility and confidence in Board/ Service National press interest Independent external enquiry Assembly Questions	Criminal prosecution – no defence Executive officer dismissed	£250K – £1.0M
Catastrophic	Multiple fatalities Multiple permanent physical or emotional injury	Gross failure to meet professional/ national standards	Failure to meet National Targets >2 quarters by significant margin. Significant failure >35% in service provision	Full Public Enquiry PAC Hearing [redacted]	Criminal prosecution – no defence Executive officer fined or imprisoned	More than £1.0M

[redacted]

APPENDIX 3

RISK LIKELIHOOD ASSESSMENT TABLE

LEVEL	DESCRIPTION
ALMOST CERTAIN	LIKELY TO RECUR IN MOST CIRCUMSTANCES
LIKELY	WILL PROBABLY RECUR BUT IS NOT PERSISTENT ISSUE
POSSIBLE	MAY OCCUR OCCASIONALLY
UNLIKELY	DO NOT EXPECT TO HAPPEN AGAIN BUT IS POSSIBLE
RARE	DO NOT BELIEVE WILL EVER HAPPEN AGAIN

RISK GRADING MATRIX

LIKELIHOOD		IMPACT / SEVERITY				
		1	2	3	4	5
		Insignificant	Minor	Moderate	Major	Catastrophic
5	Almost Certain	Y	A	A	R	R
4	Likely	Y	Y	A	R	R
3	Possible	G	Y	Y	A	R
2	Unlikely	G	G	Y	A	A
1	Rare	G	G	Y	A	A

Y – yellow G – green A – amber R - red

Health and Social Care Board

Health and Social Care Board

Governance Framework 2011/12 – 2012/13

Reference 2011/ Gov/ 04	**Responsible Officer** Head of Corporate Services	**Review Frequency** Biennial
Approved by Governance Committee	**Approval Date:** 1 December 2011	**Next review due** November 2013
Superseded documents (if applicable) HSCB Interim Governance Assurance Framework (Sept 2009) and legacy HPSS Board Governance/Risk Policies		

December 2011

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Background

Circular DAO (DFP) 5/2001 introduced the requirement for a wider Statement of Internal Control (SIC) in the accounts of the DHSSPS and of HPSS bodies. The circular referred to the Turnbull Report conclusion that a sound system of internal control must be based on a thorough and regular evaluation of the extent and nature of risks to which an organisation is exposed. The HRRI Review (1999) into risk management in the HPSS, concluded that, while good work was being done, the approach across the HPSS and within individual bodies tended to be fragmented and inconsistent.

Circular HSS (PPM) 6/2002 announced that the DHSSPS, in recognition of the importance of a sound system of risk management, had entered into a license agreement with Standards Australia for the use of their internationally recognised risk management standard AS/NZS 4360:1999 (now updated to 2004 model). The application of this internationally recognised approach to risk management would be seen as an important piece of evidence in support of a Statement of Internal Control.

The application of Controls Assurance standards within the HPSS, was announced in Circular HSS (PPM) 8/2002. This process would enable individual HPSS organisations to provide evidence that they are doing their reasonable best to protect users, staff, the public and other stakeholders against risk of all kinds. It is a means by which Chief Executives as Accountable Officers can discharge their responsibilities and provide assurances to the Department, the Assembly and the Public.

In January 2003 the DHSS&PS issued guidance under Circular HSS (PPM) 10/2002, specific to clinical and social care governance. The guidance was to enable HPSS organisations to formally begin the process of developing and implementing clinical and social care governance arrangements within their respective organisations and set a framework for action which highlighted the roles, responsibilities, reporting and monitoring mechanisms that are necessary to ensure delivery of high quality health and social care.

The circular also stipulated the requirement that this new guidance should be read in the context of previous guidance already issued on the implementation of a common system of risk management and the development of controls assurance standards for financial and organisational aspects of governance.

The Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003 imposed a 'statutory duty of quality' on HPSS Boards and Trusts. To support this legal responsibility, the Quality Standards for Health and Social Care have been issued by DHSSPS. They will be used by the new Regulation, Quality Improvement Authority (RQIA) to assess the quality of care provided by the HPSS.

In April 2009, DHSSPS issued 'An Assurance Framework: *A Practical Guide for Boards of DHSSPS Arm's Length bodies'.* The Framework guidance which is

mandatory is intended to help the Boards of HSC organisations, and other arm's length bodies of DHSSPS, improve the effectiveness of their systems of internal control.

The HSC Performance and Assurance Roles and Responsibilities MIPB 74/09 were issued in April 2009. Its role, to set out performance and assurance roles and responsibilities in relation to four key HSC domains and to identify the key functions and associated roles and responsibilities of DHSSPS, HSCB, PHA, BSO, Trusts and other Arm's Length Bodies.

In May 2009 the DHSSPS Accounting Officer wrote to accounting officers of each DHSSPS arm's length body, requesting a mid year statement concerning the condition of the system of internal control within their respective organisation's as at the end of the September each year.

Circular HSC (SQSD) 08/2010, announced that responsibility for management of Serious Adverse Incident (SAI) reporting transferred from the DHSSPS (Department) to the Health and Social Care Board (HSCB) working in partnership with the Public Health Agency (PHA), with effect from 1st May 2010.

As a standard requirement of *Managing Public Money Northern Ireland, DHSSPS* must agree a DFP-approved Management Statement/Financial Memorandum (MS/FM) with each of its arm's length bodies. This was approved by the Board of the HSCB at its meeting in May 2011.

DHSSPS have produced a Framework Document to meet the statutory requirements placed upon it by the Health and Social Care (Reform) Act (NI) 2009. The Framework Document describes the roles and functions of the various health and social care bodies and the systems than govern their relationships with each other and the Department.

Introduction

The Health and Social Care Board (HSCB) has a range of statutory duties, and shall, as a body corporate, exercise the functions assigned to it by DHSSPS, including those set out in Article 8(1-7) of the Health and Social Care (Reform) Act (NI) 2009 and any other statutory provisions deemed by DHSSPS to be functions of the HSCB, including the Governance Resources and Accounts Act (NI) 2001.

The overall aim of the HSCB, working in close collaboration with the Public Health Agency (PHA), is to improve health and social well-being outcomes, through a reduction in preventable disease and ill-health, achieved by effective, high quality, safe, equitable and efficient health and social care.

It is therefore vital the HSCB establishes robust governance arrangements to ensure it discharges its functions in a way which ensures that risks are managed as effectively and efficiently as possible and to acceptable standards of quality. The specific objective is to protect the organisation against loss, the threat of loss and the consequences of loss, whilst at the same time having a framework in place that highlights the roles, responsibilities, reporting and monitoring mechanisms that are necessary to ensure commissioning and delivery of high quality health and social care.

The HSCB has a duty to protect users, carers, staff and others in the planning and delivery of services. Reducing risk is not just about financial or management probity it is about improving the quality of services and user experience of those services. This means that equal priority needs to be given to the obligations of governance across all aspects of the organization. There is a need to cover financial, organisational and clinical and social care and a need for these to be truly integrated within the organisation's culture. Good governance hinges on having clear objectives, sound practices, a clear understanding of the risks run by the organisation and effective monitoring arrangements. Any organization seeking to 'continuously improve the quality of services and safeguarding high standards of care' must put in place an accountability framework which permeates all levels of responsibility within the organisation.

Within the HSCB this is achieved by the adoption of an overarching Governance Framework (Framework).

Strategic Context

Corporate Governance is the system by which an organisaiton is directed and controlled, at its most senior levels, in order to achieve its objectives and meet the necessary standards of accountability, probity and openness.

The Audit Commission has defined corporate governance in health and social care as ‘the systems and processes by which health bodies lead, direct and control their functions, in order to achieve organisational objectives, and by which they relate to their partners and the wider community’.

The Governance Framework is principally concerned with ensuring the HSCB has the basic building blocks in place for good governance through development and implementation of a sound system of internal control.

This Framework therefore highlights the key components that underpin a sound system of governance and internal control, which will assist the Board of the HSCB, through the Chief Executive, to sign the annual Governance and Mid Year Assurance Statements.

HSCB Governance Structure
Roles and Responsibilities

The Board of the HSCB

The HSCB's Board must ensure that effective arrangements are in place to provide assurance on risk management, governance and internal control. The Board has corporate responsibility for ensuring that the HSCB fulfils the aims and objectives set by the Department/Minister, and for promoting the efficient, economic and effective use of staff and other resources by the HSCB.

The Board must set up an Audit Committee and a Governance Committee to provide independent advice on the effectiveness of the internal control and risk management systems.

The Governance Committee

The Governance Committee will support the Board in all aspects of corporate and clinical and social care governance. It will assist the Board in these functions by providing an independent and objective review of:

- the adequacy and effectiveness of the system of internal control and to ensure a robust assurance framework is maintained;
- how risks and opportunities are identified and managed;
- the information provided to the Board,
- compliance with law, guidance and codes of conduct and accountability

The Governance Committee shall give an assurance[1] to the Board each year on the adequacy and effectiveness of the system of internal control in operation within the HSCB.

The Audit Committee

The Audit Committee will support the Board and Accounting Officer by reviewing the comprehensiveness of assurances in meeting the Board and Accounting Officer's assurance needs and reviewing the reliability and integrity of these assurances.

The Audit Committee will constructively challenge:

[1] HM Treasury "Management of Risk – Principles and Concepts" (October 2004) defines assurance as:"an evaluated opinion, based on evidence gained from review on the organisation's governance, risk management and internal control framework"

- Assurance providers as to whether the scope of their activity meets the Board and Accounting Officer's assurance need and;
- The actual assurances to test that they are founded on sufficient reliable evidence and that the conclusions are reasonable in the context of the evidence

From time to time there may be some items eg. the Governance and Mid Year Assurance Statements which will be required to be approved by both Governance and Audit Committees. In these circumstances a joint meeting of both Committees may be convened.

Local Commissioning Groups (LCGs) (Belfast, Northern, South Eastern, Southern, Western)

Local Commissioning Groups are the point of local leadership in commissioning health and social care. The framework of the HSCB's Commissioning Plan will articulate the vision, purpose and control of the commissioning function for LCGs to deliver effective and efficient commissioning in their areas. They will need to understand, interact with, respond and adapt to their own situation and the external environment. Each LCG will be required to contribute to the HSCB's strategic planning process to improve health and wellbeing, provide high quality health outcomes and reduce inequalities in its local population.

Pharmacy Practices Committee

The primary role of the Pharmacy Practices Committee is to exercise the functions of the Board under Regulation 6(9) of the Pharmaceutical Servicers Regulations (NI) 1997; www.**legislation**.gov.uk/id/nisr/**1997**/381 on behalf of the Board and in accordance with Schedule 4 of the same Regulations.

Reference Committee

The role of the Reference Committee is to exercise the HSCB's function under the Disciplinary Procedures Regulations (NI) 1996 www.legislation.gov.uk/nisr/**1996**/137/made with respect to the referral of disciplinary matters.

Where the Reference Committee receives information which it considers could amount to an allegation that a practitioner has failed to comply with his/her terms of service, it shall decide on the appropriate course of action.

Remuneration and Terms of Service Committee

The primary role of the Remuneration and Terms of Service Committee is to advise the Board about appropriate remunerations and terms of service for the Chief Executive and other Senior Executives.

Review Panel

The role of the Review Panel is to hear representations from a doctor where the Board is proposing conditional inclusion in the Performers' List, contingent removal, suspension and also removal under Regulation 10 (4) from the Primary Medical Performers List to hear the case put forward by the Board's Investigating Officer: and make a determination.

Chief Executive (Accounting Officer)

The Chief Executive as Accounting Officer, is personally responsible for safeguarding the public funds of which he/she has charge; for ensuring propriety and regularity in the handling of those funds; and for the day-to-day operations and management of the HSCB. In addition, he/she should ensure that the HSCB as a whole is run on the basis of the standards (in terms of governance, decision-making and financial management) set out in Box 3.1 to MPMNI www.afmdni.gov.uk/pubs/**MPMNI**/mpm_chapters.pdf

Head of Corporate Services

The Head of Corporate Services will report through the Chief Executive to the Board on all operational governance issues.

Governance Manager

The Governance Manager will support the Head of Corporate Services and take the lead role in the development and implementation of Governance arrangements within the HSCB. He/she will be responsible for developing systems and procedures for the effective promotion and maintenance of a governance and risk management culture within the HSCB.

Other Groups/Forums

Governance Officer Group

The Governance Officer Group is a multi-disciplinary team who are accountable to the HSCB Senior Management Team for the operational implementation of a Governance Framework across the HSCB.

Information Governance Steering Group

The Information Governance Steering Group is an organisation wide group and reports to the HSCB Senior Management Team and the HSCB Governance Committee. Its purpose is to support and drive the broader information governance agenda and provide the Board with the assurance that effective information governance best practice mechanisms are in place within the organisation.

Business Continuity Management Project Team

The Business Continuity Management Project Team is a multi-disciplinary team accountable to the HSCB Senior Management Team for the operational implementation of a Business Continuity Plan that complies with BS25999 standard www.**bs25999**.com

Regional Serious Adverse Incident (SAI) Review Group

The Regional SAI Review Group meets on a bi-monthly basis to consider a range of reports and analysis of SAIs. Membership of the group is made up of professionals and senior managers from across the HSCB and PHA. A section of the meeting is designated to the detailed consideration of significant SAI investigation reviews, identified learning and agreed actions.

Regional Complaints Group

The Regional Complaints Group meets on a quarterly basis to consider information pertaining to HSCB complaints, Family Practitioner complaints and HSC Trust complaints. Membership of the group is made up of professionals and senior managers from across the HSCB and PHA. The meetings primarily focus on the subject of complaints raised the particular specialties they relate to; systems in place to manage complaints; timescales, identified learning and agreed actions.

Safety and Quality Services Group

The Safety and Quality Service Group meet on a quarterly basis for the purpose of monitoring the arrangements necessary to ensure both the PHA and HSCB meet their statutory duty of quality *Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.* Membership of the group is made up of professionals and senior managers from across the HSCB and PHA.

The Primary Medical Performers List Advisory Committee

The Primary Medical Performers List (PMPL) Advisory Committee is a multiprofessional, multiagency group which provides advice to the HSCB on the affective discharge of its duties under the "Health and Personal Social Services (Primary Medical Services Performers Lists) Regulations (Northern Ireland) 2004 and outsegment amendments. This includes advice on the conditional inclusion, contingent removal and suspension of GP's from the PMPL, on policy development, and on the development of primary and secondary legislation in relation to the PMPL. The Committee includes representatives of the Patient and Client Council (PCC), the Northern Ireland Medical and Dental Training and Agency (NIMDTA), DHSSPS, the General Practices Committee (GPC), the Business Services Organisation (BSO) and the Directorate of Integrated Care of HSCB.

The Regional Professional Panel

The Regional Professional Panel (RPP) is a multiprofessional multiorganisational group which assesses relevant expressions of concern about underperformance of Family Practitioner Services practitioners, establishes the degree of seriousness of concerns and provides advice on the management of cases of concern. The panel is comprised of representatives of GP, dental, optometric and pharmaceutical bodies, representatives of relevant Royal Colleges, the Pharmaceutical Society of Northern Ireland (PSNI), the Northern Ireland Medical and Dental Training Agency (NIMDTA), the Patient and Client Council (PCC), the Directorate of Integrated Care of HSCB, and user representatives from two of the five Local Commissioning Groups (LCGs). The panel meets at the frequency required to manage ongoing cases of concern effectively, usually monthly.

The Pharmacy Networking Group

The Pharmacy Networking Group (PNG) has been established to enable collaboration and cooperation between the HSCB, DHSSPS, the Pharmaceutical Society for Northern Ireland (PSNI) and the Business Services Organisation. This supports the investigation of complaints raised regarding pharmacists,

pharmaceutical premises. The PNG operates under a memorandum of understanding between the four organisations and enables the discharge of their relative legislative duties while assuring an integrated and consistent approach.

Independent Assurances

It is vital the Board ensures that it has proper and independent assurances on the soundness and effectiveness of the systems and processes in place for meeting its objectives and delivering appropriate outcomes.

The Audit Committee must therefore obtain the necessary information to assure the Board that the systems of internal control are operating effectively and for this, it relies on the work of Internal Audit and that of the External Auditor.

Internal Audit

The HSCB has in place an internal audit function that meets the standards set out in the NHS Internal Audit Manual. The appointed auditors provide the Audit Committee with an objective opinion on the effectiveness of the HSCB's system on internal control.

External Audit

The Audit Committee shall rely upon the certification of the accuracy, probity and legality of the Annual Accounts provided by the External Auditor, combined with more detailed internal audit review of systems and procedures, in discharging its responsibilities for ensuring sound internal control systems and accurate accounts and providing such assurances to the Board.

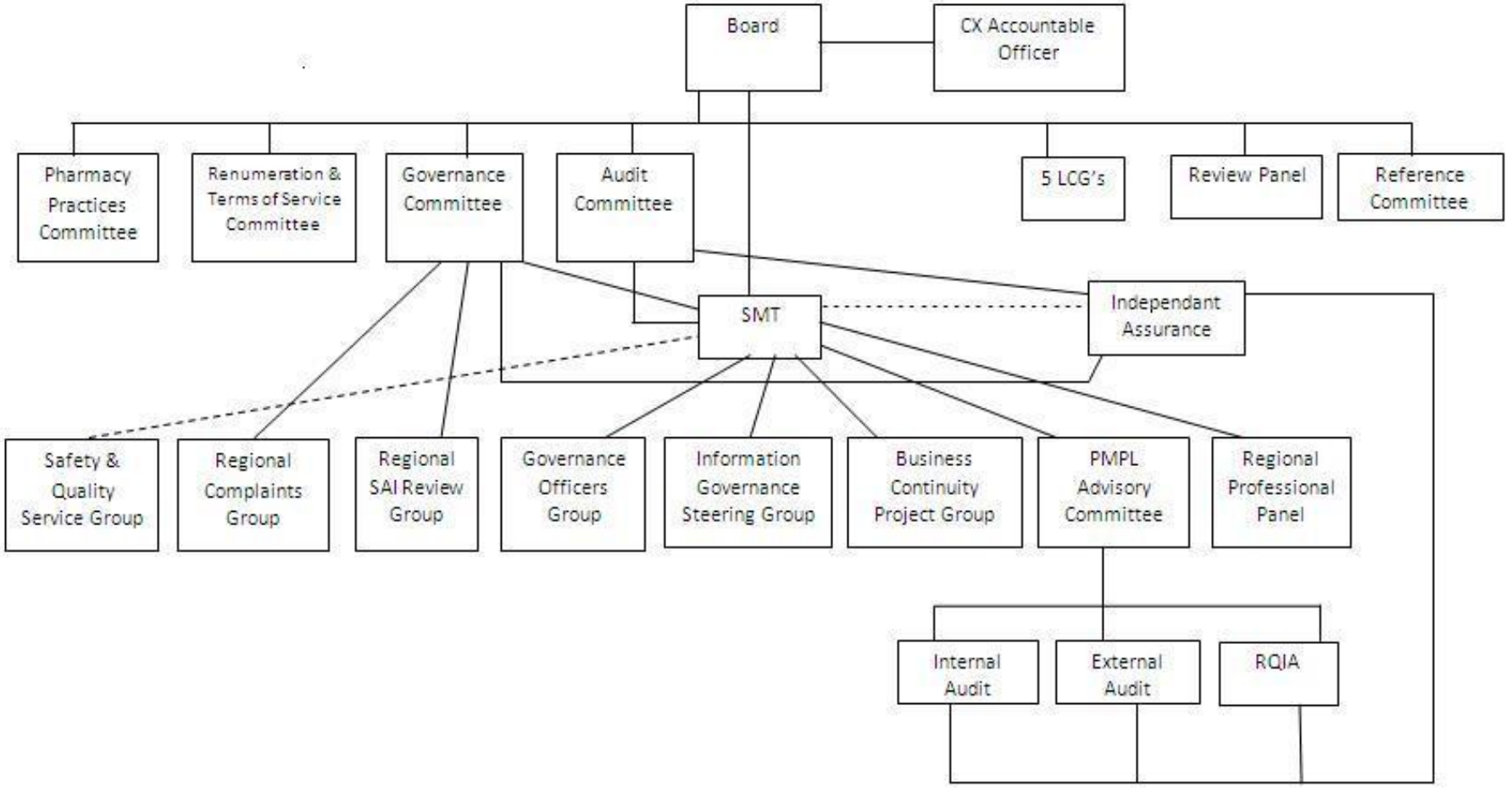
The Regulation Quality Improvement Authority (RQIA)

The RQIA is the independent health and social care regulatory body for Northern Ireland, and forms an integral part of the new health and social care structures. In its work RQIA encourages continuous improvement in the quality of these services through a programme of inspections and reviews.

The HSCB will ensure recommendations from any internal review/inspection carried out by RQIA will be taken forward and where relevant used to inform and improve access to, and the quality of services across the HSC.

Page overleaf provides a diagrammatic overview of the HSCB's Governance structure.

Governance Structure in HSCB



Managing Risk

The HSCB recognise risk management is a key component of the Governance Framework and it is therefore essential that systems and processes are in place to identify and manage all risks as far as reasonably possible.

All organisations engaged in the provision of health and social care carry a significant number of risks which have the potential to cause harm to service users, patients, visitors or staff and loss to the organisation. The purpose of risk management is not to remove all risk but to ensure that risks are recognised and their potential to cause loss fully understood. Based on this information, action can be taken to direct appropriate levels of resource at controlling the risk or minimising the effect of potential loss.

The HSCB has recognised the need to adopt such an approach and has put in place an independently assured risk management system that conforms to the principles contained in the Australian/New Zealand AS/NZS 4360:2004, standard (adopted by DHSSPS) and which ensures there is a systematic and unified process for the management of risks across all areas of the Board's activity. This has led to the implementation of a fully functioning risk register at both directorate and corporate levels. *Appendix 1 – Process for the Management of Board Wide Risks* provides a more detailed description of this process and identifies the process for the escalation and de-escalation of Board wide risks.

Categorisation of Risk

All risks do not carry the same likelihood of occurrence or degree of consequence in terms of actual or potential impact on service users, patients, staff, visitors, the organisation, or its reputation or assets.

Once the organisation's objectives have been approved and a consensus on principal risks reached it is important to ensure a consistent and uniform approach is taken in categorising risks in terms of their level of priority in order that appropriate action is taken at the appropriate level of the organisation.

The HSCB has adopted a 'five by five' risk quantification matrix (annex 1, appendix 1); that is consistent with DHSSPS mandatory guidance *An Assurance Framework: A Practical Guide for Boards of DHSSPS Arm's Length Bodies.* This matrix which is used to categorise potential risks, incidents, complaints and claims, facilitates the prioritisation of risk in terms of likelihood and consequence. In doing so, this will help identify the nature and degree of action required and levels of accountability for ensuring such action is taken.

Acceptable Risk

The HSCB recognises that it is impossible and not always desirable to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources in order to achieve health and social care benefits for the local population.

From time to time the HSCB may be willing to accept a certain level of risk. For example: promoting independence for individuals; or in order to take advantage of a new and innovative service; or due to the high costs of eliminating a risk in comparison with the potential threat. In these circumstances the risk will continue to remain on the risk register and will be monitored and reviewed at regular intervals.

However, as a general principle the HSCB will seek to eliminate and control all risks which have the potential to:

- harm staff, service users, patients, visitors and other stakeholders;
- have a high potential for incidents to occur; would result in loss of public confidence in the HSCB and/or its partner agencies or would have severe financial consequences and which would prevent the HSCB from carrying out its functions on behalf of the population.

Key Components of the Governance Framework

The HSCB overarching Governance Framework links the key individual governance and risk management components that have been established and developed within the HSCB. It will be this Framework, together with the supporting mechanisms listed below that will provide the basic building blocks for good governance through the development and implementation of a comprehensive system of internal control.

Corporate Plan

The HSCB Corporate Plan does not seek to duplicate the detailed objectives and activities set out in the Commissioning Plan, but rather to outline the key objectives for the organisation in addition to those associated with the Commissioning Plan, and those that will support its delivery.

As such, the Corporate Plan includes objectives that primarily relate to how the HSCB will seek to commission the delivery of high quality health and social care services for the population of Northern Ireland, and how it conducts its business and ensures that its organisational arrangements are fit for purpose.

Taken together with the Commissioning Plan and policies for the effective and efficient management of resources, the Corporate Plan will provide an overarching planning framework for the work of the HSCB.

Assurance Framework

The Assurance Framework provides the systematic assurances required by the Board of Directors on the effectiveness of the system of internal control by highlighting the reporting and monitoring mechanisms that are necessary to ensure commissioning and delivery of high quality health and social care. It provides a clear, concise structure for reporting key information to the Board of the HSCB, its various committees, SMT and other groups/forums.

It will identify which of the organisation's objectives are at risk because of the inadequacies in the operation of controls, or where the HSCB has insufficient assurance about them. In conjunction with the HSCB's Corporate Risk Register, Corporate and Commissioning Plans it should also provide structured assurance about how risks are managed effectively to deliver agreed objectives. This will supply a basis for the spread of good practice throughout the organisation and allow the HSCB to determine where to make the most efficient and effective use of resources.

Fully Functioning Risk Register

The HSCB has in place a fully functioning risk register operating across all areas of the Board's activity. This includes an overarching Corporate Risk Register together with six Directorate Risk Registers.

The aim of the Risk Register is to maintain a recognised process whereby the Board of the HSCB is kept informed, and has access to the principle risks which face the organisation and the actions being taken to resolve or reduce these risks. The Corporate Risk Register has clear links to the HSCB's Corporate Plan and Assurance Framework.

Statement on Internal Control (Governance Statement)

The Chief Executive as Accounting Officer is required to sign a full Statement on Internal (SIC) at the end of each financial year. The SIC provides assurances to DHSSPS that the HSCB has effective systems of internal control. These systems need to identify risks relating to the achievement of objectives, including the statutory duty of quality, and should be capable of evaluating the nature and extent of those risks and of managing them efficiently, effectively and economically.

Mid-Year Assurance Statement

The Chief Executive as Accounting Officer is required to sign a Mid Year Assurance Statement (MYAS) at the end of the second quarter of each financial year. The MYAS provides assurances at the end of the second financial quarter to DHSSPS that the HSCB continues to attest to the robustness of its organisation's system of internal control and also highlights any significant risks not identified in the previous SIC.

Annual Controls Assurance Standards (CAS) Programme

A key element of the HSCB's Governance Framework is evidence of compliance with the Controls Assurance Standards as set by DHSSPS for each financial reporting period.

The CAS programme provides the necessary assurance to the Senior Management Team and the Governance Committee, that the HSCB has a programme in place for the self assessment of compliance and identification of required action to meet the required levels of compliance for those standards applicable to the HSCB, for the each financial reporting period.

Procedure for the Management of Follow up of Serious Adverse Incidents

The requirement on HSC organisations to routinely report SAIs to DHSSPS ceased on 1 May 2010. From this date, the revised arrangements for the reporting and follow up of SAIs, pending the full implementation of the Regional Adverse Incident Learning (RAIL) system, transferred to the HSCB working in close partnership with the PHA and RQIA.

The purpose of the procedure is to provide guidance to HSC Trusts, Family Practitioner Services (FPS) and Independent Service Providers (ISP) in relation to the reporting and follow up of Serious Adverse Incidents (SAIs) arising during the course of the business of a HSC organisation/Special Agency or commissioned service

Social Care Governance Framework

The Social Care Governance Framework highlights the mechanisms in place that will assure the Board that the HSCB is meeting its statutory and mandatory requirements in respect of social care and children.

Information Governance Strategy

The Information Governance Strategy provides the vehicle to ensure the HSCB has a robust and effective Information Governance Framework in place to allow the HSCB to fully discharge its strategic duties and to ensure that overall corporate compliance is met both in relation to legal and statutory obligations and in meeting all relevant information governance related codes of practice.

Business Continuity Management Project Plan

The Business Continuity Project Plan provides the necessary arrangements and actions in order to allow the HSCB to have in place a Business Continuity Plan to BS25999 Standard by March 2012.

Governance Related Policies and procedures

- **Whistle Blowing Policy**

  The Health and Social Care Board is committed to developing an environment of openness and honesty which encourages staff to contribute views to all aspects of its activities.

The Whistle blowing Policy enables staff to raise concerns about any malpractices at an early stage and in the right way.

- **Incident / Near Miss Reporting Policy and Procedure**

  The HSCB recognises that the overall aim of any incident reporting system is to reduce the number of workplace injuries and adverse incidents to a minimum. To achieve such an aim it is important that we not only seek to adopt a proactive safety culture, but that we also record and report all incidents/near misses that occur, in order to learn from them. The Incident / Near Miss Reporting Policy and Procedure will assist in providing a safe working environment for staff, service users and visitors and will ultimately lead to the delivery of safer services.

- **Policy for the Management of Complaints**

  This policy sets out how the HSCB should deal with complaints raised by service users or former service users. It outlines for staff a consistent procedure on how complaints relating to the HSCB, its actions and decisions are handled. It also demonstrates the monitoring of complaints processes and outcomes relating to the HSCB, 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).

The list of governance related policies and procedures are non-exhaustive and may be added to during the period this framework is in place.

Establishment and Implementation of a Governance Strategy

During the period this framework is in place the HSCB will establish a Governance Strategy and supporting implementation plan. This will provide a structured approach to take forward any governance related action required whether from the result of an audit, RQIA review, DHSSPS guidance or planned review.

Until such times as the strategy and implementation plan are established an interim action plan (appendix 2) has been developed highlighting action required, timescales and lead officer.

Conclusion

In summary, the Governance Framework provides an overview of the governance arrangements currently operating within the HSCB. It is intended to resolve uncertainties and deepen understanding of how the HSCB manages its internal control system in order to achieve its objectives and meet the necessary standards of accountability, probity and openness.

It provides a clear, concise outline of the key governance components that underpin the HSCB's system of internal control which will assist the Board of the HSCB, through the Chief Executive, to attest to the robustness of the internal control system when signing the annual Governance and Mid Year Assurance Statements.

The framework will be in place for the period 2011/12 - 2012/13. During this time governance arrangements will continue to be established and developed in line with statutory/mandatory requirements, guidance issued by DHSSPS and as a result of ongoing review processes.

Health and Social Care Board

Process for the Management of Board Wide Risks

Introduction

A Risk Register is a management tool that enables an organisation to understand its comprehensive risk profile. It is simply a repository for all risk information. This repository is the hub of the internal control system, given that it should contain the objectives, risks and controls for the whole organisation. It therefore makes sense for the organisation's review of the system of internal control to centre on the Risk Register.

The Controls Assurance Standard for Risk Management (issued by the Department of Health and Social Services and Public Safety (DHSSPS); requires all HSC organisations to maintain a risk register. The Health & Social Services Board (HSCB, Board) has identified the need for a fully functioning risk register across all areas of activity throughout the organisation.

Aim of the Risk Register

The aim of the Risk Register is to maintain a recognised process whereby the Board of the HSCB is kept informed, and has access to the principle risks which face the organisation and the actions being taken to resolve or reduce these risks. The HSCB recognises the need for risk management to be part of the organisation's culture and integrated into all business and planning processes. It is therefore important the risk register has clear links to the HSCB Corporate Plan and Assurance Framework.

Dimensions of the HSCB Risk Register

The HSCB has in place a fully functioning risk register operating across all areas of the Board's activity. This includes an overarching Corporate Risk Register together with the following Directorate Risk Registers:

- Commissioning
- Corporate Services
- Finance
- Integrated Care
- Performance Management and Service Improvement
- Social Care and Children's

Whilst the Public Health Agency (PHA) have their own separate risk register both Directors of Public Health and Nursing & Allied Health Professionals; are involved in the quarterly review of the HSCB's Corporate Risk Register in light of risks surrounding the joint commissioning process.

Process

The following explains the process from the initial identification of a risk, risk grading, how the risk should be managed and escalation/de-escalation of grading and/or from directorate to corporate registers.

Assessing the Risk

Having identified an actual or potential risk, each directorate must evaluate the risk through the risk assessment process, using the HSCB's Risk Quantification Matrix (see annex 1). All risks will be graded in terms of likelihood and impact i.e. how likely it is that the risk becomes a reality and if it does the impact or consequence to the HSCB.

Managing the Risk

Each risk identified will be managed according to its risk severity.

The following indicates the four levels of severity which dictate how the risk will be managed:

- **Low Risks**

  Risks assessed at this level will be accepted at directorate level. Additional controls may be applied where deemed appropriate. The risk will continue to be monitored and reviewed quarterly on the Directorate Risk Register.

- **Medium/Major Risks**

  Risks at this level which are regarded as being within the control of individual directors will be accepted at directorate level. The risk will continue to be monitored and reviewed quarterly on the Directorate Risk Register.

  Risks at this level which are regarded as being outside the direct control of the relevant director will be forwarded to the Senior Management Team (SMT) for consideration of escalation to the Corporate Register. If SMT agree the risk is outside the direct control of a director they will refer the risk to the Governance Committee for inclusion on the Corporate Risk Register.

  If the Governance Committee approves the risk as corporate, it will be formally escalated to the Corporate Register and will continue to be monitored as part of the Corporate Risk Register quarterly review.

- **Catastrophic Risks**

All directorate risks identified at this level will be forwarded to SMT for them to validate and forward to the Governance Committee for inclusion/ approval on the Corporate Risk Register where it will continue to be monitored as part of the Corporate Risk Register quarterly review.

Risk Escalation/ De-escalation

- **Escalation**

  Where risk severity has increased due to inadequate controls being in place, the risk should be re-evaluated using the HSCB's Risk Quantification Matrix and where necessary, the grading of risk escalated. In some instances this may also involve the escalation of a directorate risk to the Corporate Risk Register which will be validated and approved by SMT and the Governance Committee.

  Escalation of risk will be part of the rotational quarterly review; however when a risk severity is identified or raised to 'catastrophic' this should be brought to the attention of SMT as soon as it becomes apparent.

- **De-escalation**

  During each quarterly review, action taken to mitigate risks since will be considered. If it is deemed that the likelihood and impact of the risk occurring has been reduced, the risk should be re-evaluated using the HSCB's Risk Quantification Matrix and where necessary, the grading of risk de-escalated. In some instances this may involve removal of risks from a register or de-escalating a corporate risk to a Directorate Register.

Approval of Register/s

- **Directorate Registers**

  Individual directors will be responsible for approving quarterly review of their respective Directorate Registers.

- **Corporate Register**

  The Corporate Register will be approved quarterly initially by SMT for onward referral to the Governance Committee for approval on behalf the Board.

  The Corporate Register will be referred to the Board annually 'for information'

HSCB Risk Quantification Matrix and Table

Category / Impact	INSIGNIFICANT	MINOR	MODERATE	MAJOR	CATASTROPHIC
PEOPLE (Any person affected by an incident: Staff, User, Visitor, Contractor)	Minor incident Minor injury/harm First aid administered	Short-term injury/harm requiring medical treatment. < 3 days absence. Emotional distress. (Recovery expected within days /weeks.)	Semi permanent physical/emotional injuries/trauma/harm requiring hospital admission / specialist treatment or support (recovery expected within 1 year).	Fatality. Permanent disability physical/emotional /trauma/harm.	Multiple fatalities Multiple permanent disability physical/emotional /trauma/harm.
RESOURCES (Safeguard services avoiding business interruption/problems with service provision)	No impact on public health social care Minimal disruption to routine activities of staff and organisation Insignificant unmet need	Short term impact on public health social care Minor impact on staff, service delivery and organisation, rapidly absorbed. Minor unmet need	Moderate impact on public health and social care. Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. Moderate unmet need	Significant impact on public health and social care. Significant impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations. Significant unmet need	Severe impact on public health and social care. Severe impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations. Severe unmet need
FINANCE & ASSESTS (Protect assets of the organisation and avoid financial loss)	Financial Impact of < £10k	Financial Impact of £10k - <£50k	Financial Impact of £50k - <£100k	Financial Impact of £100k - <£1m	Financial Impact > £1m
INFORMATION (Protect information assets of the organisation and avoid loss)	Minor loss of non-personal information	Loss of information – short term inability to provide service	Loss of or unauthorised access to sensitive / business critical information - short term inability to provide service	Loss of or corruption of sensitive / business critical information sustained inability to provide service	Permanent loss of or corruption of sensitive/business critical information inability to provide service

Category / Impact	INSIGNIFICANT	MINOR	MODERATE	MAJOR	CATASTROPHIC
ENVIRONMENT (Air, Land, Water, Waste management)	Nuisance release	Minor on site release contained by organisation	Moderate on site release contained by organisation	Significant release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc)	Toxic release affecting off-site with detrimental effect requiring outside assistance.
REPUTATION (Adverse publicity, complaints, Legal/Statutory Requirements, Litigation)	Informal complaint Local public/political concern. Local press < 1day coverage Little effect on staff morale Minor out-of-court settlement Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	Local level internal investigation into an incident/complaint. Local public/political concern. Extended local press < 7 day coverage Local adverse publicity with minor effect on staff morale/public confidence. Legal challenge Minor out-of-court settlement Audit / Inspection – recommendations can be addressed by low level management action	Internal investigation (high level), into an incident/complaint. Regional public/political concern. Regional/National press < 3 days coverage DHSSPS notification Significant effect on staff morale/public confidence Legal challenge Civil action – no defence / Improvement Notice Audit / Inspection – challenging recommendations that can be addressed action plan	External investigation or Independent Review into an incident or complaint. National Media interest > 3days Public confidence in the organisation undermined Questions in Assembly Criminal prosecution /Prohibition notice. Executive Officer dismissed. Audit / Inspection – Critical Report	Major public / political concern. Full Public Enquiry. Critical PAC Hearing Criminal prosecution – no defence. Executive Officer fined or imprisoned. Audit / Inspection – Severely critical Report
QUALITY, STATUTORY & PROFESSIONAL STANDARDS (including government priorities, targets and organisational objectives)	Minor non compliance. Up to 1% off planned service provision target Up to 1 month late	Single failure to meet internal standard or follow protocol. 1 ?5 % off planned service provision target Fail to meet National target 1quarter. Up to 3 months late	Repeated failure to meet internal standards or follow protocols. 2-4 ?5-20 % off planned service provision target Fail to meet National target 2 quarters. Up to 6 months late	Failure to meet national standards. Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities 5-10 >20% off planned service provision target Fail to meet National target > 2 quarters. Up to 12 months late	Gross failure to meet external/national standards. Gross failure to meet professional standards or statutory functions/ responsibilities 5-10 >35% off planned service provision target Fail to meet National target > 2 quarters. > 12 months late

Risk Assessment

Step 1 Determine the Risk Management Objective compromised. If there is more than one select the criteria with the highest impact.

Determining Likelihood

Descriptor	Description
Almost certain	Will occur or does occur regularly
Likely	Will probably occur, Likely to occur imminently
Possible	May occur occasionally
Unlikely	Don't expect it to happen but it is conceivable
Rare	Could only happen in exceptional circumstances

Step 2 Determine the likelihood of the risk occurring. This is based on the likelihood of the event occurring in any one year

Determining the level of risk

IMPACT	Risk Quantification Matrix				
5 - Catastrophic	High	High	Extreme	Extreme	Extreme
4 – Major	High	High	High	High	Extreme
3 - Moderate	Medium	Medium	Medium	Medium	High
2 – Minor	Low	Low	Low	Medium	Medium
	Low	Low	Low	Low	Medium

Step 3 Plot the Impact along the vertical axis and the likelihood against the horizontal axis this will determine the level of risk.

For example;
Risk Impact = Moderate
Risk Likelihood = Possible
Risk Score = Medium

1 – Insignificant					
LIKELIHOOD	A Rare	B Unlikely	C Possible	D Likely	E Almost Certain

Interim Governance Action Plan

Work Area / Topic	Action	Responsibility	Implementation Date
Governance	Establish a Governance Strategy and supporting Governance Implementation plan based on the four accountability domains	Head of Corporate Services in conjunction with the Governance Officers Group	July 2012
Governance	Review the Regional SAI Procedure for the Reporting and Follow up of SAIs	Head of Corporate Services in conjunction with the Regional SAI Review Group	April 2012
Governance	Develop and Implement the HSCB Corporate Plan for 2012/13	Head of Corporate Services	April 2012
Complaints & Litigation	Develop the Business Continuity Plan so it complies with the required BS25999 Standard	Head of Corporate Services in conjunction with Business Continuity Management Project Team	March 2012
Governance	Reviews of the following governance related processes: • Quarterly Review of Risk Registers • Bi-annual reviews of Corporate Plan and Assurance Framework • Review, development and establishment of governance related	Head of Corporate Services	Ongoing
Governance	Development of Annual Controls Assurance Programme	Head of Corporate Services	Aug/Sept 2012
Corporate Services	Implementation of recommendations from the outcome of audits, reviews and inspections	Head of Corporate Services	Ongoing

Health and Social Care Board

Health and Social Care Board

Governance Framework 2015 - 2016

Reference GC/JAN/2015/Item 16	**Responsible Officer** Director of Corporate Services	**Review Frequency** Biennial
Approved by Governance Committee	**Approval Date:** 29 January 2015	**Next review due** January 2017
Superseded documents (if applicable) HSCB Governance Framework – 2011/12 – 2012/13 HSCB Interim Governance Assurance Framework (Sept 2009) and legacy HPSS Board Governance/Risk Policies		

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Background

Circular HSC (F) 62/2012 introduced the requirement for the completion of an annual Governance Statement (GS) for inclusion within the annual report and accounts for the 2012-13 financial year. The Governance Statement replaces the requirement for an annual Statement of Internal Control (SIC).

In May 2009 the DHSSPS Accounting Officer wrote to accounting officers of each DHSSPS arm's length body, requesting a mid year statement concerning the condition of the system of internal control within their respective organisation's as at the end of the September each year.

Circular HSS (PPM) 6/2002 announced that the DHSSPS, in recognition of the importance of a sound system of risk management, had entered into a license agreement with Standards Australia for the use of their internationally recognised risk management standard AS/NZS 4360:1999 (now updated to 2004 model). The application of this internationally recognised approach to risk management would be seen as an important piece of evidence in support of a Statement of Internal Control.

The application of Controls Assurance standards within the HPSS was announced in Circular HSS (PPM) 8/2002. This process would enable individual HPSS organisations to provide evidence that they are doing their reasonable best to protect users, staff, the public and other stakeholders against risk of all kinds. It is a means by which Chief Executives as Accountable Officers can discharge their responsibilities and provide assurances to the Department, the Assembly and the Public.

In January 2003 the DHSS&PS issued guidance under Circular HSS (PPM) 10/2002, specific to clinical and social care governance. The guidance was to enable HPSS organisations to formally begin the process of developing and implementing clinical and social care governance arrangements within their respective organisations and set a framework for action which highlighted the roles, responsibilities, reporting and monitoring mechanisms that are necessary to ensure delivery of high quality health and social care.

The circular also stipulated the requirement that this new guidance should be read in the context of previous guidance already issued on the implementation of a common system of risk management and the development of controls assurance standards for financial and organisational aspects of governance.

The Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003 imposed a 'statutory duty of quality' on HPSS Boards and Trusts. To support this legal responsibility, the Quality Standards for Health and Social Care have been issued by DHSSPS. They will be used by the new Regulation, Quality Improvement Authority (RQIA) to assess the quality of care provided by the HPSS.

In April 2009, DHSSPS issued 'An Assurance Framework: *A Practical Guide for Boards of DHSSPS Arm's Length bodies'.* The Framework guidance which is mandatory is intended to help the Boards of HSC organisations, and other arm's length bodies of DHSSPS, improve the effectiveness of their systems of internal control.

The HSC Performance and Assurance Roles and Responsibilities MIPB 74/09 were issued in April 2009. Its role, to set out performance and assurance roles and responsibilities in relation to four key HSC domains and to identify the key functions and associated roles and responsibilities of DHSSPS, HSCB, PHA, BSO, Trusts and other Arm's Length Bodies.

Circular HSC (SQSD) 08/2010 announced that responsibility for management of Serious Adverse Incident (SAI) reporting transferred from the DHSSPS (Department) to the Health and Social Care Board (HSCB) working in partnership with the Public Health Agency (PHA), with effect from 1st May 2010. In October 2013, the HSC Board issued a revised procedure for the Reporting and Follow-Up of Serious Adverse Incidents.

Circular HSC (SQSD) 10/2010 advises on the operation of an Early Alert System, the arrangements to manage the transfer of Serious Adverse Incident (SAI) reporting arrangements from the Department to the HSC Board, working in partnership with the Public Health Agency and the incident reporting roles and responsibilities of Trusts, family practitioner services, the new regional organisations, the Health & Social Care (HSC) Board and Public Health Agency (PHA), and the extended remit of the Regulation & Quality Improvement Authority (RQIA). http://www.dhsspsni.gov.uk/hsc__sqsd__10-10.pdf

As a standard requirement of *Managing Public Money Northern Ireland, DHSSPS* must agree a DFP-approved Management Statement/Financial Memorandum (MS/FM) with each of its arm's length bodies. This was approved by the Board of the HSCB at its meeting in May 2011.

DHSSPS have produced a Framework Document to meet the statutory requirements placed upon it by the Health and Social Care (Reform) Act (NI) 2009. The Framework Document describes the roles and functions of the various health and social care bodies and the systems than govern their relationships with each other and the Department.

DHSSPS Memo dated 17 July 2013 from Chief Medical Officer introduced the HSCB/PHA protocol on the dissemination of guidance/information to the HSC and the assurance arrangements where these are required. The protocol assists the HSCB/PHA in determining what actions would benefit from a regional approach rather than each provider taking action individually.

Circular HSS (MD) 8/2013 replaces HSS (MD) 06/2006 and advises of a revised Memorandum of Understanding (MOU) when investigating patient or client safety incidents. This revised MOU is designed to improve appropriate information sharing and co-ordination when joint or simultaneous investigations are required when a serious incident occurs.
http://www.dhsspsni.gov.uk/ph_mou_investigating_patient_or_client_safety_incidents.pdf

Introduction

The Health and Social Care Board (HSCB) has a range of statutory duties, and shall, as a body corporate, exercise the functions assigned to it by DHSSPS, including those set out in Article 8(1-7) of the Health and Social Care (Reform) Act (NI) 2009 and any other statutory provisions deemed by DHSSPS to be functions of the HSCB, including the Governance Resources and Accounts Act (NI) 2001.

The overall aim of the HSCB, working in close collaboration with the Public Health Agency (PHA), is to improve health and social well-being outcomes, through a reduction in preventable disease and ill-health, achieved by effective, high quality, safe, equitable and efficient health and social care.

It is therefore vital the HSCB establishes robust governance arrangements to ensure it discharges its functions in a way which ensures that risks are managed as effectively and efficiently as possible and to acceptable standards of quality. The specific objective is to protect the organisation against loss, the threat of loss and the consequences of loss, whilst at the same time having a framework in place that highlights the roles, responsibilities, reporting and monitoring mechanisms that are necessary to ensure commissioning and delivery of high quality health and social care.

The HSCB has a duty to protect users, carers, staff and others in the planning and delivery of services. Reducing risk is not just about financial or management probity it is about improving the quality of services and user experience of those services. This means that equal priority needs to be given to the obligations of governance across all aspects of the organization. There is a need to cover financial, organisational and clinical and social care and a need for these to be truly integrated within the organisation's culture. Good governance hinges on having clear objectives, sound practices, a clear understanding of the risks run by the organisation and effective monitoring arrangements. Any organization seeking to 'continuously improve the quality of services and safeguarding high standards of care' must put in place an accountability framework which permeates all levels of responsibility within the organisation.

Within the HSCB this is achieved by the adoption of an overarching Governance Framework (Framework).

Strategic Context

Corporate Governance is the system by which an organisation is directed and controlled, at its most senior levels, in order to achieve its objectives and meet the necessary standards of accountability, probity and openness.

The Audit Commission has defined corporate governance in health and social care as 'the systems and processes by which health bodies lead, direct and control their functions, in order to achieve organisational objectives, and by which they relate to their partners and the wider community'.

The Governance Framework is principally concerned with ensuring the HSCB has the basic building blocks in place for good governance through development and implementation of a sound system of internal control.

This Framework therefore highlights the key components that underpin a sound system of governance and internal control, which will assist the Board of the HSCB, through the Chief Executive, to sign the annual Governance and Mid-Year Assurance Statements.

HSCB Governance Structure
Roles and Responsibilities

The Board of the HSCB

The HSCB's Board must ensure that effective arrangements are in place to provide assurance on risk management, governance and internal control. The Board has corporate responsibility for ensuring that the HSCB fulfils the aims and objectives set by the Department/Minister, and for promoting the efficient, economic and effective use of staff and other resources by the HSCB.

The Board must set up an Audit Committee and a Governance Committee to provide independent advice on the effectiveness of the internal control and risk management systems.

In accordance with Section 7 (1) of the Health and Social Care (Reform) Act (Northern Ireland) 2009 the Board needs to have Standing Orders and Schedules on:

- Powers reserved to the Board and;
- Powers delegated by the Board.

The Governance Committee

The Governance Committee will support the Board in all aspects of corporate and clinical and social care governance. It will assist the Board in these functions by providing an independent and objective review of:

- the adequacy and effectiveness of the system of internal control and to ensure a robust assurance framework is maintained;
- how risks and opportunities are identified and managed;
- the information provided to the Board,
- compliance with law, guidance and codes of conduct and accountability

The Governance Committee shall give an assurance[1] to the Board each year on the adequacy and effectiveness of the system of internal control in operation within the HSCB.

[1] HM Treasury "Management of Risk – Principles and Concepts" (October 2004) defines assurance as: "an evaluated opinion, based on evidence gained from review on the organisation's governance, risk management and internal control framework"

The Audit Committee

The Audit Committee will support the Board and Accounting Officer with regard to their responsibilities for issues of risk, control and governance and associated assurance through a process of constructive challenge.

The Audit Committee will constructively challenge:

- Assurance providers as to whether the scope of their activity meets the Board and Accounting Officer's assurance need and;
- The actual assurances to test that they are founded on sufficient reliable evidence and that the conclusions are reasonable in the context of the evidence

From time to time there may be some items e.g. the Governance and Mid Year Assurance Statements which will be required to be approved by both Governance and Audit Committees. In these circumstances a joint meeting of both Committees may be convened.

Local Commissioning Groups (LCGs) (Belfast, Northern, South Eastern, Southern, Western)

Local Commissioning Groups are the point of local leadership in commissioning health and social care. The framework of the HSCB's Commissioning Plan will articulate the vision, purpose and control of the commissioning function for LCGs to deliver effective and efficient commissioning in their areas. They will need to understand, interact with, respond and adapt to their own situation and the external environment. Each LCG will be required to contribute to the HSCB's strategic planning process to improve health and wellbeing, provide high quality health outcomes and reduce inequalities in its local population.

Pharmacy Practices Committee

The primary role of the Pharmacy Practices Committee is to exercise the functions of the Board under Regulation 6(9) in accordance with paragraph 2 (6) of the Pharmaceutical Services Regulations (NI) 1997; www.**legislation**.gov.uk/id/nisr/**1997**/381 on behalf of the Board and in accordance with Schedule 4 of the same Regulations.

Reference Committee

The role of the Reference Committee is to exercise the HSCB's function under the Health and Social Care (Disciplinary Procedures) Regulations (Northern Ireland) 2014 www.legislation.gov.uk/nisr/2014/267/resources with respect to the referral of disciplinary matters.

Where the Reference Committee receives information which it considers could amount to an allegation that a practitioner has failed to comply with his/her terms of service, it shall decide on the appropriate course of action.

Remuneration and Terms of Service Committee

The primary responsibility of the Remuneration and Terms of Service Committee is to make recommendations to the Board on all aspects of remuneration and terms and conditions of employment for the Chief Executive and other Executive Directors.

Review Panel

The role of the Review Panel is to hear representations from a doctor where the Board is proposing conditional inclusion in the Performers' List, contingent removal, suspension and also removal under Regulation 10 (4) from the Primary Medical Performers List to hear the case put forward by the Board's Investigating Officer and make a determination.

Chief Executive (Accounting Officer)

The Chief Executive as Accounting Officer, is personally responsible for safeguarding the public funds of which he/she has charge; for ensuring propriety and regularity in the handling of those funds; and for the day-to-day operations and management of the HSCB. In addition, he/she should ensure that the HSCB as a whole is run on the basis of the standards (in terms of governance, decision-making and financial management) set out in Box 3.1 to MPMNI www.afmdni.gov.uk/pubs/**MPMNI**/mpm_chapters.pdf

Director of Corporate Services

The Director of Corporate Services will report through the Chief Executive to the Board on all operational governance issues.

Governance Manager

The Governance Manager will support the Director of Performance and Corporate Services and take the lead role in the development and implementation of Governance arrangements within the HSCB. He/she will be responsible for developing systems and procedures for the effective promotion and maintenance of a governance and risk management culture within the HSCB.

Other Groups/Forums

Senior Management Team (SMT) – The SMT currently comprises the Chief Executive, Director of Commissioning, Director of Finance, Director of Performance and Corporate Services, Director of Social Care and Children, Director of Integrated Care, Director of Transforming Your Care, and Director of eHealth and External Collaboration.

The Public Health Agency Medical Director/Director of Public Health and Director of Nursing and AHPs and the BSO Director of Human Resources are also members of the HSCB Senior Management Team.

Quality, Safety and Experience Group (QSE)

The Quality, Safety and Experience Group (QSE) oversee all issues relating to safety, effectiveness and patient client focus within the HSCB and PHA.

This group allows senior staff to share information, approve policy and identify areas of concern. The group meets monthly and is chaired by the PHA Executive Director of Nursing, Midwifery and Allied Health Professionals.

An overview of the QSE governance and assurance structure is outlined in Appendix 1.

Serious Adverse Incident Review Sub-Group

The Serious Adverse Incident Review Sub Group (SAIRSG) meets on a monthly basis to consider a range of reports and analysis of SAIs. The group is co-chaired by the HSCB Governance Manager and the PHA Senior Manager for Safety, Quality and Patient Experience. Membership of the group is made up of professionals and senior managers from across the HSCB and PHA.

The SAIRSG provides assurances that appropriate structures, systems and processes are in place within the HSCB and PHA for the management and follow-up of serious adverse incidents arising during the course of the business of an HSC organisation or commissioned service.

The SAIRSG also has responsibility (in conjunction with the QSE and SQA Team) to ensure that trends, examples of best practice and learning are identified and disseminated in a timely manner.

Regional Complaints Sub-Group

The Regional Complaints Sub-Group meets monthly to consider complaints arising from regional HSC services. The group makes key recommendations for action and agrees issues to be referred to the QSE. The group is chaired by the HSCB Complaints/Litigation Manager. Membership of the group is made up of professionals and senior managers from across the HSCB and PHA.

Safety and Quality Alerts Team (SQAT)

The Safety and Quality Alerts (SQA) Team meets fortnightly and is responsible for coordinating the implementation of regional safety and quality alerts, letters and guidance issued by the DHSSPS, HSCB, PHA, RQIA and other organisations. The SQA Team is chaired by the PHA Medical Director/Director of Public Health is made up of professionals and senior managers from across the HSCB and PHA. This provides a mechanism for gaining regional assurance that alerts and guidance have been implemented or that there is an existing robust system in place to ensure implementation.

The Team 'closes' an Alert when it is assured that an Alert has been implemented, or there is an existing robust system in place to ensure implementation.

Governance Officer Group

The Governance Officer Group is a multi-disciplinary team who are accountable to the HSCB Senior Management Team for the operational implementation of a Governance Framework across the HSCB. One of the functions of this group is to consider and agree any issues that require to be brought to the attention of the Governance Committee

Information Governance Steering Group

The Information Governance Steering Group is an organisation wide group and reports to the HSCB Senior Management Team and the HSCB Governance Committee. Its purpose is to support and drive the broader information governance agenda and provide the Board with the assurance that effective information governance best practice mechanisms are in place within the organisation.

Business Continuity Management Project Team

The Business Continuity Management Project Team is a multi-disciplinary team accountable to the HSCB Senior Management Team for the operational implementation of a Business Continuity Plan that complies with BS25999 standard www.**bs25999**.com and ISO 22301.

Assessment Panel

The Assessment Panel will consider and determine, where the Board has rejected a closure notice, whether a GMS contractor should be permitted to close his list of patients, and if so, the terms on which he should be permitted to do so and to consider where the Board wishes to assign new patients to contractors which have closed their lists of patients.

Disciplinary Committees

There are four Disciplinary Committees embracing Dental, Optometry and Pharmacy plus a Joint Committee. Each Committee is comprised of members of the geographical area covered by each of the four local offices. Three laypersons are appointed by the Board for each local office as well as a representative from each of the three professions.

The Primary Medical Performers List Advisory Committee

The Primary Medical Performers List (PMPL) Advisory Committee is a multi-professional, multiagency group which provides advice to the HSCB on the affective discharge of its duties under the "Health and Personal Social Services (Primary Medical Services Performers Lists) Regulations (Northern Ireland) 2004 and outsegment amendments. This includes advice on the conditional inclusion, contingent removal and suspension of GP's from the PMPL, on policy development, and on the development of primary and secondary legislation in relation to the PMPL. The Committee includes representatives of the Patient and Client Council (PCC), the Northern Ireland Medical and Dental Training and Agency (NIMDTA), DHSSPS, the General Practices Committee (GPC), the Business Services Organisation (BSO) and the Directorate of Integrated Care of HSCB.

The Regional Professional Panel

The Regional Professional Panel (RPP) is a multi-professional multi-organisational group which assesses relevant expressions of concern about underperformance of Family Practitioner Services practitioners, establishes the degree of seriousness of concerns and provides advice on the management of cases of concern. The panel is comprised of representatives of GP, dental, optometric and pharmaceutical bodies, representatives of relevant Royal Colleges, the Pharmaceutical Society of Northern Ireland (PSNI), the Northern Ireland Medical and Dental Training Agency (NIMDTA), the Patient and Client Council (PCC), the Directorate of Integrated Care of HSCB, and user representatives from two of the five Local Commissioning Groups (LCGs). The panel meets at the frequency required to manage on-going cases of concern effectively, usually monthly.

The Pharmacy Networking Group (PNG)

The Pharmacy Networking Group (PNG) has been established to enable collaboration and cooperation between the HSCB, DHSSPS, the Pharmaceutical Society for Northern Ireland (PSNI) and the Business Services Organisation. This supports the investigation of complaints raised regarding pharmacists, pharmaceutical premises. The PNG operates under a memorandum of understanding between the four organisations and enables the discharge of their relative legislative duties while assuring an integrated and consistent approach.

The Local Intelligence Network (LIN)

The Controlled Drugs (Supervision of Management and Use) Regulations (Northern Ireland) 2009 were introduced in order to ensure the safer management and use of controlled drugs (CDs) in health care. It requires certain organisations called Designated Bodies (regulation 3) to appoint an Accountable Officer who has responsibility for the management of controlled drugs both within their Designated Body and any other organisation that provides services under arrangements with that Designated Body. The regulations require Accountable Officers to take appropriate action where concerns are well-founded and these actions may include disclosing the name of the Relevant Person to other designated Bodies and Responsible Bodies. This is done via the Local Intelligence Network chaired by the HSCB Accountable Officer, and in accordance with the record-keeping requirements detailed in regulation 29. Each organisation which is a member of the LIN must have robust governance systems in place to ensure that the sharing of personal data both internally and externally is in compliance with the legislative framework for information sharing.

Independent Assurances

It is vital the Board ensures that it has proper and independent assurances on the soundness and effectiveness of the systems and processes in place for meeting its objectives and delivering appropriate outcomes.

The Audit Committee must therefore obtain the necessary information to assure the Board that the systems of internal control are operating effectively and for this, it relies on the work of Internal Audit and that of the External Auditor.

Internal Audit

The HSCB has in place an internal audit function that meets the standards set out in the NHS Internal Audit Manual. The appointed auditors provide the Audit Committee with an objective opinion on the effectiveness of the HSCB's system on internal control.

External Audit

The Audit Committee shall rely upon the certification of the accuracy, probity and legality of the Annual Accounts provided by the External Auditor, combined with more detailed internal audit review of systems and procedures, in discharging its responsibilities for ensuring sound internal control systems and accurate accounts and providing such assurances to the Board.

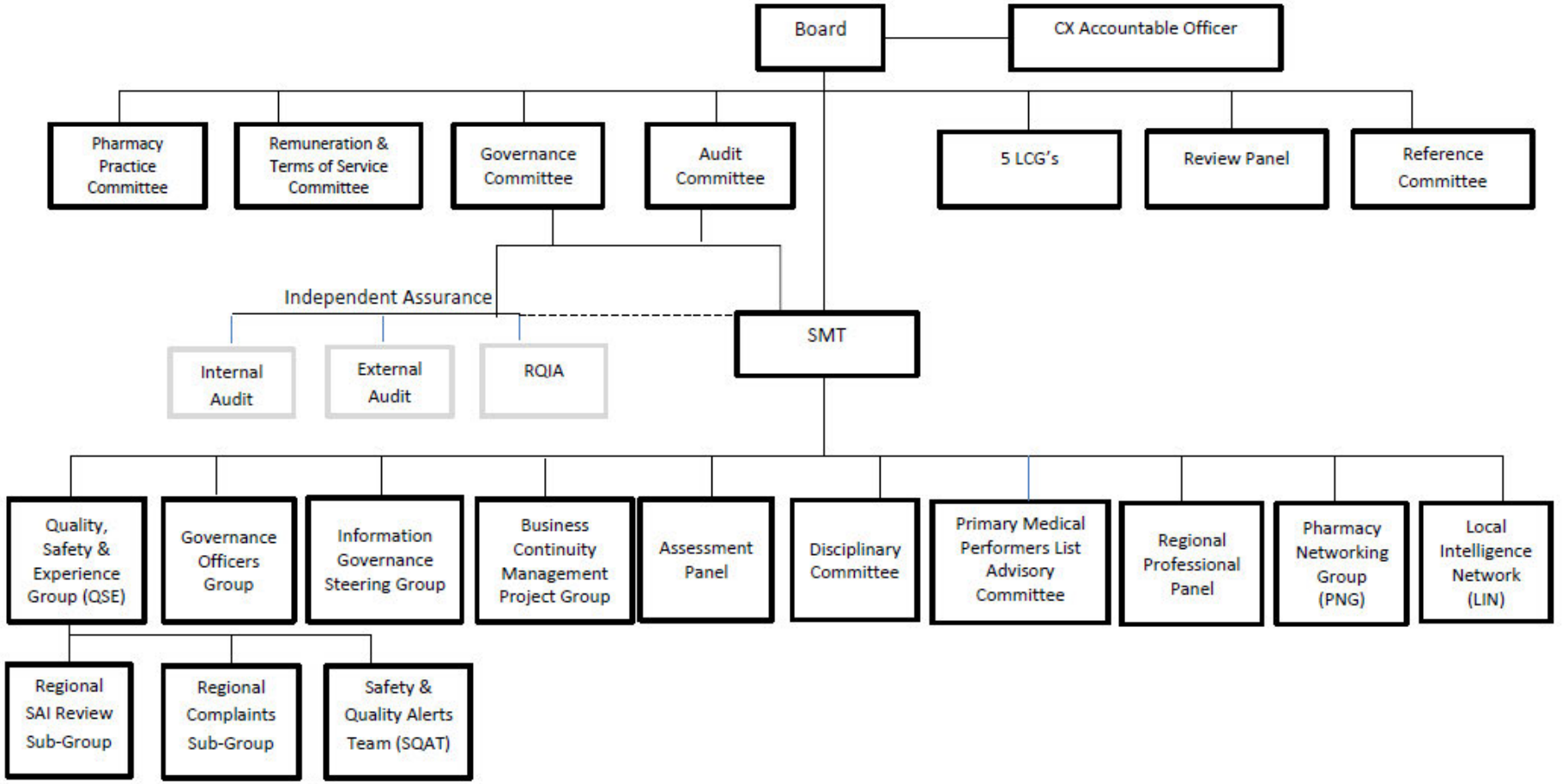
The Regulation Quality Improvement Authority (RQIA)

The RQIA is the independent health and social care regulatory body for Northern Ireland, and forms an integral part of the new health and social care structures. In its work RQIA encourages continuous improvement in the quality of these services through a programme of inspections and reviews.

The HSCB will ensure recommendations from any internal review/inspection carried out by RQIA will be taken forward and where relevant used to inform and improve access to, and the quality of services across the HSC.

Page overleaf provides a diagrammatic overview of the HSCB's Governance structure.

Governance Structure in HSCB



Managing Risk

The HSCB recognise risk management is a key component of the Governance Framework and it is therefore essential that systems and processes are in place to identify and manage all risks as far as reasonably possible.

All organisations engaged in the provision of health and social care carry a significant number of risks which have the potential to cause harm to service users, patients, visitors or staff and loss to the organisation. The purpose of risk management is not to remove all risk but to ensure that risks are recognised and their potential to cause loss fully understood. Based on this information, action can be taken to direct appropriate levels of resource at controlling the risk or minimising the effect of potential loss.

The HSCB has recognised the need to adopt such an approach and has put in place an independently assured risk management system that conforms to the principles contained in the Australian/New Zealand AS/NZS 4360:2004 standard (adopted by DHSSPS) and which ensures there is a systematic and unified process for the management of risks across all areas of the Board's activity. This has led to the implementation of a fully functioning risk register at both directorate and corporate levels. *Appendix 2 – Process for the Management of Board Wide Risks* provides a more detailed description of this process and identifies the process for the escalation and de-escalation of Board wide risks.

Risk Appetite

• Categorisation of Risk

All risks do not carry the same likelihood of occurrence or degree of impact (consequence) in terms of actual or potential impact on service users, patients, staff, visitors, the organisation, or its reputation or assets.

Once the organisation's objectives have been approved and a consensus on principal risks reached it is important to ensure a consistent and uniform approach is taken in categorising risks in terms of their level of priority in order that appropriate action is taken at the appropriate level of the organisation.

The HSC Regional Risk Matrix has been adopted by the HSCB with effect from April 2013 (annex 1, appendix 1); that is consistent with DHSSPS mandatory guidance *An Assurance Framework: A Practical Guide for Boards of DHSSPS Arm's Length Bodies.* This matrix which is used to categorise potential risks, incidents, complaints and claims, facilitates the prioritisation of risk in terms of likelihood and impact (consequence). In doing so, this will help identify the nature and degree of action required and levels of accountability for ensuring such action is taken.

- **Acceptable Risk**

The HSCB recognises that it is impossible and not always desirable to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources in order to achieve health and social care benefits for the local population.

From time to time the HSCB may be willing to accept a certain level of risk. For example: promoting independence for individuals; or in order to take advantage of a new and innovative service; or due to the high costs of eliminating a risk in comparison with the potential threat. In these circumstances the risk will continue to remain on the risk register and will be monitored and reviewed at regular intervals.

However, as a general principle the HSCB will seek to eliminate and control all risks which have the potential to:

- harm staff, service users, patients, visitors and other stakeholders.
- have a high potential for incidents to occur; would result in loss of public confidence in the HSCB and/or its partner agencies or would have severe financial consequences and which would prevent the HSCB from carrying out its functions on behalf of the population.

- **Risk Activity**

As part of the board-led system of risk management, the Corporate Register is presented to the Governance Committee for discussion and approval at each of its meetings and annually to the Board. The Board is also informed of significant risks by way of the annual Governance and Mid-Year Assurance statements.

Key Components of the Governance Framework

The HSCB overarching Governance Framework links the key individual governance and risk management components that have been established and developed within the HSCB. It will be this Framework, together with the supporting mechanisms listed below that will provide the basic building blocks for good governance through the development and implementation of a comprehensive system of internal control.

Standing Orders

The Standing Orders, reserved and delegated powers and Standing Financial Instructions provide a comprehensive business framework for the HSCB and enables the organisation to discharge its functions. They reflect the following: Framework Document (September 2011); Management Statement/Financial Memorandum; Code of Conduct and Code of Accountability for Board Members of HSC bodies (2011); 7 Nolan Principles; Public Service Values and; Code of Openness.

The HSCB Standing Orders and Standing Financial Instructions are reviewed on an annual basis, considered by the HSCB Audit Committee and approved at the subsequent public Board Meeting. Section 6 of the Standing Orders relates to the Conduct of Board Business and includes, amongst others, potential conflicts of interest. This section also applies to the conduct of public meetings of the Local Commissioning Groups (LCGs).

Corporate Plan

The HSCB Corporate Plan does not seek to duplicate the detailed objectives and activities set out in the Commissioning Plan, but rather to outline the key objectives for the organisation in addition to those associated with the Commissioning Plan, and those that will support its delivery.

As such, the Corporate Plan includes objectives that primarily relate to how the HSCB will seek to commission the delivery of high quality health and social care services for the population of Northern Ireland, and how it conducts its business and ensures that its organisational arrangements are fit for purpose.

Taken together with the Commissioning Plan and policies for the effective and efficient management of resources, the Corporate Plan will provide an overarching planning framework for the work of the HSCB.

Assurance Framework

The Assurance Framework provides the systematic assurances required by the Board of Directors on the effectiveness of the system of internal control by

highlighting the reporting and monitoring mechanisms that are necessary to ensure commissioning and delivery of high quality health and social care. It provides a clear, concise structure for reporting key information to the Board of the HSCB, its various committees, SMT and other groups/forums.

It will identify which of the organisation's objectives are at risk because of the inadequacies in the operation of controls, or where the HSCB has insufficient assurance about them. In conjunction with the HSCB's Corporate Risk Register, Corporate and Commissioning Plans it should also provide structured assurance about how risks are managed effectively to deliver agreed objectives. This will supply a basis for the spread of good practice throughout the organisation and allow the HSCB to determine where to make the most efficient and effective use of resources.

Fully Functioning Risk Register

The HSCB has in place a fully functioning risk register operating across all areas of the Board's activity. This includes an overarching Corporate Risk Register together with eight Directorate Risk Registers.

The aim of the Risk Register is to maintain a recognised process whereby the Board of the HSCB is kept informed, and has access to the principle risks which face the organisation and the actions being taken to resolve or reduce these risks. The Corporate Risk Register has clear links to the HSCB's Corporate Plan and Assurance Framework.

Governance Statement

The Chief Executive as Accounting Officer is required to sign a full Governance Statement at the end of each financial year. The Governance Statement provides assurances to DHSSPS that the HSCB has effective systems of internal control. These systems need to identify risks relating to the achievement of objectives, including the statutory duty of quality, and should be capable of evaluating the nature and extent of those risks and of managing them efficiently, effectively and economically.

Mid-Year Assurance Statement

The Chief Executive as Accounting Officer is required to sign a Mid-Year Assurance Statement (MYAS) at the end of the second quarter of each financial year. The MYAS provides assurances at the end of the second financial quarter to DHSSPS that the HSCB continues to attest to the robustness of its organisation's system of internal control and also highlights any significant risks not identified in the previous Governance Statement.

Annual Controls Assurance Standards (CAS) Programme

A key element of the HSCB's Governance Framework is evidence of compliance with the Controls Assurance Standards as set by DHSSPS for each financial reporting period.

The CAS programme provides the necessary assurance to the Senior Management Team and the Governance Committee, that the HSCB has a programme in place for the self-assessment of compliance and identification of required action to meet the required levels of compliance for those standards applicable to the HSCB, for the each financial reporting period.

Procedure for the Management of Follow up of Serious Adverse Incidents (October 2013)

The requirement on HSC organisations to routinely report SAIs to DHSSPS ceased on 1 May 2010. From this date, the revised arrangements for the reporting and follow up of SAIs transferred to the HSCB working in close partnership with the PHA and RQIA.

The Procedure for the Reporting and Follow up of SAIs was implemented across the HSC in May 2010 and was subsequently revised in October 2013. The purpose of the procedure is to provide guidance to all Departmental Arm's Length Bodies, in relation to the reporting and follow up of Serious Adverse Incidents (SAIs) arising during the course of the business of a HSC organisation/Special Agency or commissioned service

Social Care Governance Framework

The Social Care Governance Framework highlights the mechanisms in place that will assure the Board that the HSCB is meeting its statutory and mandatory requirements in respect of social care and children.

Information Governance Framework

The Information Governance Policy and Strategy provide the vehicle to ensure the HSCB has a robust and effective Information Governance Framework in place to allow the HSCB to fully discharge its strategic duties and to ensure that overall corporate compliance is met both in relation to legal and statutory obligations and in meeting all relevant information governance related codes of practice.

Business Continuity Management Project Plan

The Business Continuity Project Plan provides the necessary arrangements and actions in order to allow the HSCB to have in place a Business Continuity Plan to ISO 22301 Standard by January 2015.

Corporate Governance Related Policies and procedures

- **Whistle Blowing Policy**

  The Health and Social Care Board is committed to developing an environment of openness and honesty which encourages staff to contribute views to all aspects of its activities.

  The Whistle blowing Policy enables staff to raise concerns about any malpractices at an early stage and in the right way.

- **Incident / Near Miss Reporting Policy and Procedure**

  The HSCB recognises that the overall aim of any incident reporting system is to reduce the number of workplace injuries and adverse incidents to a minimum. To achieve such an aim it is important that we not only seek to adopt a proactive safety culture, but that we also record and report all incidents/near misses that occur, in order to learn from them. The Incident / Near Miss Reporting Policy and Procedure will assist in providing a safe working environment for staff, service users and visitors and will ultimately lead to the delivery of safer services.

- **Policy for the Management of Complaints**

  This policy sets out how the HSCB should deal with complaints raised by service users or former service users. It outlines for staff a consistent procedure on how complaints relating to the HSCB, its actions and decisions are handled. It also demonstrates the monitoring of complaints processes and outcomes relating to the HSCB, 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).

The list of governance related policies and procedures are non-exhaustive and may be added to during the period this framework is in place.

Conclusion

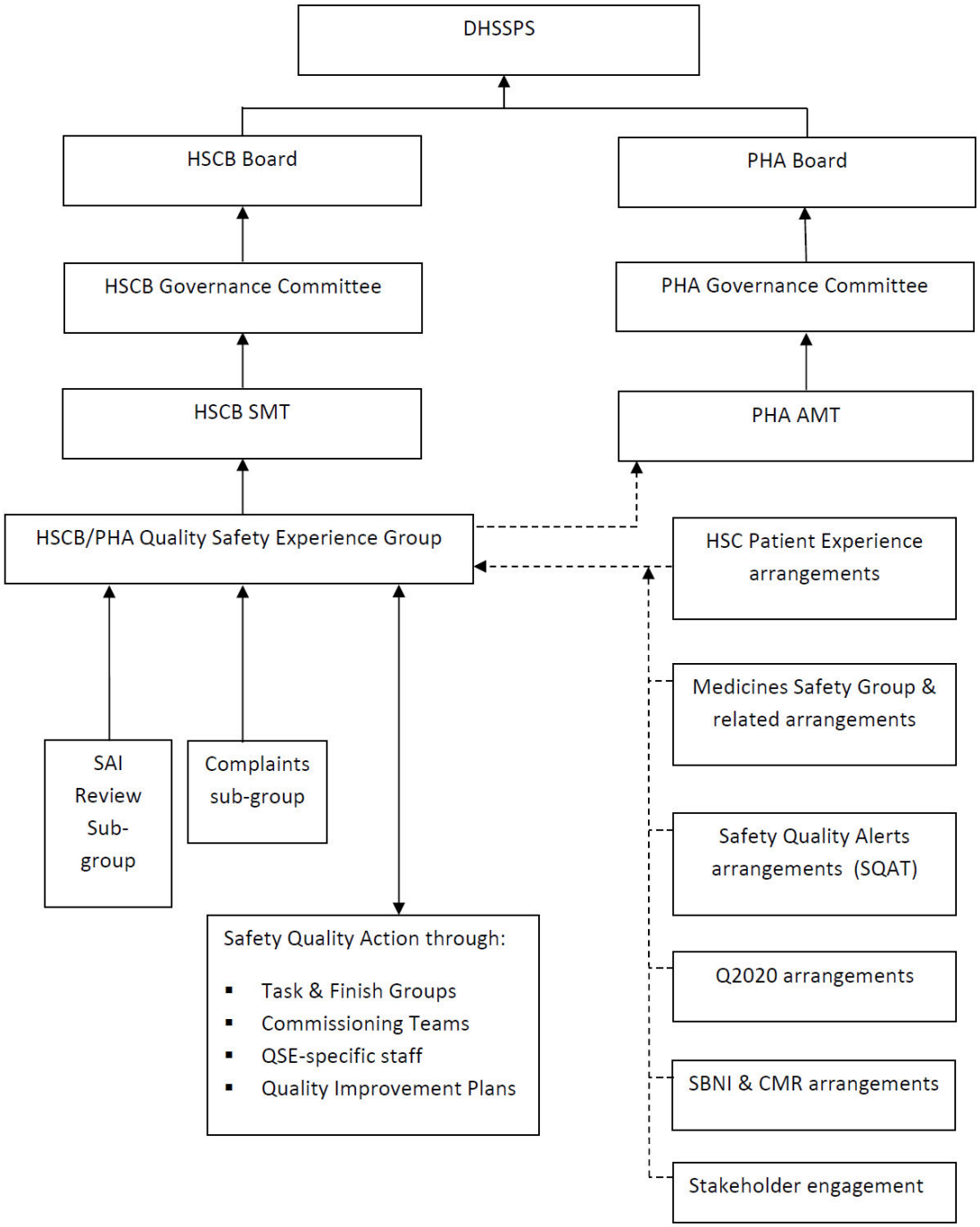
In summary, the Governance Framework provides an overview of the governance arrangements currently operating within the HSCB. It is intended to resolve uncertainties and deepen understanding of how the HSCB manages its internal control system in order to achieve its objectives and meet the necessary standards of accountability, probity and openness.

It provides a clear, concise outline of the key governance components that underpin the HSCB's system of internal control which will assist the Board of the HSCB, through the Chief Executive, to attest to the robustness of the internal control system when signing the annual Governance and Mid-Year Assurance Statements.

The framework will be in place for the next two years. During this time governance arrangements will continue to be established and developed in line with statutory/mandatory requirements, guidance issued by DHSSPS and as a result of on-going review processes.

Appendix 1

Diagrammatic Overview of Quality Safety Experience Internal Coordination Arrangements – HSCB/PHA



Appendix 2

Health and Social Care Board

Health and Social Care Board

Process for the Management of Board Wide Risks

1.0 Introduction

A Risk Register is a management tool that enables an organisation to understand its comprehensive risk profile. It is simply a repository for all risk information. This repository is the hub of the internal control system, given that it should contain the objectives, risks and controls for the whole organisation. It therefore makes sense for the organisation's review of the system of internal control to centre on the Risk Register.

The Controls Assurance Standard for Risk Management (issued by the Department of Health and Social Services and Public Safety (DHSSPS); requires all HSC organisations to maintain a risk register. The Health & Social Services Board (HSCB, Board) has identified the need for a fully functioning risk register across all areas of activity throughout the organisation.

1.1 Aim of the Risk Register

The aim of the Risk Register is to maintain a recognised process whereby the Board of the HSCB is kept informed, and has access to the principle risks which face the organisation and the actions being taken to resolve or reduce these risks. The HSCB recognises the need for risk management to be part of the organisation's culture and integrated into all business and planning processes. It is therefore important the risk register has clear links to the HSCB Corporate Plan and Assurance Framework.

1.2 Dimensions of the HSCB Risk Register

The HSCB has in place a fully functioning risk register operating across all areas of the Board's activity. This includes an overarching Corporate Risk Register together with the following Directorate Risk Registers:

- Commissioning
- Corporate Services
- Finance
- Integrated Care
- Performance Management and Service Improvement
- Social Care and Children
- Transforming your Care
- e-Health and External Collaboration

Whilst the Public Health Agency (PHA) have their own separate risk register both Directors of Public Health and Nursing & Allied Health Professionals; are involved in the reviews of the HSCB's Corporate Risk Register in light of risks surrounding the joint commissioning process.

1.3 Risk Activity

Reviews for both directorate and corporate registers are carried out at least three times per year in line with Governance Committee meetings. Each review reflects additions/amendments in respect of:

- Identification/removal of risk
- De-escalation/escalation of risk
- Existing controls
- Internal and external assurances
- Gaps in controls and assurances
- Action being taken forward

2.0 Process

The following explains the process from the initial identification of a risk, risk grading, how the risk should be managed and escalation/de-escalation of grading and/or from directorate to corporate registers.

2.1 Assessing the Risk

Having identified an actual or potential risk, each directorate must evaluate the risk through the risk assessment process, using the HSC Regional Risk Matrix (see annex 1). All risks will be graded in terms of likelihood and impact i.e. how likely it is that the risk becomes a reality and if it does the impact or consequence to the HSCB.

2.2 Managing the Risk

Each risk identified will be managed according to its risk severity.

The following indicates the four levels of severity which dictate how the risk will be managed:

- **Low Risks**

  Risks assessed at this level will be accepted at directorate level. Additional controls may be applied where deemed appropriate. The risk will continue to be monitored and reviewed on the Directorate Risk Register.

- **Medium/High Risks**

  Risks at this level which are regarded as being within the control of individual directors will be accepted at directorate level. The risk will continue to be monitored and reviewed on the Directorate Risk Register.

  Risks at this level which are regarded as being outside the direct control of the relevant director will be forwarded to the Senior Management Team (SMT) for consideration of escalation to the Corporate Register. If SMT agree the risk

is outside the direct control of a director it will be referred to the Governance Committee for inclusion on the Corporate Risk Register.

If the Governance Committee approves the risk as corporate, it will be formally escalated to the Corporate Register and will continue to be monitored as part of the Corporate Risk Register review.

- **Extreme Risks**

All directorate risks identified at this level will be forwarded to SMT for them to validate and forward to the Governance Committee for inclusion/ approval on the Corporate Risk Register where it will continue to be monitored as part of the Corporate Risk Register review.

2.3 Risk Escalation/ De-escalation

- **Escalation**

Where risk severity has increased due to inadequate controls being in place, the risk should be re-evaluated using the HSC Risk Matrix and where necessary, the grading of risk escalated. In some instances this may also involve the escalation of a directorate risk to the Corporate Risk Register which will be validated and approved by SMT and the Governance Committee.

Escalation of risk will be part of the review process; however when a risk severity is identified or raised to 'extreme' this should be brought to the attention of SMT as soon as it becomes apparent.

- **De-escalation**

During each review, action taken to mitigate risks since the previous review will be considered. If it is deemed that the likelihood and impact of the risk occurring has been reduced, the risk should be re-evaluated using the HSC Risk Matrix and where necessary, the grading of risk de-escalated. In some instances this may involve removal of risks from a register or de-escalating a corporate risk to a Directorate Register.

2.4 Approval of Register/s

- **Directorate Registers**

Individual directors will be responsible for approving review of their respective Directorate Registers.

- **Corporate Register**

The Corporate Register will be approved at least three times per year, initially by SMT for onward referral to the Governance Committee for approval on behalf the Board.

The Corporate Register will be referred to the Board annually 'for information'

HSC Regional Impact Table – with effect from April 2013

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	MINOR (2)	MODERATE (3)	MAJOR (4)	CATASTROPHIC (5)
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Minimal injury requiring no/ minimal intervention. • Non-permanent harm lasting less than one month (1-4 day extended stay). • Emotional distress (recovery expected within days or weeks). • Increased patient monitoring	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Increase in length of hospital stay/care provision by 5-14 days.	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

HSC Regional Risk Matrix – April 2013

HSC Regional Risk Likelihood Scoring Table – with effect from April 2013

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

HSC Regional Risk Matrix – with effect from April 2013

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

Health and Social Care Board

Health and Social Care Board

Governance Framework 2019 - 2021

Reference	**Responsible Officer** Head of Corporate Services	**Review Frequency** Biennial
Approved by Governance Committee	**Approval Date:** 7 February 2019	**Next review due** January 2021
Superseded documents (if applicable) HSCB Governance Framework 2015 - 2016 HSCB Governance Framework – 2011/12 – 2012/13 HSCB Interim Governance Assurance Framework (Sept 2009) and legacy HPSS Board Governance/Risk Policies		

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Background

Circular HSC (F) 62/2012 introduced the requirement for the completion of an annual Governance Statement (GS) for inclusion within the annual report and accounts for the 2012-13 financial year. The Governance Statement replaces the requirement for an annual Statement of Internal Control (SIC).

In May 2009 the DHSSPS Accounting Officer wrote to accounting officers of each DHSSPS arm's length body, requesting a mid-year statement concerning the condition of the system of internal control within their respective organisation's as at the end of the September each year.

Circular HSS (PPM) 6/2002 announced that the DHSSPS, in recognition of the importance of a sound system of risk management, had entered into a license agreement with Standards Australia for the use of their internationally recognised risk management standard AS/NZS 4360:1999 (now updated to 2004 model). The application of this internationally recognised approach to risk management would be seen as an important piece of evidence in support of a Statement of Internal Control.

The application of Controls Assurance standards within the HPSS was announced in Circular HSS (PPM) 8/2002. This process would enable individual HPSS organisations to provide evidence that they are doing their reasonable best to protect users, staff, the public and other stakeholders against risk of all kinds. It is a means by which Chief Executives as Accountable Officers can discharge their responsibilities and provide assurances to the Department, the Assembly and the Public.

In January 2003 the DHSS&PS issued guidance under Circular HSS (PPM) 10/2002, specific to clinical and social care governance. The guidance was to enable HPSS organisations to formally begin the process of developing and implementing clinical and social care governance arrangements within their respective organisations and set a framework for action which highlighted the roles, responsibilities, reporting and monitoring mechanisms that are necessary to ensure delivery of high quality health and social care.

The circular also stipulated the requirement that this new guidance should be read in the context of previous guidance already issued on the implementation of a common system of risk management and the development of controls assurance standards for financial and organisational aspects of governance.

The Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003 imposed a 'statutory duty of quality' on HPSS Boards and Trusts. To support this legal responsibility, the Quality Standards for Health and Social Care have been issued by DHSSPS. They will be used by the new Regulation, Quality Improvement Authority (RQIA) to assess the quality of care provided by the HPSS.

In April 2009, DHSSPS issued 'An Assurance Framework: *A Practical Guide for Boards of DHSSPS Arm's Length bodies'.* The Framework guidance which is mandatory is intended to help the Boards of HSC organisations, and other arm's length bodies of DHSSPS, improve the effectiveness of their systems of internal control.

The HSC Performance and Assurance Roles and Responsibilities MIPB 74/09 were issued in April 2009. Its role, to set out performance and assurance roles and responsibilities in relation to four key HSC domains and to identify the key functions and associated roles and responsibilities of DHSSPS, HSCB, PHA, BSO, Trusts and other Arm's Length Bodies.

Circular HSC (SQSD) 08/2010 announced that responsibility for management of Serious Adverse Incident (SAI) reporting transferred from the DHSSPS (Department) to the Health and Social Care Board (HSCB) working in partnership with the Public Health Agency (PHA), with effect from 1st May 2010. The HSC Board have issued two further revisions to the procedure, in October 2013 and the most recent in November 2016.

Circular HSC (SQSD) 10/2010 advises on the operation of an Early Alert System, the arrangements to manage the transfer of Serious Adverse Incident (SAI) reporting arrangements from the Department to the HSC Board, working in partnership with the Public Health Agency and the incident reporting roles and responsibilities of Trusts, family practitioner services, the new regional organisations, the Health & Social Care (HSC) Board and Public Health Agency (PHA), and the extended remit of the Regulation & Quality Improvement Authority (RQIA). http://www.dhsspsni.gov.uk/hsc__sqsd__10-10.pdf

In July 2009, the DHSSPS transferred responsibility for performance managing implementation of Safety and Quality Alerts to the HSCB. The process for managing safety and quality alerts is overseen by the HSCB/PHA Safety and Quality Alerts Team.

As a standard requirement of *Managing Public Money Northern Ireland, DHSSPS* must agree a DFP-approved Management Statement/Financial Memorandum (MS/FM) with each of its arm's length bodies. This was approved by the Board of the HSCB at its meeting in May 2011.

DHSSPS have produced a Framework Document to meet the statutory requirements placed upon it by the Health and Social Care (Reform) Act (NI) 2009. The Framework Document describes the roles and functions of the various health and social care bodies and the systems than govern their relationships with each other and the Department.

DHSSPS Memo dated 17 July 2013 from Chief Medical Officer introduced the HSCB/PHA protocol on the dissemination of guidance/information to the HSC and the assurance arrangements where these are required. The protocol assists the HSCB/PHA in determining what actions would benefit from a regional approach rather than each provider taking action individually.

Circular HSS (MD) 8/2013 replaces HSS (MD) 06/2006 and advises of a revised Memorandum of Understanding (MOU) when investigating patient or client safety incidents. This revised MOU is designed to improve appropriate information sharing and co-ordination when joint or simultaneous investigations are required when a serious incident occurs. http://www.dhsspsni.gov.uk/ph_mou_investigating_patient_or_client_safety_incidents.pdf

DoH issued a letter on 1 June 2018 advising HSC organisations that the AS/NZ risk management standard previously used by the Department and ALBs was obsolete. The letter indicated AS/NZ could continue to be referenced in historical documents but all new material on risk management must not contain references in relation to the standard. The letter also indicated a group of leads from the larger HSC organisations were adopting a framework based on the ISO standard 31000:2018

Introduction

The Health and Social Care Board (HSCB) has a range of statutory duties, and shall, as a body corporate, exercise the functions assigned to it by DHSSPS, including those set out in Article 8(1-7) of the Health and Social Care (Reform) Act (NI) 2009 and any other statutory provisions deemed by the Department of Health to be functions of the HSCB, including the Government Resources and Accounts Act (NI) 2001.

The overall aim of the HSCB, working in close collaboration with the Public Health Agency (PHA), is to improve health and social well-being outcomes, through a reduction in preventable disease and ill-health, achieved by effective, high quality, safe, equitable and efficient health and social care.

It is therefore vital the HSCB establishes robust governance arrangements to ensure it discharges its functions in a way which ensures that risks are managed as effectively and efficiently as possible and to acceptable standards of quality. The specific objective is to protect the organisation against loss, the threat of loss and the consequences of loss, whilst at the same time having a framework in place that highlights the roles, responsibilities, reporting and monitoring mechanisms that are necessary to ensure commissioning and delivery of high quality health and social care.

The HSCB has a duty to protect users, carers, staff and others in the planning and delivery of services. Reducing risk is not just about financial or management probity it is about improving the quality of services and user experience of those services. This means that equal priority needs to be given to the obligations of governance across all aspects of the organization. There is a need to cover financial, organisational and clinical and social care and a need for these to be truly integrated within the organisation's culture. Good governance hinges on having clear objectives, sound practices, a clear understanding of the risks run by the organisation and effective monitoring arrangements. Any organization seeking to 'continuously improve the quality of services and safeguarding high standards of care' must put in place an accountability framework which permeates all levels of responsibility within the organisation.

Within the HSCB this is achieved by the adoption of an overarching Governance Framework (Framework).

Strategic Context

Corporate Governance is the system by which an organisation is directed and controlled, at its most senior levels, in order to achieve its objectives and meet the necessary standards of accountability, probity and openness.

The Audit Commission has defined corporate governance in health and social care as 'the systems and processes by which health bodies lead, direct and control their functions, in order to achieve organisational objectives, and by which they relate to their partners and the wider community'.

The Governance Framework is principally concerned with ensuring the HSCB has the basic building blocks in place for good governance through the development and implementation of a sound system of internal control.

This Framework therefore highlights the key components that underpin a sound system of governance and internal control, which will assist the Board of the HSCB, through the Chief Executive, to sign the annual Governance and Mid-Year Assurance Statements.

HSCB Governance Structure
Roles and Responsibilities

The Board of the HSCB

The HSCB's Board must ensure that effective arrangements are in place to provide assurance on risk management, governance and internal control. The Board has corporate responsibility for ensuring that the HSCB fulfils the aims and objectives set by the Department/Minister, and for promoting the efficient, economic and effective use of staff and other resources by the HSCB.

The Board must set up an Audit Committee and a Governance Committee to provide independent advice on the effectiveness of the internal control and risk management systems.

In accordance with Section 7 (1) of the Health and Social Care (Reform) Act (Northern Ireland) 2009 the Board needs to have Standing Orders and Schedules on:

- Powers reserved to the Board and;
- Powers delegated by the Board.

Committees of the Board

The Governance Committee

The Governance Committee will support the Board in all aspects of corporate and clinical and social care governance. It will assist the Board in these functions by providing an independent and objective review of:

- the adequacy and effectiveness of the system of internal control and to ensure a robust assurance framework is maintained;
- how risks and opportunities are identified and managed;
- the information provided to the Board,
- compliance with law, guidance and codes of conduct and accountability

The Governance Committee shall give an assurance[1] to the Board of the HSCB each year on the adequacy and effectiveness of the system of internal control in operation within the HSCB.

[1] HM Treasury "Management of Risk – Principles and Concepts" (October 2004) defines assurance as: "an evaluated opinion, based on evidence gained from review on the organisation's governance, risk management and internal control framework"

The Audit Committee

The Audit Committee will support the Board and Accounting Officer with regard to their responsibilities for issues of risk, control and governance and associated assurance through a process of constructive challenge.

The Audit Committee will constructively challenge:

- Assurance providers as to whether the scope of their activity meets the Board and Accounting Officer's assurance need and;
- The actual assurances to test that they are founded on sufficient reliable evidence and that the conclusions are reasonable in the context of the evidence

From time to time there may be some items e.g. the Governance and Mid-Year Assurance Statements which will be required to be approved by both Governance and Audit Committees. In these circumstances a joint meeting of both Committees may be convened.

Local Commissioning Groups (LCGs) (Belfast, Northern, South Eastern, Southern, Western)

Local Commissioning Groups are the point of local leadership in commissioning health and social care. The framework of the HSCB's Commissioning Plan will articulate the vision, purpose and control of the commissioning function for LCGs to deliver effective and efficient commissioning in their areas. They will need to understand, interact with, respond and adapt to their own situation and the external environment. Each LCG will be required to contribute to the HSCB's strategic planning process to improve health and wellbeing, provide high quality health outcomes and reduce inequalities in its local population.

Pharmacy Practices Committee

The primary role of the Pharmacy Practices Committee is to exercise the functions of the Board under Regulation 6(9) in accordance with paragraph 2 (6) of the Pharmaceutical Services Regulations (NI) 1997; www.**legislation**.gov.uk/id/nisr/**1997**/381 on behalf of the Board and in accordance with Schedule 4 of the same Regulations.

Reference Committee

The role of the Reference Committee is to exercise the HSCB's function under the Health and Social Care (Disciplinary Procedures) Regulations (Northern Ireland) 2016 http://www.legislation.gov.uk/nisr/2016/104/contents/ with respect to the referral of disciplinary matters for a chemist, dentist, ophthalmic, medical practitioner and opticians. It also exercises a range of functions in relation to performance concerns for general medical practitioners providing services as part of a GMS contract.

Where the Reference Committee receives information which it considers could amount to an allegation that a practitioner has failed to comply with his/her terms of service, it shall decide on the appropriate course of action, as set out in Paragraph 2 of the 2016 Regulations.

Remuneration and Terms of Service Committee

The primary responsibility of the Remuneration and Terms of Service Committee is to make recommendations to the Board on all aspects of remuneration and terms and conditions of employment for the Chief Executive and other Executive Directors (Code of Accountability for Board Members of HSC Bodies, April 2011).

Review Panel

The role of the Review Panel is to hear representations from a doctor where the Board is proposing conditional inclusion in the Performers' List, contingent removal, suspension and also removal under Regulation 10 (4) from the Primary Medical Performers List to hear the case put forward by the Board's Investigating Officer and make a determination.

Assessment Panel

The Assessment Panel will consider and determine, where the Board has rejected a closure notice, whether a GMS contractor should be permitted to close his list of patients, and if so, the terms on which he should be permitted to do so and to consider where the Board wishes to assign new patients to contractors which have closed their lists of patients.

Disciplinary Committee

The role of the Disciplinary Committee is to undertake the HSCB's functions as appropriate under the Disciplinary Regulations which came into effect in 2014 and further revised in 2016. These Regulations provide for the investigation and determination of questions about whether a chemist, dentist, ophthalmic medical practitioner or optician has failed to comply with their terms of service.

The Disciplinary Committee is comprised of the following members: a legally qualified chairperson, a lay person, a representative of the profession of the practitioner – i.e. a pharmaceutical contractor, optometrist or dentist.
The Disciplinary Committee meets as required to deal with cases referred to it by the HSCB's Reference Committee.

Officers with responsibility for Governance

Chief Executive (Accounting Officer)

The Chief Executive as Accounting Officer, is personally responsible for safeguarding the public funds of which he/she has charge; for ensuring propriety and regularity in the handling of those funds; and for the day-to-day operations and management of the HSCB. In addition, he/she should ensure that the HSCB as a whole is run on the basis of the standards (in terms of governance, decision-making and financial management) set out in Box 3.1 to MPMNI
www.afmdni.gov.uk/pubs/**MPMNI**/mpm_chapters.pdf

Head of Corporate Services

The Head of Corporate Services will report through the Chief Executive to the Board on all operational governance issues.

Governance Manager

The Governance Manager will support the Head of Corporate Services and take the lead role in the development and implementation of Governance arrangements within the HSCB and regionally in relation to the Procedure for the Reporting and Follow up of Serious Adverse Incidents (SAI). He/she will be responsible for developing systems and procedures for the effective promotion and maintenance of a governance and risk management culture within the HSCB.

Directorate Governance Leads

Directorate Governance leads are responsible operational implementation of the Governance Framework within their own directorate.

Designated Review Officer (DRO)

A DRO is a senior professional/officer within the HSCB / PHA who plays a key role in the implementation of the SAI process. He/she will have a degree of expertise in relation to the programme of care / service area where a SAI has occurred.

Other Groups/Forums

Senior Management Team (SMT)

The SMT comprises the Chief Executive, Director of Commissioning, Director of Finance, Director of Performance, Director of Social Care and Children, Director of Integrated Care, Director of Community Planning, and Head of Corporate Services.

The Public Health Agency Medical Director/Director of Public Health and Director of Nursing and AHPs and the BSO Director of Human Resources are also members of the HSCB Senior Management Team.

Quality, Safety and Experience Group (QSE)

The Quality, Safety and Experience Group (QSE) oversee all issues relating to safety, effectiveness and patient client focus within the HSCB and PHA.

This group allows senior staff to share information, approve policy and identify areas of concern. The group meets monthly and is chaired by the PHA Executive Director of Nursing, Midwifery and Allied Health Professionals.

An overview of the QSE governance and assurance structure is outlined in Appendix 1.

Safety and Quality Alerts Team (SQAT)

The Safety and Quality Alerts (SQA) Team meets fortnightly and is responsible for coordinating the implementation of regional safety and quality alerts, letters and guidance issued by the DoH, HSCB, PHA, RQIA and other organisations. The SQA Team is chaired by the PHA Medical Director/Director of Public Health is made up of professionals and senior managers from across the HSCB and PHA. This provides a mechanism for gaining regional assurance that alerts and guidance have been implemented or that there is an existing robust system in place to ensure implementation.

The Team 'closes' an Alert when it is assured that an Alert has been implemented, or there is an existing robust system in place to ensure implementation.

Serious Adverse Incident Review Sub-Group

The purpose of the Serious Adverse Incident Learning Sub Group (SAILSG) is to provide assurances that appropriate structures, systems and processes are in place within the HSCB and PHA for the management and follow up of serious adverse incidents arising during the course of the business of an HSC organisation/Special Agency or commissioned service.

The SAILSG has oversight across all professional groups and has responsibility to ensure that themes and trends, best practice and learning is identified and

disseminated in a timely manner, in conjunction with the HSCB/PHA Quality and Safety Experience Group (QSE) and Safety and Quality Alert Team (SQAT).

SAI Professional Groups

A number of professional groups from individual programmes of care have been established which allow HSCB/PHA Designated Review Officers (DRO) who share the same area of expertise to meet and discuss SAI reviews and where relevant identify regional learning prior to closure of the SAI. These professional groups also provide support to DROs when they may require advice in relation to specific SAIs.

Regional Complaints Sub-Group

The Regional Complaints Sub-Group meets quarterly to consider complaints arising from regional HSC services. The group makes key recommendations for action and agrees issues to be referred to the QSE. The group is chaired by the HSCB Complaints/Litigation Manager. Membership of the group is made up of professionals and senior managers from across the HSCB and PHA.

Information Governance Steering Group

The Information Governance Steering Group is an organisation wide group and reports to the HSCB Senior Management Team and the HSCB Governance Committee. Its purpose is to support and drive the broader information governance agenda and provide the Board with the assurance that effective information governance best practice mechanisms are in place within the organisation.

Business Continuity Management Project Team

The Business Continuity Management Project Team is a multi-disciplinary team accountable to the HSCB Senior Management Team for the operational implementation of a Business Continuity Plan that complies with BS25999 standard www.**bs25999**.com and ISO 22301.

The Primary Medical Performers List Advisory Committee

The Primary Medical Performers List (PMPL) Advisory Committee is a multi-professional, multiagency group which provides advice to the HSCB on the effective discharge of its duties under the “Health and Personal Social Services (Primary Medical Services Performers Lists) Regulations (Northern Ireland) 2004 and out segment amendments. This includes advice on the conditional inclusion, contingent removal and suspension of GPs from the PMPL, policy development, and the development of primary and secondary legislation in relation to the PMPL. The Committee includes representatives of the Patient and Client Council (PCC), the Northern Ireland Medical and Dental Training and Agency (NIMDTA), DoH, the

General Practices Committee (GPC), the Business Services Organisation (BSO) and the Directorate of Integrated Care of HSCB.

The Regional Professional Panel

The Regional Professional Panel (RPP) is a multi-professional multi-organisational group which assesses relevant expressions of concern about underperformance of Family Practitioner Services practitioners, establishes the degree of seriousness of concerns and provides advice on the management of cases of concern. The panel is comprised of representatives of GP, dental, optometric and pharmaceutical bodies, representatives of relevant Royal Colleges, the Pharmaceutical Society of Northern Ireland (PSNI), the Northern Ireland Medical and Dental Training Agency (NIMDTA), the Patient and Client Council (PCC), the Directorate of Integrated Care of HSCB, and user representatives from two of the five Local Commissioning Groups (LCGs). The panel meets at the frequency required to manage on-going cases of concern effectively, usually quarterly.

The Pharmacy Networking Group (PNG)

The Pharmacy Networking Group (PNG) has been established to enable collaboration and cooperation between the HSCB, DoH, the Pharmaceutical Society for Northern Ireland (PSNI) and the Business Services Organisation. This supports the investigation of complaints raised regarding pharmacists, pharmaceutical premises. The PNG operates under a memorandum of understanding between the four organisations and enables the discharge of their relative legislative duties while assuring an integrated and consistent approach.

The Local Intelligence Network (LIN)

The Controlled Drugs (Supervision of Management and Use) Regulations (Northern Ireland) 2009 were introduced in order to ensure the safer management and use of controlled drugs (CDs) in health care. It requires certain organisations called Designated Bodies (regulation 3) to appoint an Accountable Officer who has responsibility for the management of controlled drugs both within their Designated Body and any other organisation that provides services under arrangements with that Designated Body. The Regulations require Accountable Officers to take appropriate action where concerns are well-founded and these actions may include disclosing the name of the Relevant Person to other Designated Bodies and Responsible Bodies. This is done via the Local Intelligence Network chaired by the HSCB Accountable Officer, and in accordance with the record-keeping requirements detailed in Regulation 29. Each organisation which is a member of the LIN must have robust governance systems in place to ensure that the sharing of personal data both internally and externally is in compliance with the legislative framework for information sharing.

Independent Assurances

It is vital the Board ensures that it has proper and independent assurances on the soundness and effectiveness of the systems and processes in place for meeting its objectives and delivering appropriate outcomes.

The Audit Committee must therefore obtain the necessary information to assure the Board that the systems of internal control are operating effectively and for this, it relies on the work of Internal Audit and that of the External Auditor.

Internal Audit

The HSCB has in place an internal audit function that meets the standards set out in the NHS Internal Audit Manual. The appointed auditors provide the Audit Committee with an objective opinion on the effectiveness of the HSCB's system on internal control.

External Audit

The Audit Committee shall rely upon the certification of the accuracy, probity and legality of the Annual Accounts provided by the External Auditor, combined with more detailed internal audit review of systems and procedures, in discharging its responsibilities for ensuring sound internal control systems and accurate accounts and providing such assurances to the Board.

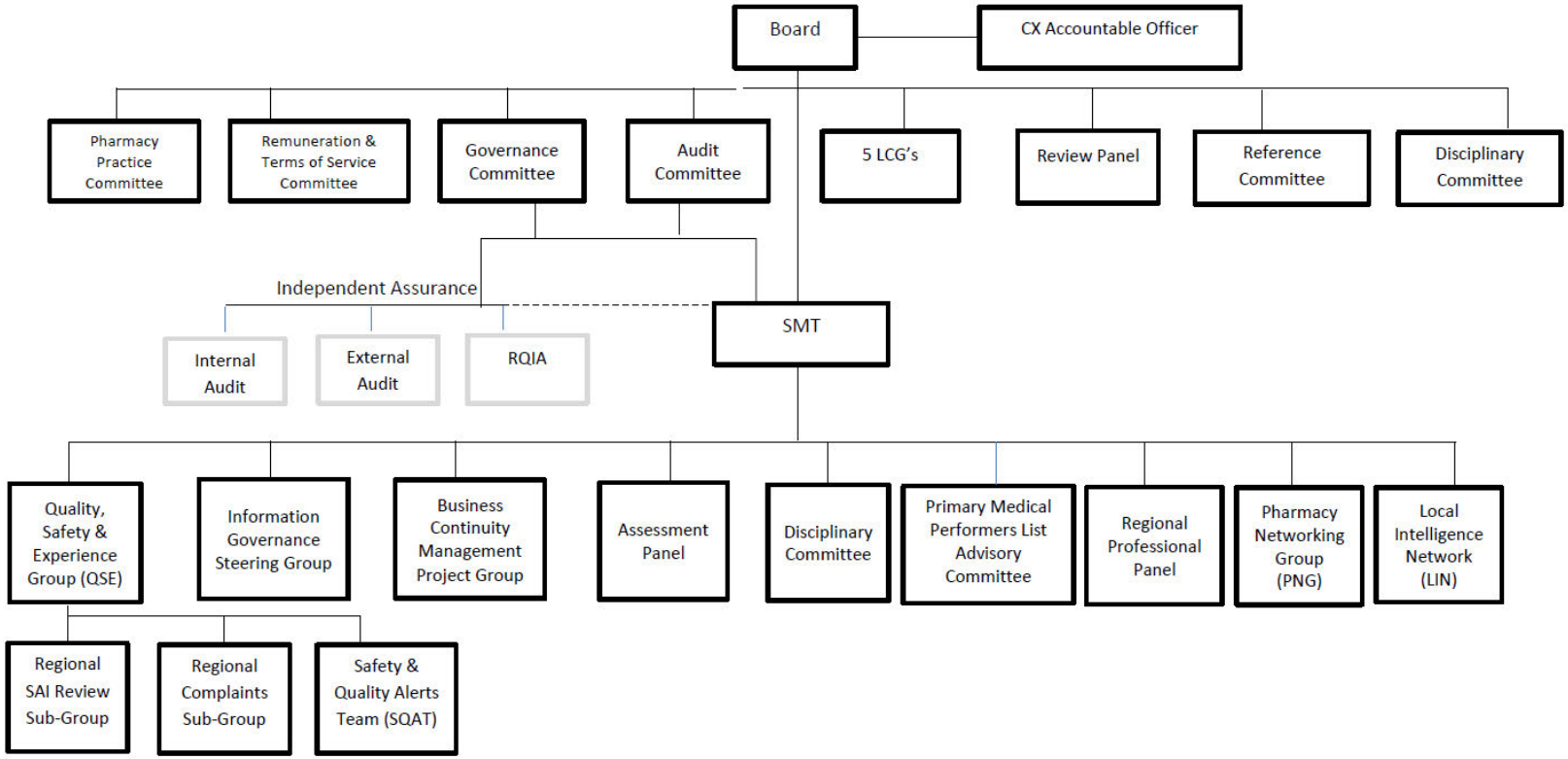
The Regulation Quality Improvement Authority (RQIA)

The RQIA is the independent health and social care regulatory body for Northern Ireland, and forms an integral part of the new health and social care structures. In its work RQIA encourages continuous improvement in the quality of these services through a programme of inspections and reviews.

The HSCB will ensure recommendations from any internal review/inspection carried out by RQIA will be taken forward and where relevant used to inform and improve access to, and the quality of services across the HSC.

Page overleaf provides a diagrammatic overview of the HSCB's Governance structure.

Governance Structure in HSCB



Managing Risk

The HSCB recognise risk management is a key component of the Governance Framework and it is therefore essential that systems and processes are in place to identify and manage all risks as far as reasonably possible.

All organisations engaged in the provision of health and social care carry a significant number of risks which have the potential to cause harm to service users, patients, visitors or staff and loss to the organisation. The purpose of risk management is not to remove all risk but to ensure that risks are recognised and their potential to cause loss fully understood. Based on this information, action can be taken to direct appropriate levels of resource at controlling the risk or minimising the effect of potential loss.

The HSCB has recognised the need to adopt such an approach and has put in place an independently assured risk management system that conforms to the principles of the regionally agreed HSC Regional Model for Risk Management. This model is based on the principles of the ISO 31000:2018 standard[2] which largely has the same broad principles, framework and processes which the former AS/NZ standard[3] used. In implementing this model, the HSCB has agreed (along with all other Departmental Arm's Length Bodies) to adopt the 'spirit' of ISO 31000:2018, by applying the principles of the standard, but will not be seeking accreditation.

This will ensure there continues to be a systematic and unified process for the management of risks across all areas of the Board's activity by having in place a fully functioning risk register at both directorate and corporate levels. *Appendix 2 – Process for the Management of Board Wide Risks* provides a more detailed description of this process and identifies the process for the escalation and de-escalation of Board wide risks.

Risk Appetite

- **Categorisation of Risk**

All risks do not carry the same likelihood of occurrence or degree of impact (consequence) in terms of actual or potential impact on service users, patients, staff, visitors, the organisation, or its reputation or assets.

Once the organisation's objectives have been approved and a consensus on principal risks reached it is important to ensure a consistent and uniform approach is taken in categorising risks in terms of their level of priority in order that appropriate action is taken at the appropriate level of the organisation.

[2] BSI ISO 31000:2018 Risk Management Guidelines
[3] AS/NZS:2009: Risk Management

The HSC Regional Risk Matrix (appendix to the HSC Risk Management Model has been adopted by the HSCB (annex 1, appendix 1); and is also consistent with DHSSPS mandatory guidance *An Assurance Framework: A Practical Guide for Boards of DHSSPS Arm's Length Bodies.* This matrix which is used to categorise potential risks, incidents, complaints and claims; facilitates the prioritisation of risk in terms of likelihood and impact (consequence). In doing so, this will help identify the nature and degree of action required and levels of accountability for ensuring such action is taken.

- **Acceptable Risk**

The HSCB recognises that it is impossible and not always desirable to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources in order to achieve health and social care benefits for the local population.

From time to time the HSCB may be willing to accept a certain level of risk. For example: promoting independence for individuals; or in order to take advantage of a new and innovative service; or due to the high costs of eliminating a risk in comparison with the potential threat. In these circumstances the risk will continue to remain on the risk register and will be monitored and reviewed at regular intervals.

However, as a general principle the HSCB will seek to eliminate and control all risks which have the potential to:

- harm staff, service users, patients, visitors and other stakeholders.
- have a high potential for incidents to occur; would result in loss of public confidence in the HSCB and/or its partner agencies or would have severe financial consequences and which would prevent the HSCB from carrying out its functions on behalf of the population.

- **Risk Activity**

As part of the board-led system of risk management, the Corporate Register is approved by SMT on a quarterly basis; approved by Governance Committee at least three times per year in line with its meetings; and presented annually to the Board. The Board is also informed of significant risks by way of the annual Governance and Mid-Year Assurance statements.

Key Components of the Governance Framework

The HSCB overarching Governance Framework links the key individual governance and risk management components that have been established and developed within the HSCB. It will be this Framework, together with the supporting mechanisms listed below that will provide the basic building blocks for good governance through the development and implementation of a comprehensive system of internal control.

Standing Orders

The Standing Orders, reserved and delegated powers and Standing Financial Instructions provide a comprehensive business framework for the HSCB and enables the organisation to discharge its functions. They reflect the following: Framework Document (September 2011); Management Statement/Financial Memorandum; Code of Conduct and Code of Accountability for Board Members of HSC bodies (2011); 7 Nolan Principles; Public Service Values and; Code of Openness.

The HSCB Standing Orders and Standing Financial Instructions are reviewed on an annual basis, considered by the HSCB Audit Committee and approved at the subsequent public Board Meeting. Section 6 of the Standing Orders relates to the Conduct of Board Business and includes, amongst others, potential conflicts of interest. This section also applies to the conduct of public meetings of the Local Commissioning Groups (LCGs).

Corporate Plan

The HSCB Corporate Plan does not seek to duplicate the detailed objectives and activities set out in the Commissioning Plan, but rather to outline the key objectives for the organisation in addition to those associated with the Commissioning Plan, and those that will support its delivery.

As such, the Corporate Plan includes objectives that primarily relate to how the HSCB will seek to commission the delivery of high quality health and social care services for the population of Northern Ireland, and how it conducts its business and ensures that its organisational arrangements are fit for purpose.

Taken together with the Commissioning Plan and policies for the effective and efficient management of resources, the Corporate Plan will provide an overarching planning framework for the work of the HSCB.

The Corporate Plan is reviewed both mid-year and at year end.

Assurance Framework

The Assurance Framework provides the systematic assurances required by the Board of Directors on the effectiveness of the system of internal control by highlighting the reporting and monitoring mechanisms that are necessary to ensure commissioning and delivery of high quality health and social care. It provides a clear, concise structure for reporting key information to the Board of the HSCB, its various committees, SMT and other groups/forums.

It will identify which of the organisation's objectives are at risk because of the inadequacies in the operation of controls, or where the HSCB has insufficient assurance about them. In conjunction with the HSCB's Corporate Risk Register, Corporate and Commissioning Plans it should also provide structured assurance about how risks are managed effectively to deliver agreed objectives. This will supply a basis for the spread of good practice throughout the organisation and allow the HSCB to determine where to make the most efficient and effective use of resources.

The Assurance Framework is reviewed annually.

Fully Functioning Risk Register

The HSCB has in place a fully functioning risk register operating across all areas of the Board's activity. This includes an overarching Corporate Risk Register together with seven directorate registers.

The aim of the Risk Register is to maintain a recognised process whereby the Board of the HSCB is kept informed, and has access to the principle risks which face the organisation and the actions being taken to resolve or reduce these risks. The Corporate Risk Register has clear links to the HSCB's Corporate Plan and Assurance Framework.

Governance Statement

The Chief Executive as Accounting Officer is required to sign a full Governance Statement at the end of each financial year. The Governance Statement provides assurances to DHSSPS that the HSCB has effective systems of internal control. These systems need to identify risks relating to the achievement of objectives, including the statutory duty of quality, and should be capable of evaluating the nature and extent of those risks and of managing them efficiently, effectively and economically.

Mid-Year Assurance Statement

The Chief Executive as Accounting Officer is required to sign a Mid-Year Assurance Statement (MYAS) at the end of the second quarter of each financial year. The MYAS provides assurances at the end of the second financial quarter to DHSSPS

that the HSCB continues to attest to the robustness of its organisation's system of internal control and also highlights any significant risks not identified in the previous Governance Statement.

Procedure for the Management of Follow up of Serious Adverse Incidents (November 2016)

The Procedure for the Reporting and Follow up of SAIs was implemented across the HSC in May 2010 and was subsequently revised in October 2013 and again in November 2016. The purpose of the procedure is to provide guidance to all Departmental Arm's Length Bodies, in relation to the reporting and follow up of Serious Adverse Incidents (SAIs) arising during the course of the business of a HSC organisation/Special Agency or commissioned service.

Protocol for the Reporting and Follow up of the DoH Early Alert System

In June 2010, the process for Early Alerts was introduced by the Department of Health (DoH). Circular HSC (SQSD) 64/16 issued 28 November 2016, provided updated guidance on the operation of the Early Alert System. This system is designed to ensure that the Department (and thus the Minister) receive prompt and timely details of events (*these may include potential serious adverse incidents*) which may require urgent attention or possible action by the Department.

The Early Alert System provides a channel which enables Chief Executives and their senior staff (*Director level or higher*) in HSC organisations to notify the Department, in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, and which may require immediate attention by the Minister, Chief Professional Officers or policy leads, and/or require urgent regional action by the DoH.

Organisations are also required to alert the HSCB of all Early Alert notifications to DoH.

The purpose of this protocol, which is a joint protocol with PHA) is to provide guidance to staff working within the HSCB and PHA on the internal processes for the effective management of Early Alerts where:

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a) The Early Alert has occurred in HSCB/PHA and is required to be reported to DoH;

   and/or

b) The HSCB has received a copy of the Early Alert from a reporting organisation in line with the above circular and it will be managed in conjunction with the Procedure for the Reporting and Follow up of Serious Adverse Incidents.

SQAT Procedure

The Health and Social Care Board (HSCB) and Public Health Agency (PHA) are responsible for the co-ordination and implementation of Safety and Quality Alerts.

The HSCB/PHA Regional Procedure for Safety and Quality Alerts is in place to ensure effective communication and liaison between relevant organisations in relation to Safety and Quality Alerts. The procedure outlines the management, dissemination and assurance arrangements for Safety and Quality Alerts issued by the HSCB/PHA, DoH, RQIA and other confidential reports rather than each provider taking action individually. The procedure was reviewed and updated in July 2018 and issued to all relevant HSC organisations.

Social Care Governance Framework

The Social Care Governance Framework highlights the mechanisms in place that will assure the Board that the HSCB is meeting its statutory and mandatory requirements in respect of social care and children.

Information Governance Framework

The Information Governance Policy and Strategy provide the vehicle to ensure the HSCB has a robust and effective Information Governance Framework in place to allow the HSCB to fully discharge its strategic duties and to ensure that overall corporate compliance is met both in relation to legal and statutory obligations and in meeting all relevant information governance related codes of practice.

Business Continuity Management Project Plan

The Business Continuity Project Plan provides the necessary arrangements and actions in order to allow the HSCB to have in place a Business Continuity Plan to ISO 22301 Standard.

Corporate Governance Related Policies and procedures

- **Whistle Blowing Policy**

  This policy applies to all HSCB staff and sets out the arrangements by which HSC staff can raise concerns and what they can expect from the HSCB in terms of protections under the law. It provides guidance how to encourage staff to raise concerns and how the HSCB will deal effectively with concerns in an open and transparent way.

  The policy is based on the HSC Whistleblowing Framework and Model Policy developed, in collaboration with the DoH and HSC organisations in response

to the recommendations arising from the RQIA Review of the Operation of HSC Whistleblowing arrangements 2016.

- **Incident / Near Miss Reporting Policy and Procedure**

  The HSCB recognises that the overall aim of any incident reporting system is to reduce the number of workplace injuries and adverse incidents to a minimum. To achieve such an aim it is important that we not only seek to adopt a proactive safety culture, but that we also record and report all incidents/near misses that occur, in order to learn from them to prevent recurrence.

  This procedure applies to the reporting of all incidents within the Board, which occur on Board premises or as a result of a service provided by a Board employee.

  This procedure contributes to:

  - Managing risk and minimising the risk of adverse incidents
  - Ensuring that all possible lessons are learned and shared
  - Supporting staff through potentially distressing circumstances

- **Policy for the Management of Complaints**

  This policy sets out how the HSCB should deal with complaints raised by service users or former service users. It outlines for staff a consistent procedure on how complaints relating to the HSCB, its actions and decisions are handled. It also demonstrates the monitoring of complaints processes and outcomes relating to the HSCB, 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).

The list of governance related policies and procedures are non-exhaustive and may be added to during the period this framework is in place.

Conclusion

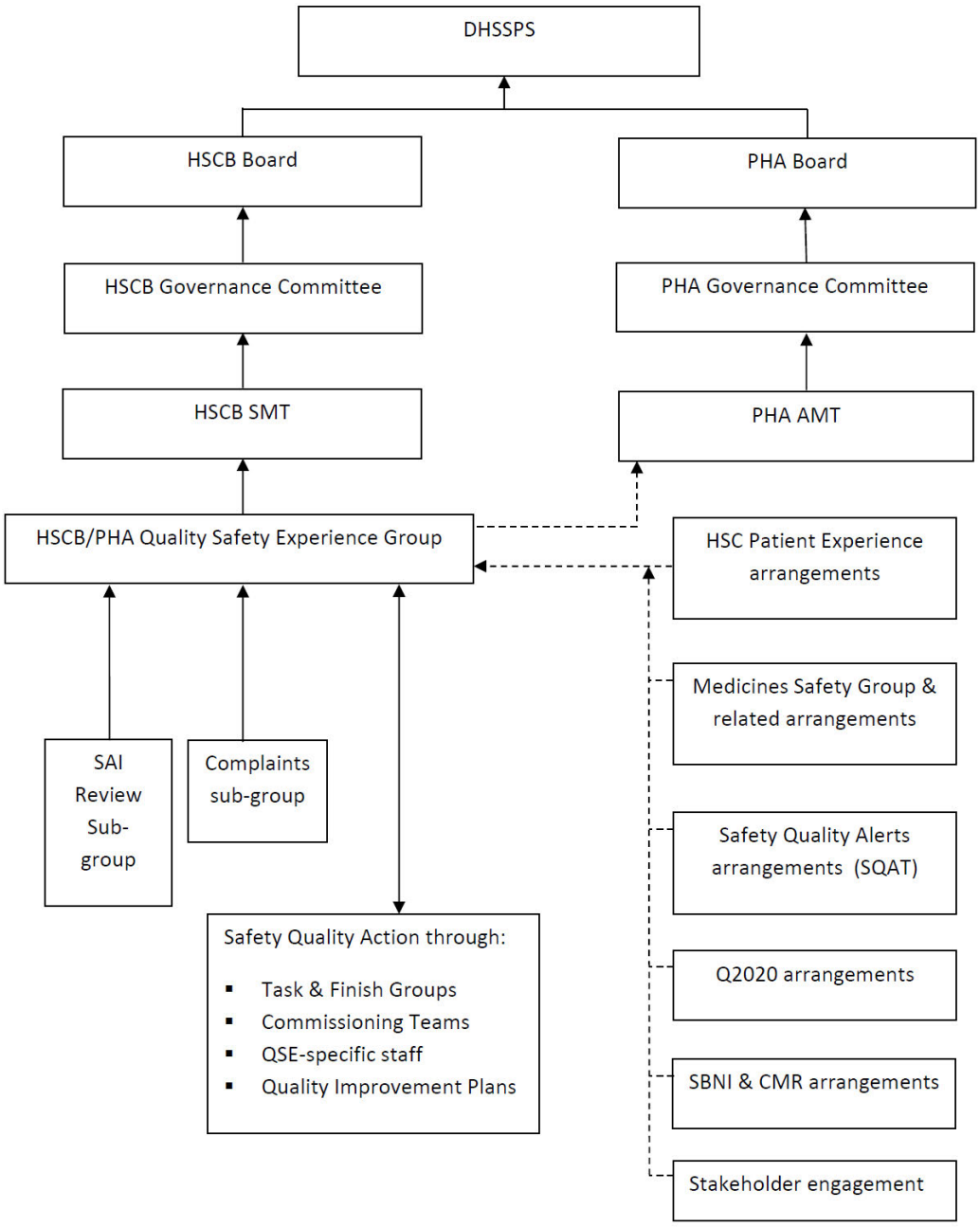
In summary, the Governance Framework provides an overview of the governance arrangements currently operating within the HSCB. It is intended to resolve uncertainties and deepen understanding of how the HSCB manages its internal control system in order to achieve its objectives and meet the necessary standards of accountability, probity and openness.

It provides a clear, concise outline of the key governance components that underpin the HSCB's system of internal control which will assist the Board of the HSCB, through the Chief Executive, to attest to the robustness of the internal control system when signing the annual Governance and Mid-Year Assurance Statements.

The framework will be in place for the next two years. During this time governance arrangements will continue to be established and developed in line with statutory/mandatory requirements, guidance issued by DoH and as a result of on-going review processes.

Appendix 1

Diagrammatic Overview of Quality Safety Experience Internal Coordination Arrangements – HSCB/PHA



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Appendix 2

Health and Social Care Board

Health and Social Care Board

Process for the Management of Board Wide Risks

1.0 Introduction

A Risk Register is a management tool that enables an organisation to understand its comprehensive risk profile. It is simply a repository for all risk information. This repository is the hub of the internal control system, given that it should contain the objectives, risks and controls for the whole organisation. It therefore makes sense for the organisation's review of the system of internal control to centre on the Risk Register.

The Health & Social Services Board (HSCB, Board) has identified the need for a fully functioning risk register across all areas of activity throughout the organisation.

1.1 Aim of the Risk Register

The aim of the Risk Register is to maintain a recognised process whereby the Board of the HSCB is kept informed, and has access to the principle risks which face the organisation and the actions being taken to resolve or reduce these risks. The HSCB recognises the need for risk management to be part of the organisation's culture and integrated into all business and planning processes. It is therefore important the risk register has clear links to the HSCB Corporate Plan and Assurance Framework.

1.2 Dimensions of the HSCB Risk Register

The HSCB register operates across all areas of the Board's activity. This includes an overarching Corporate Risk Register together with the following Directorate Risk Registers:

- Commissioning
- Corporate Services
- Finance
- Integrated Care
- Performance Management and Service Improvement
- Social Care and Children
- e-Health and External Collaboration

Whilst the Public Health Agency (PHA) have their own separate risk register both Directors of Public Health and Nursing & Allied Health Professionals; are involved in the reviews of the HSCB's Corporate Risk Register in light of risks surrounding the joint commissioning process.

1.3 Risk Activity

Reviews for both directorate and corporate registers are carried out on a quarterly basis with reviews for the second and fourth quarters being a substantive review and first and third quarter reviews being 'by exception'. Substantive reviews will involve the Governance team meeting with the Directorate Governance leads within each directorate. The Corporate Risk Register will be approved by SMT on a quarterly basis and by the Governance Committee at least three times per year in line with Governance Committee meetings. Each review reflects additions/amendments in respect of:

- Identification/removal of risk
- De-escalation/escalation of risk
- Existing controls
- Internal and external assurances
- Gaps in controls and assurances
- Action being taken forward

Consideration will be given to all risks on the Corporate Risk Register, as to whether the specific risk should also be included in the annual Governance and Mid-year Assurance statement as an internal control divergence.

2.0 Process

The following explains the process from the initial identification of a risk, risk grading, how the risk should be managed and escalation/de-escalation of grading and/or from directorate to corporate registers.

2.1 Assessing the Risk

Having identified an actual or potential risk, each directorate must evaluate the risk through the risk assessment process, using the HSC Regional Risk Matrix (2018) (see annex 1). All risks will be graded in terms of likelihood and impact i.e. how likely it is that the risk becomes a reality and if it does the impact or consequence to the HSCB.

2.2 Managing the Risk

Each risk identified will be managed according to its risk severity.

The following indicates the four levels of severity which dictate how the risk will be managed:

- **Low Risks**

  Risks assessed at this level will be accepted at directorate level. Additional controls may be applied where deemed appropriate. The risk will continue to be monitored and reviewed on the Directorate Risk Register.

- **Medium/High Risks**

  Risks at this level which are regarded as being within the control of individual directors will be accepted at directorate level. The risk will continue to be monitored and reviewed on the Directorate Risk Register.

  Risks at this level which are regarded as being outside the direct control of the relevant director will be forwarded to the Senior Management Team (SMT) for consideration of escalation to the Corporate Register. If SMT agree the risk is outside the direct control of a director it will be referred to the Governance Committee for inclusion on the Corporate Risk Register.

  If the Governance Committee approves the risk as corporate, it will be formally escalated to the Corporate Register and will continue to be monitored as part of the Corporate Risk Register review.

- **Extreme Risks**

  All directorate risks identified at this level will be forwarded to SMT for them to validate and forward to the Governance Committee for inclusion/approval on the Corporate Risk Register where it will continue to be monitored as part of the Corporate Risk Register review.

2.3 Risk Escalation/ De-escalation

- **Escalation**

  Where risk severity has increased due to inadequate controls being in place, the risk should be re-evaluated using the HSC Risk Matrix and where necessary, the grading of risk escalated. In some instances this may also involve the escalation of a directorate risk to the Corporate Risk Register which will be validated and approved by SMT and the Governance Committee.

  Escalation of risk will be part of the review process; however when a risk severity is identified or raised to 'extreme' this should be brought to the attention of SMT as soon as it becomes apparent.

- **De-escalation**

  During each review, action taken to mitigate risks since the previous review will be considered. If it is deemed that the likelihood and impact of the risk occurring has been reduced, the risk should be re-evaluated using the HSC Risk Matrix and where necessary, the grading of risk de-escalated. In some instances this may involve removal of risks from a register or de-escalating a corporate risk to a Directorate Register.

2.4 Approval of Register/s

- **Directorate Registers**

  Individual directors will be responsible for approving review of their respective Directorate Registers.

- **Corporate Register**

  The Corporate Register will be approved quarterly by SMT and at least three times per year by the Governance Committee for approval on behalf the Board.

  The Corporate Register will be referred to the Board annually 'for information' normally as at the end of the fourth quarter.

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid • Non-permanent harm lasting less than one month • Admission to hospital for observation or extended stay (1-4 days duration) • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.

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DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

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Annex 1

HSC REGIONAL RISK MATRIX – WITH EFFECT FROM APRIL 2013 (updated June 2016 & August 2018)

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

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

Health and Social Care Board

Health and Social Care Board

Risk Management Policy

Version 1 - January 2021

Approved by SMT -12 January 2021
Approved by GAC - 19 January 2021

1.0 Background and Introduction

The Health and Social Care Board (HSCB) recognise risk management is a key component of its Governance Framework and it is therefore essential that systems and processes are in place to identify and manage all risks as far as reasonably possible.

All organisations engaged in the provision of health and social care carry a significant number of risks which have the potential to cause harm to service users, patients, visitors or staff and loss to the organisation. The purpose of risk management is not to remove all risk but to ensure that risks are recognised and their potential to cause loss fully understood. Based on this information, action can be taken to direct appropriate levels of resource at controlling the risk or minimising the effect of potential loss.

1.1 Definition of Risk

Risk is the chance of something happening that will have an impact upon objectives i.e. uncertainty of outcome. Risk management includes identifying and assessing risks and then responding to them. Controls must be commensurate with the nature of the risk.

1.2 Good Risk Management:

- Allows an organisation to have increased confidence in achieving its desired outcomes;

- Effectively constrains threats to acceptable levels;

- Allows an organisation to take informed decisions about exploiting opportunities; and

- Allows stakeholders to have increased confidence in the organisation's corporate governance and ability to deliver.

2.0 The Risk Management Process

2.1 It is important that the HSCB has a clear, effective and practical system of risk management, which should be fully embedded in its governance arrangements at all levels within the organisation. Guidelines for the assessment of risk are attached as an addendum to the policy.

2.2 The process for managing risk is the same at any level in the organisation:

- **Establish the context** – what are the statutory obligations, the strategic vision or the business objectives of the organisation?

- **Identify** – What might happen that could adversely impact on all or some of the above?

- **Assess** – Analyse and evaluate the nature of the risk as follows:

    - **Determine Inherent Risk** – what is the likelihood of the risk occurring and the impact it will cause if it does actually happen, if no mitigating measures are applied to the risk?

    - **Determine Residual Risk** - what is the level of risk remaining after current internal control actions are exercised?

    - **Determine Risk Appetite** – this is the overall amount of risk the organisation is prepared to accept or tolerate in pursuit of its objectives.

Classification	Description
Averse	Avoidance of risk and uncertainty is a key organisational objective.

Minimalist	Preference for ultra-safe business delivery options that have a low degree of inherent risk and only have a potential for limited reward.
Cautious	Preference for safe delivery options that have a low degree of residual risk and may only have limited potential for reward.
Open	Willing to consider all potential delivery options and choose the one that is most likely to result in successful delivery while also providing an acceptable level of reward (and value for money etc.)
Hungry	Eager to be innovative and to choose options offering potentially higher business rewards, despite greater inherent risk.

  - **Determine treated risk** – Once risk appetite has been established the target risk can be set. This is the expected status of the risk after planned actions have been taken.

- **Review** – is the action being taken sufficient to constrain the risk to an acceptable level?

- **Report** – How are we monitoring whether or not the risk profile is changing? Are we recording the information and decisions being taken? Are we reporting the information? Are we providing robust assurance that the risk is being effectively and appropriately managed? Are we escalating the risk if required?

3.0 Risk Registers

Risk management is an organisation-wide responsibility. Within the HSCB there are two key levels at which the risk management process is formally documented. This includes an overarching Corporate Risk Register together with the following Directorate Risk Registers:

- Commissioning
- Digital Health and Care NI
- Finance
- Integrated Care
- Performance Management and Corporate Services
- Social Care and Children

Whilst the Public Health Agency (PHA) have their own separate risk register both Directors of Public Health and Nursing & Allied Health Professionals; are involved in the reviews of the HSCB's Corporate Risk Register in light of risks surrounding the commissioning process.

The Corporate Risk Register focuses on the principal risks to the HSCBs delivery of its statutory responsibilities and strategic objectives. Directorate Risk Registers focus primarily on the risks to the achievement of Directorate objectives. The direct connection between the Corporate Business Plan and Directorate objectives must be mirrored in the risk management process.

3.1 Corporate Risk Register

- In the development of the Corporate Business Plan each year, HSCB Senior Management Team (SMT) must identify key risks to the

achievement of its strategic objectives and carry out an assessment of each risk.

- The HSCB strives for a 'hungry' risk appetite but recognises the need for an 'open' risk appetite in those areas where the HSCB cannot afford to fail. **Note: Corporate responsibility is assumed where a 'hungry' risk appetite has been agreed.**

- Following approval by SMT, the Corporate Risk Register is submitted to the Governance and Audit Committee for approval on a quarterly basis and to HSCB Board for noting on an annual basis at the same time as the HSCB Business Plan. Although individual risks will have lead directors the HSCB Senior Management Team is collectively responsible for the management of risks.

3.2 Directorate Risk Registers

- Directors must develop risk registers in response to their Directorate objectives and are responsible for ensuring that their Directorate objectives are fully linked to their Directorate risk register.

- Directorate risk registers are reviewed on a quarterly basis at the same time as the Corporate risk register and approved by the relevant Director. Directorate registers are noted by SMT on a rotational basis throughout the year.

- Where a risk identified at Directorate level becomes unmanageable within the Directorate's resources, or where it threatens to impact on Corporate objectives or across Directorates, it can be escalated to SMT for inclusion on the Corporate Risk Register. The relevant Director, in consultation with the Chief Executive, is responsible for the formal escalation.

3.3 Accountability

The Governance Team within the Performance and Corporate Services Directorate is responsible for co-ordinating the development of HSCB risk register. Each Director is however ultimately responsible for the identification, management and required escalation of their own Directorate risks and for those risks where they are the nominated lead for any Corporate risk on behalf of SMT.

Guidelines for the Assessment of Risk

Introduction

These guidelines have been produced to enable those risks identified and included within the risk registers to be analysed and assessed on a consistent basis across the organisation. This exercise involves determining the existing controls and analysing the risks in terms of their impact and likelihood with those controls in place.

Assessment Process

Risk Appetite

Risk appetite can be defined as the amount and type of risk that an organisation is willing to take in order to meet its objectives. Risk appetite levels are outlined below:

Classification	Description
Averse	Avoidance of risk and uncertainty is a key organisational objective.
Minimalist	Preference for ultra-safe business delivery options that have a low degree of inherent risk and only have a potential for limited reward.
Cautious	Preference for safe delivery options that have a low degree of residual risk and may only have limited potential for reward.
Open	Willing to consider all potential delivery options and choose the one that is most likely to result in successful delivery while also providing an acceptable level of reward (and value for money etc.)
Hungry	Eager to be innovative and to choose options offering potentially higher business rewards, despite greater inherent risk.

Residual Risk Assessment

The Residual Risk Assessment is the likelihood of something happening and the impact that it will cause if it does actually happen, taking into account those

mitigating measures/strategic controls that have been applied to the risk. The Residual Risk Assessment does not take into account any planned mitigating measures/strategic controls that have not yet been applied to the risk.

In order to establish the residual risk, an assessment should be carried out to consider the effect of the mitigating measures/strategic controls currently in place on both the likelihood and impact of the risk. When the assessment of the Residual Risk has been completed and compared to the Risk Appetite the extent of any action required should then become clear.

Treated Risk Assessment (Target Risk)

The Treated Risk Assessment is the point at which the level of risk is considered acceptable and sufficiently mitigated. In order to establish the treated risk level, consideration will need to be given to the context of the risk, the agreed Risk Appetite for the risk, the residual risk assessment score and the impact that any ongoing actions have had on the level of risk. Further actions, strategic controls/mitigating measures may need to be developed or considered in order to reduce the residual risk to the acceptable treated risk level.

Assessment of Level of Risk (refer to Risk Matix – Appendix 1)

The level of risk is a product of two values:

i) Impact

This involves assessing the impact of the risk, should it materialise, upon the successful achievement of the business objectives. The values range from **1 (Insignificant)** to **5 (Catastrophic)**. Table 1 (Assessment of Risk – Impact) on page 11 provides an illustration of the categories of risk impact and provides guidance to help assess the appropriate impact.

ii) Likelihood

Table 2 (Assessment of Risk – Likelihood) on page 12 sets out the qualitative measures of likelihood and provides further detail to assist in identifying the

appropriate likelihood of the risk. The values range from **1 (Rare)** to **5 (Almost certain to occur)**.

The overall level of risk **(Low, Medium, or High)** is determined by applying the measurement of impact and the measurement of likelihood to the matrix set out in Table 3 (Assessment of Risk – Level of Risk) on page 13, for example a risk with a 'Moderate' impact and 'Almost Certain' likelihood would have a High level of risk, whereas a risk with 'Moderate' impact and 'Possible' likelihood would be assigned a Medium level of risk.

Risk Register Template

The template used to record both Corporate and Directorate registers is set out in Appendix 2 on page 14 with key risk register terms defined on page 15.

Table 1: Assessment of Risk – Impact

The impact of a risk on the successful achievement of a business objective is measured on a rising scale of 1 to 5, where 1 represents 'insignificant' impact and 5 stands for 'catastrophic' impact. The table below is provided as helpful guidance to illustrate the differing levels of impact a realised risk may have on a number of Departmental criteria. Measurement is generally subjective so, when recording an impact assessment, it is it important to document the assumptions underlying the assessment.

Impact	Non-achievement of key objectives	Reputation/ Publicity	Financial consequence	Litigation
	Anything that poses a threat to the achievement of the department's objectives, programmes or service delivery for citizens	Anything that could damage the reputation of a department or undermine the public's confidence in it	Failure to guard against impropriety, malpractice waste or poor value for money (financial scale indicative only)	Failure to comply with regulations such as those covering health and safety and the environment
1. Insignificant	Minor non-compliance	Within unit Local press <1 day coverage	Negligible financial loss - less than £1,000	Minor out-of-court settlement
2. Minor	Single failure to meet internal standards	Regulator concern Local press <7 day of coverage	Low financial loss - between £1,000 and £9,999	Civil action Improvement notice
3. Moderate	Repeated failures to meet internal standards	National media <3 day coverage Department executive action	Medium financial loss - between £10,000 and £99,999	Class action Criminal prosecution Prohibition Notice
4. Major	Failure to meet national standards	National media >3 day of coverage Questions in the Assembly	High financial loss – between £100,000 and £499,999	Criminal prosecution – no defence
5. Catastrophic	Gross failure to meet professional standards	Full Public Enquiry	Extreme financial loss - £500,000 or more	Executive officer fined or imprisoned

Table 2: Assessment of Risk – Likelihood

The likelihood of a risk occurring is also measured on five-part scale, rising from 1 (rare) to 5 (almost certain to occur). Again, as experience and subjectivity play a large part in this assessment, it is important to document the assumptions underlying the assessment. The table below illustrates the degrees of assessed likelihood.

CODE	DESCRIPTOR	DESCRIPTION
1	Rare	<5% likelihood of impact happening
2	Unlikely	5% to 20% likelihood of occurrence
3	Possible	20% to 50% likelihood of occurrence
4	Likely	50% to 80% likelihood of occurrence
5	Almost Certain	>80% likelihood of occurrence

Table 3: Assessment of Risk – Level of Risk

Level of risk is a product of the values for Impact and Likelihood, and is determined by applying each of these to the matrix below. The three parameters are Low, Medium or High. For example, a risk with a 'Moderate' impact and 'Almost Certain' likelihood would have High level of risk whereas a risk with a 'Moderate' impact and 'Possible' likelihood would constitute a Medium level of risk.

IMPACT	Risk Quantification Matrix				
5 - Catastrophic	Low (5)	Medium (10)	High (15)	High (20)	High (25)
4 – Major	Low (4)	Medium (8)	High (12)	High (16)	High (20)
3 - Moderate	Low (3)	Medium (6)	Medium (9)	High (12)	High (15)
2 – Minor	Low (2)	Low (4)	Medium (6)	Medium (8)	Medium (10)
1 – Insignificant	Low (1)	Low (2)	Low (3)	Low (4)	Low (5)
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
	Likelihood				

Blank Risk Register Template

Risk Register Ref: Description of Risk

1	2	3	4	5	6		7		8	9
Identifier	Risk	Objective(s)	SRO	Risk Appetite	Assessment Residual Risk (Current) Overall Rating 12 (High)		Assessment Treated Risk (Target) Overall Rating 8 (Med)		Action Planned, Target Date & Owner	Actions completed, Completion Date & Owner
					Impact	Likelihood	Impact	Likelihood		
					4	3	4	2		

Risk Register – Key Terms

1	**Identifier:**	Unique identifier assigned to the HSCB Risk
2	**Risk:**	Uncertainty of outcomes of actions or events (may provide positive opportunities or negative threats)
3	**Objective(s):**	Departmental Business Plan Objective(s) that relate to the HSCB Risk
4	**SRO:**	Senior Responsible Officer for the management of the risk and any additional action necessary
5	**Risk Appetite:**	The amount of risk the HSCB is prepared to accept, tolerate or be exposed to in pursuit of its strategic objectives
6	**Residual Risk (Current):**	The level of risk remaining after current internal control actions have been exercised. It should be acceptable and justifiable within the risk appetite
7	**Treated Risk (Target):**	The expected status of the risk after planned actions have been taken
8	**Action Planned, Target Date & Owner:**	Planned enhancements to existing controls to mitigate against risks, date for implementation and Business Area responsible for implementation
9	**Actions Completed, Completion date & Owner**	Completed enhancements to existing controls to mitigate against risks, date implemented and Business Area responsible for implementation

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HUMAN RESOURCES DIRECTORATE

POLICY AND PROCEDURE ON POST ENTRY TRAINING, DEVELOPMENT AND EDUCATION

1. Introduction

The Business Services Organisation wishes to encourage staff to undertake training and educational development which is linked to its overall Vision, Aim and Values, and is directly related to the achievement of its objectives and through performance management appraisals, is relevant to individuals present or immediately foreseeable work responsibilities.

The BSO is committed to the provision of equality of opportunity in training and development regardless of age, religious belief, political opinion, gender or marital status, sexual orientation, race or ethnic origin, disability, domestic responsibility or Trade Union membership.

2. Policy

a) BSO management is expected to provide the necessary support to staff who wish to embark on post entry training and education.

b) BSO management is expected to identify training, development and educational needs of its staff and in such cases, where appropriate, support will be given to staff in respect of finance, time off and mentoring.

c) Staff also have a responsibility to identify on an ongoing basis training, development and educational needs which will enhance effectiveness and improve performance.

d) In cases where staff decide to undertake training or educational development and make application for financial support, time off or mentoring support, such applications will be assessed by BSO management against the following criteria:-

   i. Relevance to the BSO's Aims, Vision and Value;
   ii. In keeping with the management standards which have been identified as appropriate to the BSO;
   iii. Relevance to the individual's present or immediately foreseeable work responsibilities;
   iv. Previous training support given;

v. Ability of the individual to undertake and complete the course of training or study;
vi. The overall cost;
vii. The length of the course of training or study; and
viii. The exigencies of the service.

It should be emphasised that, when evening class courses are available, day release *may* not be approved.

It may be that some or all of the three "supports" viz. finance, time off and mentoring can be made available but this decision is entirely one for BSO management to make. The granting of financial support will not automatically give staff access to time off or mentoring support in any one year. The extent to which the three supports are available in a "package" or separately is entirely a matter for BSO management and will be reassessed each year.

The overall guiding principle governing the provision of support will be the exigencies of the service at time of application**.**

3. Courses/Programmes considered relevant for support

In general, the BSO will provide support to courses which meet the criteria described above but in order to give some guidance on courses likely to meet the criteria the following courses/ programmes will be considered appropriate:-

i. Institute of Health Services Management courses;
ii. Chartered Institute of Personnel and Development courses;
iii. Institute of Chartered Secretaries and Administration courses;
iv. Chartered Institute of Purchasing and Supply course;
v. Chartered Institute of Public Finance and Accountancy courses;
vi. Certificate, Diploma, Degree and Masters programmes provided by the University of Ulster, Open University or Queen's University of Belfast which are H&SS Management orientated;
vii. BTEC National and Higher National Certificates with subjects directly relevant to H&SS management and supervision;
viii. Typing and Computing qualifications appropriate to duties.

This list is not exhaustive. It must be noted that each application for support to undertake post entry training must be judged on its merits and, therefore, while the above guidance is given other courses/programmes are not automatically excluded. The BSO recognises the changing situation in respect of educational methods used and courses/programmes offered and will constantly review the relevance and appropriateness of post entry training available.

4. Procedure

(a) On deciding to pursue a course of study, staff should complete the application for Post Entry Training and discuss the course content with their Director who will, before giving approval, consider the criteria at paragraph 2(d) taking into consideration financial assistance, mentoring support and time off. Any source of study must be relevant to the individuals Personal Development Plan.

(b) If the Director gives approval, completed Post Entry Training application forms together with relevant literature about the course (including a list of modules/subjects to be undertaken) should be forwarded to the Human Resources Directorate before formally confirming whether or not approval has been granted. The Human Resources Directorate will also advise the Finance Directorate where an application has been approved. A record of the approval will also be put on to the HR Information Management System.

Requests for leave and/or expenses should be made at least 4 weeks prior to commencement of each academic year. Continued approval will also depend on standards of attendance and performance. Fees will not be paid in retrospect to any member of staff who has not been given approval either by their Director or the Director of Human Resources.

5. General Provisions

5.1 Reimbursement of Expenses

Employees should pay for the Course they wish to undertake (following approval) and 75% of these expenses will be reimbursed by forwarding your receipts directly to the Human Resources Department, Business Services Organisation, 2 Franklin Street, Belfast (contact telephone number 028 90 535672).

The normal rate of reimbursement is 75% of expenses incurred for –

- Course enrolment fees
- Examination fees
- Text books expenses up to a maximum of £30.00 for each subject

Please note that you ***must*** provide confirmation of which subjects are to be studied each year (via official clarification from the College/University), and when claiming reimbursement for textbook expenses you should stipulate which textbook is being bought for which subject. Every effort should be made to borrow books from libraries or purchase second-hand from other students.

5.1.1 If a member of staff leaves the BSO or fails to complete an approved course of study they will be requested to refund either part or all of the costs of the course of study.

5.1.2 Should the reason for non-completion of a course be related to pregnancy it is not envisaged that there will be a request to repay course fees etc.

5.1.3 There will be no additional payments for subsistence or travel.

5.1.4 It will not be possible for the BSO to fund the costs of production of Dissertation for a Masters degree.

5.2 Membership of Professional Bodies

Membership fees for Professional Bodies (of which membership is imperative to complete the course) shall be granted for the duration of the course only. They will also be reimbursed at a rate of 75%, with the employee paying 25% of the cost of membership fees.

5.3 Time Off/Special Leave

Time off should not exceed the equivalent of one whole working day per week during the period of the course of instruction. Paid leave will be given to attend summer school related to Open University courses conditional upon the course of study being work related. Where leave is granted as block release it should not exceed 65 days in any leave year.

Officers will be granted a half-day's leave on the day of the examination whether the time is outside working hours or not. A day's leave will also be granted per examination for study purposes.

The requesting officer's Director should forward all requests for full-time courses of study and research secondments to the Director of Human Resources.

5.4 Resits

In the event of a member of staff needing to resit an examination, a half-day's leave on the day of the examination will be granted. There will be no reimbursement for the exam fees and no study leave for resits.

6. Monitoring Arrangements

Application of the Policy will be monitored to ensure adherence to the principle of Equality of Opportunity.

Business Services Organisation

Providing Support to Health and Social Care

APPLICATION FOR POST ENTRY TRAINING

ACADEMIC YEAR 2007/2008

TO BE RETURNED BY 18 AUGUST 2007

1. PERSONAL DETAILS

Name:_____

Directorate name and Address: _____

_____

Date Appointed to BSO: _____

Job Title: _____ Grade: _____

Date Appointed to Present Post: _____

2. EDUCATIONAL QUALIFICATIONS

Subject	Level	Grade	Date obtained	Method of study

3. COURSE DETAILS:

Course/Qualification to be attained: _____

_____

College/University etc.: _____

Nature of Study (Please tick):

Day-release	☐	Correspondence	☐
Half-day release	☐	Other	☐
Night Class	☐		

Length of Course (state years/months) _____

Year of study being applied for: _____

Cost/Fees:

	Course Fees	Exam Fees	Other Fees (Please State)
Year 1			
Year 2			
Year 3			
Year 4			

What assistance are you seeking?

Day-release	☐	Financial Assistance Only	☐
Half-day release	☐	Modular release	☐
Night Class	☐		

4. PREVIOUS FINANCIAL ASSISTANCE:

Have you previously received financial assistance by the BSO to attain academic qualifications? (If so please list below)

Course Title	Date of Attendance	Qualification Obtained	Method of Study

5. **TO BE COMPLETED BY APPLICANTS SEEKING APPROVAL FOR 2nd OR SUBSEQUENT YEARS OF COURSE:**

Have you previously applied for Financial Assistance ? Yes/No

Have you received Financial Assistance for all previous years of study ? Yes/No

If No, please state reasons for Financial Assistance being withheld

_____

_____

_____

Have you successfully completed all exams required for continuation of course Yes/No

If No, please state dates of re-sits, or action required for continuation of course:

_____

_____

Have Human Resources been notified of results of exams successfully completed ? Yes/No

If No, please state reasons:

_____

_____

6.

Please state your reasons for undertaking this course and its relevance to the BSO's Mission and Objectives and the relevance to your present and/or future work.

_____

_____

_____

_____

_____

MAHI - STM - 097 - 10679

ACCEPTANCE

I hereby agree to accept the Provisions as laid down in the scheme for Post Entry Training and in consideration of the Financial Assistance granted to me in accordance with the Post Entry Training Guidelines. I agree that if I decide to discontinue my studies during the Academic year that I shall refund to the BSO part or all the Financial Assistance awarded to me.

I confirm that I am not in receipt of any subsistence from an Individual Learning Account grant.

Signed: _____ Date _____

7. **TO BE COMPLETED BY YOUR DIRECTOR**

I **do/do not** approve this application for the following reasons:

_____

_____

_____

_____

Signed: _____ Date: _____

PLEASE CHECK THAT APPLICATION FORM HAS BEEN COMPLETED FULLY AND THAT THERE ARE NO OMISSIONS. COMPLETED APPLICATION FORMS MUST BE RETURNED TO THE HUMAN RESOURCES DIRECTORATE BY 18 AUGUST 2007.

8. FOR HUMAN RESOURCES DIRECTORATE'S USE ONLY

Date Received:
Course Application approved: _____ Yes/No

_____ _____
(Chief Executive) (Human Resources Director)

	Yes	No
Day Release		
Half Day Release		
Financial Assistance		
Applicant Notified		
HRMS Updated		

PERFORMANCE REVIEW

Reporting Period

//**** - **/**/****

Jobholder Name		**Staff Number**	
Job Title		**Appraiser Name**	

Personal Performance Objectives

Objective	Detail
PPO1	
PPO2	
PPO3	
PPO4	
PPO5	

Personal Development Objectives

Objective	Detail	Comments
PDO1		
PDO2		

Agreement of Objective Setting

	Appraiser	Jobholder
Agreed		
Signed		

MID-YEAR REVIEW

Date: **//**** - **/**/****

Appraiser Comments:
Narrative should clearly reflect progress against agreed objectives

Jobholder Comments:
(I agree/disagree with Appraiser's comments)

Appraiser Signature		**Jobholder Signature**	
Date		**Date**	

END-YEAR REVIEW

Date: **//******

Appraiser Comments:
Narrative should clearly reflect progress against agreed objectives

Jobholder Comments:
(I agree/disagree with Appraiser's comments)

Appraiser Signature		**Jobholder Signature**	
Date		**Date**	

Overall Comments

Appraiser Comments :
Narrative should clearly reflect successful achievement of agreed objectives and/ or plans put in place where objectives have not been achieved

Jobholder Comments:
(I agree/disagree with Appraiser's Comments)

Appraiser Signature		**Jobholder Signature**	
Date		**Date**	

FUTURE POTENTIAL/DEVELOPMENT

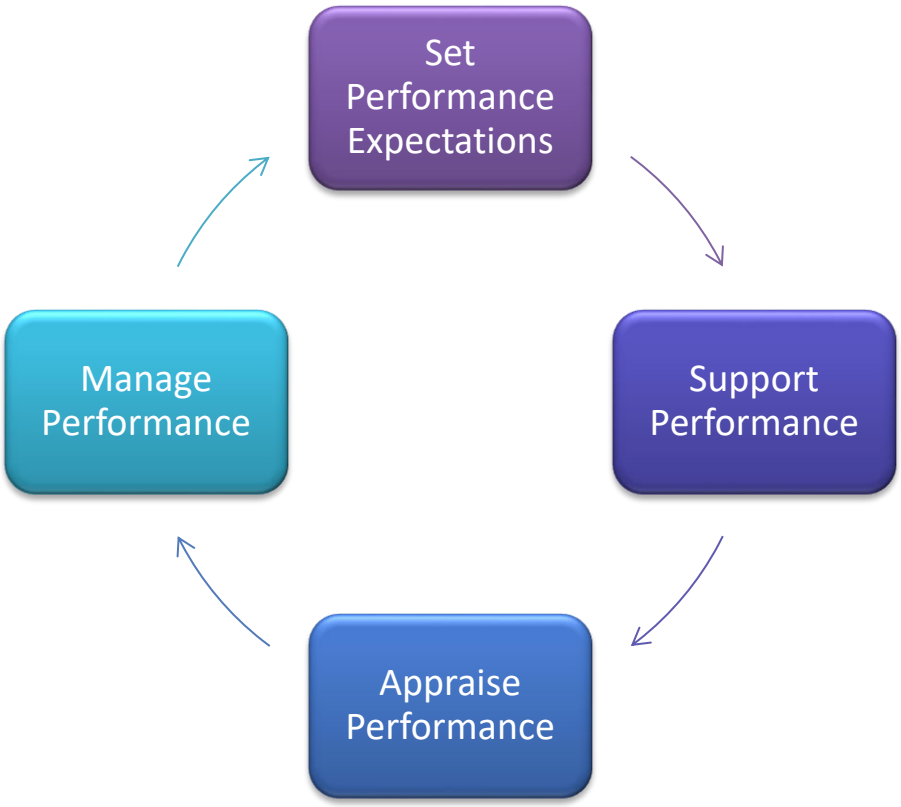
Appraiser Comments:

HSCB Appraisal Guidance Document- Employees 2021

Purpose

The appraisal process is a two-way conversation between managers and team members to:

- Recognise and acknowledge the employee's contribution/achievement.
- Provide constructive feedback and direction on performance.
- Identify individual performance objectives.
- Identify individual development needs and plan how to address them.



It can significantly enhance relationships between individuals and line managers, as well as providing an effective vehicle for objective setting and review.

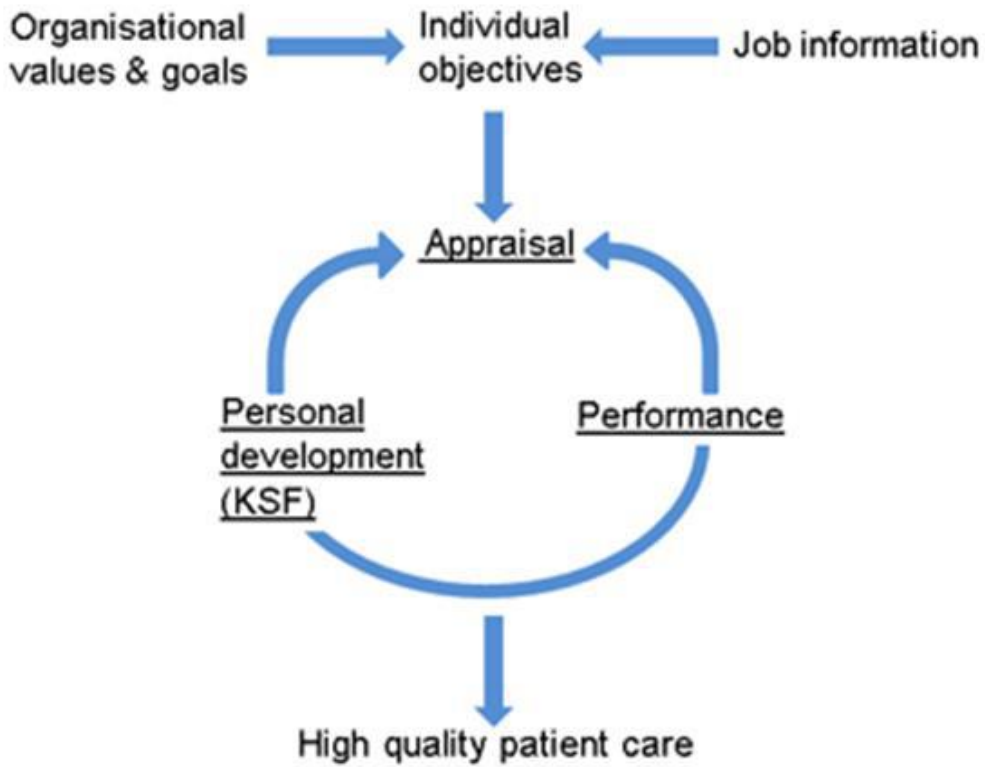
Is not just about assessing the past but also about driving behaviour that will sustain performance in the future. Performance appraisals need a culture of mutual trust and support to be truly effective.

Benefits to the individual:

- Protected time for a one-on-one discussion of important work issues that might not otherwise be addressed.
- Focus on work activities and goals, to identify and correct issues, and to encourage future performance.
- Exclusive, uninterrupted access to their supervisor.
- Recognition for their work efforts leads to enhanced motivation & satisfaction.

Benefits to the Organisation:

- Staff understand the organisations purpose, objectives and goals.
- Staff can appreciate how they contribute to organisational achievement and success.
- Motivated and committed workforce.
- Record of performance and development needs.



This new Appraisal document has two overarching parts;

Employee details
Section 1- Personal Performance Objectives
Section 2- Personal Development Objectives
Sign off.

Employee Guidance

Employee's Role – The employee is obliged to participate in the conversation; to prepare as required beforehand and to sign the completed record once it is agreed.

1. Preparation

Employees are expected to take time to reflect on the last 12 months and think about the 12 months ahead, making some notes to inform the discussion with their line manager.

2. Personal Performance Objectives

Line managers will set objectives with the employee that will align to the team objectives and overall HSCB Corporate Plan. This will make it clear for employees to see how their work contributes to the overall objective of the organisation.

Line managers will discuss with the employee their achievements and successes from the last 12 months and how their work has impacted on the outcomes for the team and wider HSCB.

Any concerns or issues arising from this reflection will be discussed and addressed. Employee behaviours in line with the HSC values (Working Together, Excellence, Openness and Honesty, Compassion) should be reflected on here.

3. Personal Development Objectives

Employees should think about any personal development they wish to avail of over the coming year. There may also be a need for further development after the objectives have been set. Employees should consider various forms of development such as;

- Management Development (e.g. HSC Leadership Centre courses)
- Internal HSCB Courses
- Self-Directed Learning (e.g. Upgrade professional membership)
- Experience at a Higher Level
- Project
- Training Not In Catalogue (New Training Request)
- Physical Demonstration
- Coaching/Mentoring
- Shadowing
- Rotation
- Reflective Practice
- Mandatory Training

It is the employee's responsibility to ensure objectives are met and any training agreed through the Personal Development Plan is completed.

4. Mid-Year and End-Year review

Time should be taken on a regular basis to discuss and review your performance against agreed objectives. Line managers will discuss with the employee their challenges and achievements against objectives to date any agree any changes or supports needed moving forwards.

4. Remote Working Process

Due to COVID-19, social distancing measures must be adhered to. This means the face to face conversation between a manager and staff member needs to be different than what we are used to. If your team has the space to continue the face to face conversation while adhering to the 2 meter social distancing rule they may go ahead as normal. If this isn't the case, appraisal conversations can be carried out using video conferencing software such as Pexip.

Some staff may not have the hardware or software to allow video conferencing to take place. Other traditional forms of communication should be considered such as telephone and email.

5. Ongoing Appraisal

Whilst there is one formal appraisal meeting at the beginning of the year, it is important to remember that your appraisal is a **live document.** There is an expectation that you meet regularly with your manager to discuss progress against your objectives and any support you require.

Manager and staff member to agree a date and time for the initial appraisal meeting. This will also include how the meeting will take place; face to face, video conference etc

Manager to send the paperwork to the staff member and prepare achievements made by the staff member in the previous year.

Staff member to complete personal information and achievements in the previous year. Consideration should also be given to any development needs identified in the previous year's performance.

During the conversation both the staff member and manager will be able to see the partially completed paperwork and work through the document.

Some time should be afforded in reflection to discuss the Health & Wellbeing of the staff member, particularly during the COVID-19.

Objectives for the year ahead to be agreed. These should be in line with team and organisational objectives. The manager should make clear to the employee how their individual objectives impact on the success of the organisation.

Manager and staff member will discuss any further development needs identified in last year's performance and any development needs to help achieve the new objectives.

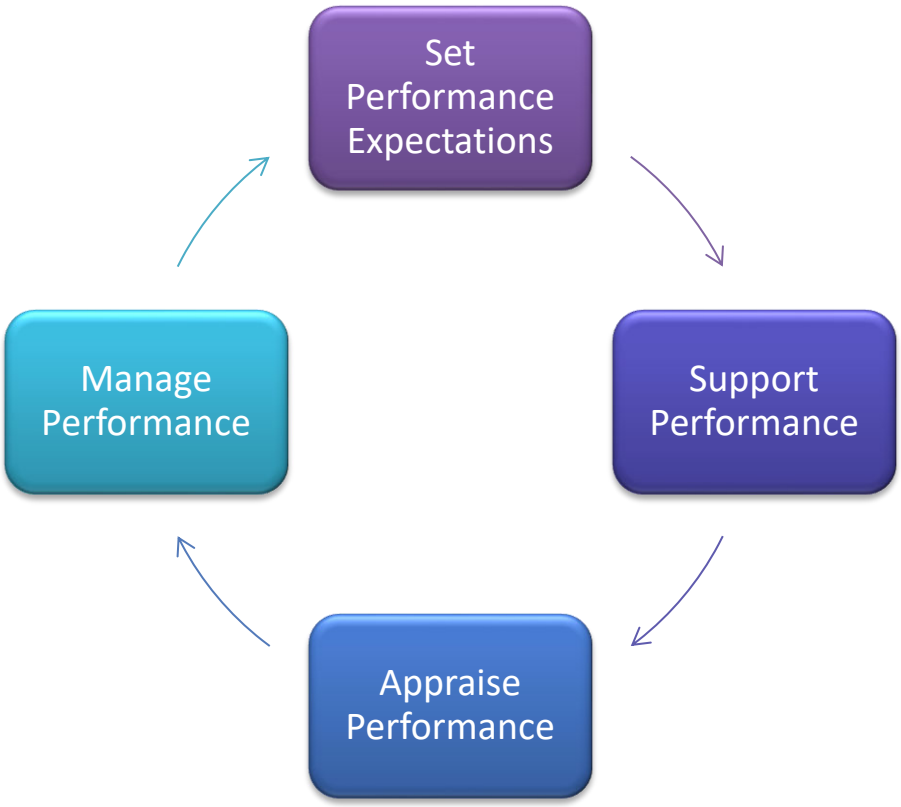
Finally, a review of the staff member's mandatory training. Mangers should ensure all training is up to date.

HSCB Appraisal Guidance Document- Managers 2021

Purpose

The appraisal process is a two-way conversation between managers and team members to:

- Recognise and acknowledge the employee's contribution/achievement.
- Provide constructive feedback and direction on performance.
- Identify individual performance objectives.
- Identify individual development needs and plan how to address them.



It can significantly enhance relationships between individuals and line managers, as well as providing an effective vehicle for objective setting and review.

It is not just about assessing the past but also about driving behaviours that will sustain performance in the future. Performance appraisals need a culture of mutual trust and support to be truly effective.

Benefits to the individual:

- Protected time for a one-on-one discussion of important work issues that might not otherwise be addressed.
- Focus on work activities and goals, to identify and correct issues, and to encourage future performance.
- Exclusive, uninterrupted access to their supervisor.
- Recognition for their work efforts leads to enhanced motivation & satisfaction.

Benefits to the Organisation:

- Staff understand the organisations purpose, objectives and goals.
- Staff can appreciate how they contribute to organisational achievement and success.
- Motivated and committed workforce.
- Record of performance and development needs.

This new Appraisal document has two overarching parts;

Employee details
Section 1- Personal Performance Objectives
Section 2- Personal Development Objectives
Sign off.

Managers Guidance

Manager's Role – The manager arranges the appraisal in terms of tracking the appraisal cycle for each employee; agreeing a convenient date and time for the conversation; organising a suitable venue; providing copies of the paperwork; recording completion; storing records**.** The manager is also responsible for completing the record of the conversation on the day, ensuring that it is sufficient in terms of content and agreed and signed by all participants.

1. Preparation

Managers should arrange a date for employee's appraisal meeting giving enough notice to allow the employee to prepare.

Finalise and confirm arrangements at least 2 weeks before date of conversation sharing the paperwork with the member of staff.

The Manager and member of staff agree preparation requirements:
Preparation demands should be light: i.e. "Think about what you want to talk about" or "Write down a few notes for discussion". Detail will be provided by the conversation which will set objectives for the coming 12 months.

Line managers should think about the team achievements over the past 12 months and how each individual played their part. This individual contribution can be discussed during the review conversation. Managers should also think about the priorities for the year ahead and how they would like each individual to contribute. They should come equipped with various training/development options their staff may wish to avail of as part of their Personal Development Plan. See section 4 for different forms of support.

2. Personal Performance Objectives

Managers should take the lead role in this section. Objectives should link to the Corporate Plan, the employees Job Description, the Business Plan and the employees own Career Aspirations. They should be SMART;

- **S**pecific
- **M**easurable
- **A**chievable
- **R**elevant/realistic
- **T**ime Dependent

Line managers will set objectives with the employee that will align to the team objectives and overall HSCB Corporate Plan. This will make it clear for employees to see how their work contributes to the overall objective of the organisation.

Line managers will discuss with the employee their achievements and successes from the last 12 months and how their work has impacted on the outcomes for the team and wider HSCB.

Any concerns or issues arising from this reflection will be discussed and addressed. Employee behaviours in line with the HSC values (Working Together, Excellence, Openness and Honesty, Compassion) should be reflected on here.

3. Personal Development Objectives

To help employees meet their objectives they may require further development and support. Both the employee and manager should agree the best options available that may help meet these objectives. A plan should be agreed when the employee should complete the training/support options identified with a realistic date of completion.

Forms of support:

- Management Development (e.g. HSC Leadership Centre courses
- Mandatory training – managers must ensure that their employees mandatory training is up to date and recorded. Employees should provide certificates from the e-learning courses that they completed. If not completed, employees should be given a timescale to have these completed.
- Internal HSCB Courses
- Self-Directed Learning (e.g. Upgrade professional membership)
- Experience at a Higher Level
- Project
- Training Not In Catalogue (New Training Request)
- Physical Demonstration
- Coaching/Mentoring
- Shadowing
- Rotation
- Reflective Practice

4. Mid-Year and End-Year review

Time should be taken on a regular basis to review performance against agreed objectives. Line managers will discuss with the employee their challenges and achievements against objectives to date. The narrative should clearly reflect this conversation and any agreed changes or plans put in place to ensure successful achievement of objectives.

5. Remote Working Process

Due to COVID-19, social distancing measures must be adhered to. This means that the face to face conversation between a manager and a staff member needs to be different than what you are used to. If your team has the space to continue the face to face conversation while

adhering to the 2 meter social distancing rule they may go ahead as normal. If this isn't the case, appraisal conversations can be carried out using video conferencing software such as Pexip. Appraisals should not be carried out over the phone as you will not be able to gauge body language or facial expressions.

Some staff may not have the hardware or software to allow video conferencing to take place. Other traditional forms of communication should be considered.

6. Tips for Appraisal

Do's	Don'ts
• Prepare for the meeting • 2 way communication • Reflection and analysis • Analyse performance not personality • Review whole period • Recognise achievement • SMART objectives • End with agreed action plan • Keep it positive • Use constructive feedback	• Store up any performance or attendance issues until the appraisal. These should be dealt with at the time. • Allow it to be a 1 way process • Leave the appraisee feeling disengaged or demotivated by the process • Go overboard on the number of objectives; keep them clear & concise

7. Recording Appraisals

Traditionally managers would open each employee appraisal on HRPTS to record that it has been started, reviewed and completed at the end of the appraisal year.

Feedback from staff and mangers through the regional Staff Survey reports suggested this was time consuming and difficult, particularly if there were structural issues with the organisational structure in the system. An additional issue identified by managers was, if a manager leaves throughout the year, the new manager will not have access to the appraisal information recorded on HRPTS.

To alleviate this piece of work an easier recording mechanism has been developed.

Each Directorate will be given a staff in post report which should be saved in a shared folder. When the initial appraisal conversation happens the manager should open the report and record against that staff member the date of the appraisal. This report should be returned to HSCB Learning & Development who will monitor and address any non-compliance issues. Further details on this process will be shared with representatives on the Organisational Workforce Development group.

8. Ongoing Appraisal

Whilst there is one formal appraisal meeting at the beginning of the year, it is important to remember that appraisals are a **live document** and you should meet regularly with your staff

to discuss their progress against the objectives you have set and any support they may require.

Manager and staff member to agree a date and time for the initial appraisal meeting. This will also include how the meeting will take place; face to face, video conference etc

Manager to send the paperwork to the staff member and prepare achievements made by the staff member in the previous year.

Staff member to complete personal information and achievements in the previous year. Consideration should also be given to any development needs identified in the previous year's performance.

During the conversation both the staff member and manager will be able to see the partially completed paperwork and work through the document.

Some time should be afforded to discuss the Health & Wellbeing of the staff member, particularly during the COVID-19.

Objectives for the year ahead to be agreed. These should be in line with team and organisational objectives. The manager should make clear to the employee how their individual objectives impact on the success of the organisation.

Manager and staff member will discuss any further development needs identified in last year's performance and any development needs to help achieve the new objectives.

Finally, a review of the staff member's mandatory training. Managers should ensure all training is up to date.

Business Services Organisation

INVESTORS IN PEOPLE®
We invest in people Silver

Assistance to Study Policy

December 2022

Policy Development Overview

Title:	Assistance to Study Policy		
Ownership:	Director of Human Resources and Corporate Services		
Equality Screened:	YES	**BSO Policy Sub Group Consulted:**	YES
Approved by:	SMT	**Date Approved:**	18th August 2022
Date Implemented:	November 2022	**Date for Review:**	November 2025
Version No.	1.0	**Supersedes:**	Post Entry Training Policy
Director Responsible:	Director of Human Resources and Corporate Services		
Lead Author:	Eamonn MacManus	**Lead Author Position:**	HR Learning & Development Manager
Department:	Human Resources	**Contact Details:**	BSO.LearningandDevelopment@hscni.net
Key Words:	Learning, Development, Support, Financial Assistance, Study, Exams, Leave		
Links to other Policies, Procedures & Guidance	• Management of Probationary Periods • Leave Pack • Employment Equality of Opportunity		

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1.0 Aim of Policy

The BSO wishes to encourage staff to undertake any training, development and education which is linked to the Strategic Objectives, Mission and Values of the organisation. BSO may offer support by way of finance and/or time off work.
This policy supports the requirement that all BSO staff must have an annual appraisal conversation and Personal Development Plan to identify development needs for which training, developmental and educational activity is required. Furthermore, there is an expectation that all employees should have at least 15 hours training per annum.

2.0 Scope of Policy

This Policy applies to employees of the BSO in relation to training, developmental and educational activity, inclusive of mandatory training.

3.0 Definitions

Training, Development and Education is defined as activity such as corporate mandatory training, an academic course, professional development programme, conference, event, e-learning course, on-the-job training, workshops, webinar or seminar that meets an identified development need.

3.1 Activity

Such activity must be:

- Mandatory: by way of statute, corporate, contract or profession; or
- Professional: substantially linked to the work of the member of staff currently or in the near future; or
- Personal: activity undertaken which will enhance long term career progression and personal growth, and in which Mandatory and Professional activity do not apply; or
- Other: For example, a conference or activity substantially linked to the work of the member of staff currently or in the future.

3.2 Activity Providers

Providers of the above activity include:

- Internal BSO directorates
- HSC Leadership Centre
- HSC Clinical Education Centre
- Other HSC providers
- Other public sector providers
- External providers

3.3 Support Arrangements

Support arrangements may include:

- Payment/Reimbursement in full or part for course or programme fees
- Payment/Reimbursement of expenses incurred
- Time off to attend training
- Time off in lieu
- Coaching/Mentoring

4.0 Responsibilities

4.1 Manager Responsibilities

Managers are expected to provide, when feasible, the necessary support to staff who wish to participate in training, education or development activity.

Managers should use this policy to aid decision making on training and development needs and requests.

Managers are expected to enable staff to identify training, development and educational needs and, where appropriate, when support may be given to staff laid out in Section 5.

Determine appropriate support for staff taking account of the following;

- Relevance to the BSO's Objectives and Values;
- Relevance to the individual's present work responsibilities, near future work responsibilities or current development need;
- Previous training support given;
- Other development needs and requests from other team members;
- Feasibility of the individual's commitment to undertake and complete the course of training or study;
- If a staff member is in a temporary contract which is due to expire;
- Satisfactory probationary period;
- The overall cost;
- The benefits of the training on the individual and team;
- The length of the course of training or study; and
- The needs of the service.

If a manager is unable to facilitate an application in whole or in part, they should explain the reason for their decision in writing at the time.

Where approval is given Management must advise of any liability for non-completion of a course or non-attendance at an event (see Section 11).

Approval to complete additional Professional or Personal Development will only be granted if all Corporate Mandatory Training is up to date.

4.2 Employee Responsibilities

Individual employees have a responsibility to:

Participate and complete all mandatory training.

Identify on an on-going basis training, developmental and educational needs which will enhance individual effectiveness and improve organisational performance.

Seek approval from their line manager for support for training, developmental or educational activity prior to the event/training commencing. Employees should provide their manager with all relevant information in order to make an informed decision on which support, if any, is to be given.

The Assistance to Study Application eForm in Section 16 must be completed, and submitted for each year of study. This form will be saved on the employee's personal file and on a HR Learning & Development database.

Requests for leave and/or expenses should normally be made at least 4 weeks prior to commencement of each academic year or event.

Understand and settle any liability for not fulfilling requirements under this policy non-completion of a course or non-attendance at an event (see Section 11).

5.0 Overview of Eligible Support for Training, Education and Development Events and Courses

All support outlined in Section 3 above is at the discretion of the line manager and budget holder if necessary. Support will be awarded subject to the criteria laid out in Section 4.1. The support mechanisms below are not entitlements and are subject to adjustment depending on the nature of the request.

Type of Development	Funding for course fees, registrations, conference fees & exam fees	Working Time off to attend (if within working pattern)	Costs for resources required e.g. books* *See section 7(b)*	Expenses: Mileage and subsistence (need to be receipted)	Time off work: study leave for exam	Time off work: for sitting exam	Time off in lieu (if outside working pattern)
Mandatory	100%	100% Paid time to attend	All costs covered	100% mileage and subsistence rates	1-day study leave	0.5 day for exam	Yes
Professional (and work related; PG training)	Up to a maximum of 75%	100% Paid time to attend	All costs covered	100% mileage and subsistence rates	1-day study leave	0.5 day for exam	N/A
Personal (development)	Up to a maximum of 50%	50% Paid time to attend. Other 50% will be annual or unpaid leave	50% of cost up to a maximum of £100 per annum	50% mileage and subsistence rates	Annual Leave	Annual Leave	N/A
Conferences	100%	100% Paid time to attend	Not applicable (unless they are presenting)	100% mileage and subsistence rates	N/A	N/A	N/A
Other: HSC Courses (e.g. Leadership Centre)	100%	100% Paid time to attend	Not applicable (unless they are presenting)	100% mileage and subsistence rates	N/A	N/A	N/A

Other: work-related Seminars/webinars	100%	100% Paid time to attend	Not applicable (unless they are presenting)	100% mileage and subsistence rates if necessary.	N/A	N/A	N/A

6.0 Time off Work, Time off in Lieu, Study Leave & Exam Leave

There are four types of leave applicable under this policy:

- Time Off with pay
- Time Off in lieu
- Exam Leave
- Study Leave

Time off for academic or educational courses or programmes will not exceed the equivalent of one whole working day per week during the period of study.

Attendance at taught courses outside of normal working hours may not attract time off in lieu, overtime or other financial reimbursement **unless attendance comes under "mandatory" activity.** Staff cannot avail of time off in lieu for such courses.

Self-directed studying outside of normal working hours does not count as working time, and thus does not attract time off in lieu, overtime or other financial reimbursement.

Exam Leave must be taken only for a half-day in which the exam is to be taken.

Study Leave should be granted for a full day prior to the day of an exam. One study day will be allowed per exam day.

No Study Leave is eligible for resit exams.

Where a course has no sit-in exams, time off or study leave is eligible for work on written assignments. This would be 1.5 days of study leave per assessment. (Equivalent to one study and half day exam leave for exam-based courses). Note; this is only for courses with no sit in exams or where, for example, a dissertation is in place of an exam. Study leave for regular assignments will not be granted.

7.0 Reimbursement of Expenses

The normal rate of reimbursement is (a maximum of) 75% of expenses incurred for:

- Course enrolment fees
- Examination fees

With increasing cost of resources, particularly text books, BSO can purchase necessary books on behalf of the staff member. These books will belong to the organisation and must be returned to an identified person to be re-used by future staff members undertaking similar studies.

If books are not returned or returned in poor condition, the staff member will be expected to pay for a replacement(s).

BSO HR is recommending local “text book libraries” to encourage others to pursue development while keeping these costs to a minimum. The previously bought text books will be reused.

Cost of resit examinations will not be reimbursed.

It will not be possible for the BSO to fund the costs of production of a Dissertation for a Master’s degree.

Travel expenses will be paid at public transport rate. Staff members can claim for car-parking fees on submission of receipt.

Expenses/Fees **will not** be paid in retrospect to any member of staff who has not been given prior approval for attendance.

8.0 Membership of Professional Bodies

Membership fees for professional bodies will not be paid by BSO, subject to the exceptions below:

- Where it is a consolidated part of the course fee and it will be for the duration of the course full membership fees will be paid. On completion of the course, professional membership fees should be paid by the member directly.

9.0 Resits

In the event of a member of staff needing to resit an examination, a half-day’s exam leave on the day of the examination will be granted. There will be no reimbursement for the exam fees and no study leave for resits.

10.0 Courses/Programmes considered relevant for Support

In general, the BSO will provide support under “Professional” and “Personal” to courses which meet the consideration highlighted earlier and lead to an award/accreditation. In order to give some guidance on courses likely to meet the criteria the following courses/ programmes will be considered appropriate, although this is not an exhaustive list:

- Institute of Healthcare Management courses;
- Chartered Institute of Personnel and Development courses;
- Institute of Chartered Secretaries and Administration courses;
- Chartered Institute of Management Accountants
- Chartered Institute of Purchasing and Supply course;
- Chartered Institute of Public Finance and Accountancy courses;
- Certificate, Diploma, Degree and Masters programmes provided by the University of Ulster, Open University or Queen’s University of Belfast which are

H&SC Management orientated;
- BTEC National and Higher National Certificates with subjects directly relevant to H&SC management and supervision;
- Recognised Trade Union developmental activity pursuant to Part 4 of Agenda for Change terms and conditions handbook.
- Nursing, Midwifery and Allied Health Professional qualifications

The BSO recognises the changing situation in respect of educational methods used and courses/programmes offered and will constantly review the relevance and appropriateness of training, education and development available.

11.0 Liability of Staff for Non-Completion of a Course / Non-Attendance at an Event

Staff members will be required to pay back all course, registration, conference fees and resource costs for non-mandatory training, education and development if they:

- fail to complete all or part of the course;
- fail to attend a scheduled conference/event;
- leave the HSC within two years of completing a training or academic course;
- leave the HSC prior to completing the course.

Staff members may be liable for the cost of paid leave taken should they fail to attend a scheduled conference/event and do not attend work.

Managers must:

- Ensure staff are aware of this section of the Policy as appropriate
- Contact Income Shared Service Centre to arrange an invoice or other method for remittance so that any liabilities can be settled.

Staff or former staff must ensure that all liabilities are settled under this section, prior to their leaving.

Liability may not normally apply in the case of:

- Death
- Pregnancy
- Sickness absence
- Bereavement
- Reasons related to disability
- Redundancy
- Retirement
- Unforeseeable circumstances relating to caring or domestic responsibilities
- Significant personal/business reason

11.1 Liability for Reimbursement

If an employee voluntarily resigns from their employment with the Organisation prior to receiving successful exam results for the current academic year, the Organisation must be reimbursed 100% of current year fees paid for by the Organisation from the start date of the course that year.

If an employee voluntarily resigns from their employment with the Organisation **within one year** of receiving financial assistance, the Organisation must be reimbursed 75% of total fees for the last year of the course.

If an employee voluntarily resigns from their employment with the Organisation **within two years** of receiving financial assistance, the Organisation must be reimbursed 50% of total fees for the last year of the course.

In such cases responsibility for recouping this money is with Line Manager. The manager should contact the Income Shared Service Centre to discuss reimbursement options.

For staff transferring to another NHS, Health and Social Care Organisation, or other public or voluntary body, the BSO will not seek reimbursement. This does not include recruitment agencies.

Where a directorate provides a specialist function, unique to the organisation and is not delivered by any other HSC Organisation, the BSO will seek reimbursement for any funded training or development as per above. Examples of this may be Procurement and Logistics and Legal Services.

12.0 Procedure for applying for Training, Education and Development

Before Applying

- Check that the course of study is included Personal Development Plan or will meet a development need.
- Source costs of course and associated costs (e.g. travel)
- Line manager discuss application with the employee. The line manager should forward all requests for external courses of study and research secondments to their Director and accountant to ensure there is budget available.
- All other Mandtory Training must be completed and up to date before applying for further Personal/Professional development.
- Employees must have successfully completed their Probationary Period before applying for further Personal/Professional development.

Application & Booking

- For internal courses' booking contact bso.learninganddevelopment@hscni.net to secure a place. There is no need to apply/book via HRPTS.
- For HSC Leadership Centre/Clinical Education Centre courses are applied through their relevant booking platform. Please ensure funding is agreed before applying. There is no need to apply/book via HRPTS. For some courses, BSO HR Learning & Development may have an active waiting list.
- For external courses' please complete the eForm in Section 16 - Assistance to Study Application – BSO Human Resources & Corporate Services Online Forms (hscni.net)
- Courses with a cost associated should get line manager & budget holder consent before applying to the course/event
- If required by external provider, a letter advising the financial support arrangements will be provided for each year of study by HR
- Any leave (e.g. exam, study) should be requested via HRPTS

Make Arrangements for External Providers

- Raise a requisition where applicable (with e-proc)
- Invoices paid (with FPM)
- Book external course as required by provider
- Book travel/accomodation if required

13.0 Claiming Reimbursement of Expenses

Reimbursement of expenses - please see the " ESS How to Guide" - How to create an expense claim.

For textbooks, staff must provide confirmation of which subjects are to be studied each year via official clarification from the College/University, to enable BSO to purchase the appropriate textbooks.

14.0 Booking Travel Abroad/Outside of Ireland

Employees are encouraged to use virtual tools where possible to avoid travel costs.

Employees should note that booking travel arrangements, e.g. flights, transfers etc., should be done through a procured agent, whom the organisation uses. This includes flights from Northern Ireland to United Kingdom.

All travel must:

- be fully justified in terms of making an important contribution to the business needs of the organisation;
- represent value for money, taking account also of the cost of time spent away from the workplace, and
- not give grounds for public criticism.

15.0 Assistance to Study Application

This form must be completed when an employee is applying for training/development provided by a non-HSC provider and where there is a cost associated.

This form can also be used to record other training/development attended by staff where there is no cost associated but they would like to have it recorded against their HR Training record.

Assistance to Study Application – BSO Human Resources & Corporate Services Online Forms (hscni.net)

16.0 Monitoring and Reviewing the Policy

It will be the responsibility of the nominated Director to ensure the Policy is implemented. This policy shall be reviewed:

- Every 3 years or;
- Following receipt of new information;
- Upon implementation of new agreements which may affect the Policy

17.0 Equality & Human Rights

The Policy has been screened for equality implications as expected by Section 75 and Schedule 9 of the Northern Ireland Act 1998. Equality Commission guidance declares that the aim of screening is to recognise those policies which are likely to have a significant influence on equality of opportunity so that greatest resources can be dedicated to these.

Using the Equality Commission's screening standards; no significant equality implications have been recognised. The policy will therefore not be subject to an equality impact assessment. The screening can be found here.

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

The BSO is committed to the provision of equality of opportunity in training and development regardless of age, religious belief, political opinion, gender or marital status, sexual orientation, race or ethnic origin, disability, domestic responsibility or Trade Union membership.

Business Services Organisation

Assistance to Study Policy 2022

HEALTH & SOCIAL CARE BOARD

MAHI - STM - 097 - 10711

ORGANISATION & WORKFORCE DEVELOPMENT STEERING GROUP

1. Membership of the Steering Group

Membership of the Steering Group should include the following:

- Assistant Director HR, Organisation & Workforce Development, BSO
- Assistant Directors HSCB
- Deputy Head of HSC Leadership Centre
- Communications Representative

Job title	Member
Business Support Manager – Intergrated care	Raymond Curran
ICT Design & Programme Control Manager (eHealth)	Mark Eustace
Commissioning	Rodger Kennedy
PMSI	Stephen McDowell
Corporate Services	Ken Moore
Assistant Director, HR - BSO	Paula Smyth
Finance	Colin Bradley
Communications	Philip Moore

2. Terms of Reference

The primary role of the HSCB Organisation and Workforce Development Steering Group is to inform, manage, co-ordinate and share, learning and development activities across the HSCB, to ensure that all staff are equipped with the necessary skills to enable them to deliver fully to the business needs of the organisation.

1. To provide an opportunity for the representatives to share information regarding progress of learning and development initiatives across the HSCB on a regular basis;
2. To provide an opportunity for the representatives to discuss issues of common interest on a secure and confidential basis;
3. To enable the representatives to commission, review and evaluate where appropriate, learning and development initiatives to ensure high quality, value for money and cost effective interventions;
4. To liaise with external agencies involved in the development of HSCB staff, including Trade Unions, education providers and regulatory bodies;
5. To identify current resources for the organisation and/or workforce development initiatives and where funding is required, prioritise and bring to the attention of SMT
6. To provide an opportunity to share best practice in terms of learning and development across the HSCB;
7. To support the principles of Investors in People (IiP) standards in order to promote a culture of continuous improvement and development and to act as Project Board for IiP implementation within the HSCB.
8. To provide opportunities for continuing Personal Development for staff involved in Learning and Development.

MAHI - STM - 097 - 10712

From: Diane Taylor

20 December 2021

Paula Smyth

Input to SPPG response

1. The purpose of this note is to outline the policies and procedures that provide the governance for the provision of education and training to SPPG staff. By way of context, management and leadership development has been offered and provided to legacy HSSB staff from 1994 by the then Provider Support Unit. From 2004, this unit became known as The Beeches and incorporated nursing, midwifery and AHP training. The HSC Leadership Centre was established in 2011 when it became a unit of the Business Services Organisation. From 2009, the newly formed Health and Social Care Board continued the legacy arrangements by purchasing services from the Leadership Centre through a Service Level Agreement. SPPG continues to buy services and currently spends £194k per annum on leadership and management development.

2. The HSC Leadership Centre is a shared service. It sells its services to client organisations across the HSC, providing leadership development, management training programmes, consultancy and digital training. It has Service Level Agreements in place with all HSC organisations, SPPG in the Department and the NI Fire and Rescue Service.

3. The HSC Leadership Centre aligns with BSO Corporate Objectives but also takes its strategic direction from the Leadership and Education Council, which comprises representatives of HSC organisations including CEXs, HR Directors and Directors of Nursing – SPPG has a CEX seat Council. The Council articulates the leadership and management needs of the workforce in order to meet organisational objectives and Departmental strategies.

4. All education, development and training provided by the HSC Leadership Centre aligns with Departmental strategies. It does not set its own policies. In recent years the strategies which have informed the work of the Centre are:

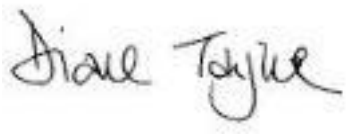
    - ***Employer of Choice (workforce strategy) 2003***
    - ***Quality 2020 (2011)***
    - ***Transforming Your Care 2013***

- ***Collective Leadership Strategy 2017***
- ***Co-Production Guide for Northern Ireland, "Connecting and Realising Value Through People"***
- ***Health and Well Being: Delivering Together 2026***
- ***Health and Social Care Workforce Strategy 2026***
- ***Health and Social Care Workforce Strategy: Second Action Plan 22/23 to 24/25***
- ***Ambition People Strategy 2021***

5. In relation to SPPG and legacy HSCB staff, the programmes and development offered by the Centre were open to senior staff and legacy HSCB and SPPG policies would have determined individual staff eligibility for programmes. SPPG (and HSCB staff) would have participated in development programmes with a regional dimension as well as in-house bespoke SPPG/HSCB programmes.

6. From 2021, SPPG has introduced a robust commissioning process with the HSC Leadership Centre, aligning its workforce development with its Ambition People Strategy.

7. I trust this helps clarify the position regarding policies and procedures in place relating to education, training and developing for SPPG (and the wider service).



Diane Taylor

Department of Health, Social Services and Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

The Employer of Choice:

Caring for Staff

Caring for Service Users

A strategy for managing and developing people in the Health and Personal Social Services

Consultative Paper – August 2001

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Annex 1 Steering Group Members

PURPOSE OF THE HUMAN RESOURCES STRATEGY

Why do we need a HR Strategy for the HPSS?

The Executive Committee of the Assembly has published its Programme for Government which sets out its priorities for tackling problems and improving public services over the next few years. This Programme was issued for public consultation and contains plans for improving the health and well being of the population and seeks to adopt a "joined up" approach across Departments.

The Programme emphasises its commitment to modernise and improve hospital and primary care services in the HPSS. The driving force of the new HPSS is quality.

For nearly thirty years, we have had integrated Health and Personal Social Services. During this period staff working in the HPSS have served with dedication, professionalism and fairness, often through difficult times. There is no doubt that the HPSS has a history to be proud of.

Throughout its existence, the HPSS has been subject to constant change and rising demands. Today there are increasing pressures for change as a result of demographic factors, clinical and technological advancements, economic constraints and the rise in public expectations. An effective HPSS Human Resources Strategy is central to the delivery of a modern, responsive, person centred HPSS.

How was the HR Strategy for the HPSS developed?

In November 1998 the Minister for Health and Social Services acknowledged that high quality services will only be delivered by staff who are well trained, well motivated and supported by their employer. He stated that a service-wide strategic framework of people management would be required, underpinned by a human resource strategy for the HPSS. The HSS Executive recognised that a Human Resources Strategy for the HPSS would be more meaningful if it was developed in partnership with staff and their representatives. As a first step a 'listening exercise' was undertaken throughout the HPSS in an attempt to identify and understand the major issues that provide the context for the human resources strategy. The results of the exercise were published in July 1999.

The next step in the process involved the establishment of the Human Resource Strategy Steering Group. The Group was convened in September 1999 and

included representatives from both management and staff side. A list of Steering Group members is attached in Annex 1.

The Group worked in partnership **"to develop a comprehensive Human Resources Strategy aimed at delivering a better, fairer workplace for staff, and thereby deliver benefits for service users."** This document represents a culmination of their work.

What's in it for me?

The Steering Group in undertaking the work was mindful that HPSS staff have experienced constant change over many years. It recognised that staff have been coping with increased workloads and ever increasing public expectation and scrutiny. Staff agendas are full. For this reason the Steering Group proceeded cautiously in an effort to ensure that the HR Strategy for the HPSS would strike a chord with every person working in the service.

This strategy has been developed to bring tangible, long term, demonstrable benefits to the HPSS workforce and ultimately to the people who use our services. The Steering Group believes that the full benefits of the Human Resource Strategy will only be realised if staff in the service are fully engaged to shape and influence the implementation and evaluation of the strategy. The group believes that we will achieve the best results if we work in partnership to decide the way forward.

Our Shared Agenda

A modernised Service is the future. It is imperative that the staff who work in the HPSS are able to make the best possible contribution, individually and collectively, to improving health and patient care. This strategy is based on the concept of partnership. Working together to create a responsive, skilled HPSS with a shared vision of improving the quality of service for those who receive treatment and care from health and social services providers.

Throughout the listening exercise strong recurrent messages can be found which confirm that staff want to be involved in all decisions that affect them: from big decisions on organisational change to the day to day decisions on how services are delivered. We need effective partnership, good communications and, above all, real teamwork. Staff recognise that they will need to be more flexible within the workplace to meet the challenge of necessary organisational changes. They in turn will need to be supported by improved employment practices, which will provide them with opportunities to adapt and learn new skills and which give reassurances on the security of their employment. It is important that staff enjoy a working environment where they are treated fairly and with respect and where all parts of the organisation work together, cutting across traditional functional boundaries.

The Steering Group believes that the HR Strategy for the HPSS will support the realisation of a modernised HPSS, delivering results for both staff and patients. No one however, should doubt the size of the task. We need to ensure that we find ways to move forward together. We must work together to both identify and meet the challenges ahead.

Making it real

The HPSS wants to become the employer of choice. If we are to improve the services we provide to service users, the HPSS needs to attract, retain and develop the best staff. We need to create the conditions within which staff can give of their best. This strategy deals with issues traditionally associated with human resources such as workforce planning; education and training; employee relations; equality and fairness and improving working lives. It is however equally important that we record the wider set of core values and beliefs which were used to inform the strategy, and which the Steering Group believes should underpin the way we do business throughout the HPSS.

As part of the listening exercise staff identified a range of values and principles that they felt should underpin the treatment of staff working in the HPSS. Staff said that there was a need throughout the HPSS to:

- recognise and appreciate the contribution of each individual staff member;
- treat others as we expect to be treated ourselves;
- make sure everybody is treated fairly with equal opportunities for all;
- be open and honest with each other;
- build high levels of trust between everybody, at all levels of the organisation;
- be flexible with staff and encourage them to be flexible.

A White Paper "Agenda for Change – Modernising the NHS Pay System" was published containing outline proposals which provide a blueprint for a new NHS pay system covering all of Great Britain and Northern Ireland. Detailed consideration is being undertaken on a partnership basis involving the major trades unions representing staff and the four territorial Health departments. Staff employed in the HPSS are linked for pay and conditions of service purposes to the pay and conditions of similar staff in the NHS, and it will be a matter for the Minister for Health, Social Services and Public Safety, in conjunction with the Assembly and the Executive Committee, to decide on local issues surrounding implementation.

The new system for the HPSS will be based on principles of efficiency, fairness, flexibility and partnership. This will give better career progression and modern conditions of service. A national job evaluation scheme is being developed for assessing all NHS and HPSS jobs and will be used to place grades on common pay spines.

When the complete package is finalised it will be for the Assembly to decide the extent of the link between the NHS framework and the local flexibility required to meet the needs of the health and personal social services.

Creating the environment, which encourages, supports and sustains change will be the challenge for the future of the HPSS. The Steering Group believes that giving life to the HR Strategy will support the creation of this environment.

Conclusions

The Steering group considered that, in order to achieve the strategic human resources agenda, the principal areas to addressed are

- Workforce Planning
- Recruitment, Retention and Return
- Improving Working Lives
- Equality and Fairness
- Education and Training
- Industrial Relations

Section 1

Workforce Planning

1.1 Workforce Planning is about seeking to predict the future demands for different types of staff and seeking to match this with supply. Its fundamental purpose is to ensure that there are sufficient staff available with the right skills to deliver high quality care to service users. Workforce Planning supports the development of a workforce which is flexible and responsive and which supports change in service delivery.

1.2 Prediction of future needs has always been difficult. It is further complicated by the need to have some slack in the system to take account of the increasing numbers of staff who need to take time out or who wish to work flexibly. Effective workforce planning must balance the training needs of staff with the demands of the service they work in; it is an exceptionally complex task. It is complex because of the number of professional groups involved, the long lead-times for training, the pace of change within the HPSS and the range of areas across the HPSS whose requirements for staff need to be taken into account.

Challenge

1.3 One of the biggest problems facing the HPSS has been our inability to carry out effective Workforce Planning. This has resulted in shortages of staff within the HPSS, excessive and inefficient use of temporary contracts across a wide range of disciplines and an over reliance on agency staff. Shortages of staff relate not only to numbers but also to an overall skill deficit in the workforce. These problems cannot be resolved by simply pledging to create more jobs. As it is often staff with specific skills and competencies that are needed, not just extra pairs of hands, additional staff may not necessarily be in the right place or have the right skills to contribute immediately to the HPSS.

1.4 While there are immediate concerns about staff shortages, focusing too narrowly on short term needs will not be enough to improve workforce planning. We need to develop our capacity to assess demand and to understand how to link workforce planning to planning for other purposes. In looking at the current arrangements for workforce planning there are separate systems that cover the various sectors, employers and staff groups within the HPSS. This has resulted in fragmentation of planning to the extent that plans for service improvements have in the past been thwarted because due consideration has not been given to the recruitment or deployment of staff needed to provide the service.

Meeting the Challenge

Key Priorities: -

To carry out a full review of the workforce planning arrangements for all groups within HPSS.
To develop a more holistic approach to workforce planning.
To continue to develop team working across professional and organisational boundaries.

Reviewing Arrangements

1.5 Traditional workforce planning arrangements have focused on staff as the providers of services. The vision for a modern HPSS is one that delivers care to people in a way that is sensitive to their needs and expectations. We need to ensure therefore, that workforce planning is an activity carried out to support the care of people and not for its own sake. This will require a shift in emphasis to ensure the needs of the service users are the focus of workforce planning arrangements. This should help us to ensure that we have the staff we need to deliver the service the users need.

A More Holistic Approach

1.6 There are currently separate systems for workforce planning across the range of professional and non-professional groups within HPSS. This has led to very different approaches to planning and poor integration between groups. Workforce plans need to be developed on a multidisciplinary basis. We need therefore to establish a simple common language for workforce planning. We need to jointly develop positive, forward thinking models for workforce planning that can be applied and understood throughout the service. This will require the development of a two-way process that allows workforce planning to be both "bottom up" and "top down", ensuring that it will be strategically led but informed by operational issues. Resources will need to be made available to enable the new planning models to be used effectively, this will in particular mean establishing an appropriate skill base, and the development of appropriate information systems. We must also ensure that all strategic/policy discussions and all business plans identify the impact of service developments on the workforce. There is a vital role for both commissioners and providers to jointly explore the staffing implications of any service development proposals to ensure they identify and provide the appropriate human resources.

Team Working

1.7 To make sure we have the staff we need to deliver a high quality, person focused service we need to examine how staff should work together to deliver that service. We need to look at the workforce in a different way – as teams of people rather than as separate disciplines. We will need to develop flexible systems that will help with the inevitable peaks and troughs in the supply and demand for different skills. This will inevitably change the way staff are used, will drive change in the skills they require and will require improvements to be made in the way training and education is provided. Effective workforce planning is inextricably linked to the education and training of staff. It is therefore critically important that the needs of service users care drive the education and training agenda (see para. 5.5).

Working Group

1.8 Effective workforce planning has a central part to play in establishing a successful Human Resource strategy. It is essential therefore that a working group, combining expertise from management and staff representatives is set up to explore this issue in detail. The working group will be required to review existing arrangements and recommend a process to enable workforce planning to be implemented effectively. The working group will report on the training requirements identified in the area of workforce planning, establish the basic information requirements for an effective workforce planning model and research methods to ensure the Human Resource implications of all policy decisions are taken into account.

Strategic Issues: -

Establish a joint working group to be charged with assessing workforce planning issues, recommending best practice and developing effective structures for integrated workforce planning.
Review approach to workforce planning to ensure it is driven by the needs of service users.
Develop a workforce planning model that will ensure plans concerning services, workforce and resources are made jointly, are consistent and are well co-ordinated.
Assess and provide the resources required to implement new planning model.
Develop team working to provide for more flexible deployment of staff and maximise the use of skills and abilities.
Improve education and training to ensure staff are equipped with the skills and knowledge they need to work in a complex, changing HPSS.
Expand the workforce to meet future demands.

SECTION 2

Recruitment, Retention and Return

2.1 The HPSS depends upon the skills and knowledge of staff and the availability of suitably qualified people to match the increasing demands placed on it. As services expand the demand for skilled staff rises and there is an ever increasing need for the HPSS to:

- **Recruit** – attract more people into the HPSS,
- **Retain** - encourage more staff to stay in the HPSS, for longer,
- **Return** - make it easier and more attractive for staff to return.

2.2 The cost to the organisation in not having the right staff in the right places, doing the right things in the right way is very substantial. There is lost investment in training when qualified people subsequently spend much of their working lives outside the HPSS. Loss of staff from the service also generates costs in recruitment and the expense of bridging gaps in staffing. Sickness levels too, are influenced by the conditions of work and the low morale generated when staffing levels are inadequate. If the experience of people working in healthcare is negative, then this is picked up by family, friends and by the media in general. People make career choices based on what they see and hear and on the views expressed around them. Negative work experiences passed on in these ways will make future recruitment more difficult and more expensive.

Challenge

2.3 There are national shortages of some skilled staff in healthcare, which has been widely acknowledged across a range of specialities. The HPSS has found it increasingly difficult to recruit staff with the right skills and experience. The resulting shortages have been compounded by high staff turnover, the inappropriate use of fixed term and temporary contracts, reliance on agency staff and increases in sickness absence. As well as placing a financial burden on the service, this self-perpetuating situation places a burden on the staff who are in work. Problems with the current grading systems and with career progression within the HPSS add to the frustrations and can leave some staff disillusioned. The outcomes are a reduction in applicants to and trainees within the HPSS and staff already in the organisation become dissatisfied with the pressures of work, which in turn creates low morale.

2.4 Demand for professional staff outside the HPSS is growing. Areas such as expanding private sectors and foreign and national heath care providers

have launched aggressive recruitment campaigns which target current and potential HPSS staff. As the HPSS reshapes itself to meet the needs of its service users it will need the best (most appropriate) staff in practice at all levels. We need staff who are looking for new positions to choose the HPSS and, to influence their decisions, we need the HPSS to have a good public image.

Meeting the Challenge

2.5. Key Priorities: -

To attract more people into the HPSS;
To encourage staff to stay in the HPSS, for longer;
To make it easier and more attractive for staff to return.

Recruit

2.6 The HPSS needs to develop an effective recruitment policy to attract the best applicants to new posts. This will inevitably involve the promotion of the HPSS as a developing, "people-friendly" organisation. Employee friendly policies provide staff with more flexibility to balance work and other responsibilities. As one of the largest employers here we have a responsibility not only to match the standards of other organisations, but also to set the pace of employment practice. There continue to be specific needs in relation to employment practice for sections of our workforce that must be addressed. These include hours of work, conditions, quality of training, career progression and flexible work patterns. We need to end the inappropriate use of fixed term and temporary contracts and to address our reliance on agency staff. In doing so we need to develop and promote best recruitment practices throughout the HPSS.

Retain

2.7 Healthcare is a 24-hour, 7 days a week activity. Providing these services should not mean asking staff to work hours which make their lives away from work more difficult. Rather, the delivery of such services should be seen as an opportunity to develop innovative working patterns to match the needs of users with the preferences of staff. By definition, supportive and employee friendly ways of working cannot be imposed. They are developed by asking, not telling. The examples of most successful practice occur where staff are allowed to be involved in making decisions affecting their own working lives. We need to examine the conditions under which staff work, to promote the physical health, mental health and well being of staff at all times and to examine how the conditions of work and morale influence sickness levels in the HPSS. Helping staff to combine work with the commitments they have outside the world of work can reduce absenteeism and help encourage trained and skilled staff to remain within the HPSS.

Return

2.8 The pool of trained and qualified staff who are not working in the HPSS is a major potential resource. Typically these are people who left to raise a family or care for a relative. They may also include some who became dissatisfied with the pressure of full time work, suffered illness or injury, or simply wanted to follow other ambitions. Given the right circumstances and support, many may want to return. To make it easier the main barriers to return need to be addressed. These are likely to be; loss of confidence in clinical competence, where an individual feels their skills have lapsed or are outdated; unsuitability of existing work patterns, where inflexible hours conflict with other commitments; no awareness of return to work opportunities within the HPSS. To address these issues the HPSS will need to develop a considered and co-ordinated set of training options for returning staff, commit to family friendly and flexible ways of working and publicise return to work opportunities through advertising and PR campaigns.

Strategic Issues:

Develop effective recruitment policies to attract the best applicants to the HPSS.
Promote uniformity in recruitment practices throughout the HPSS.
Improve employment practice within HPSS by addressing specific areas of need e.g. hours of work, conditions, quality of training, career progression, flexible working patterns.
Review the use of temporary and fixed term contracts and agency staff to allow for their use in limited and specific circumstances only.
Protect and promote the health and well being of staff within the workplace
Seek to develop effective "Managing Attendance" and "Managing Absence" programmes.
Develop a successful "return to work" initiative, which will aim to overcome the obstacles that exist for trained and qualified staff not currently working in the HPSS.

SECTION 3

Improving Working Lives

3.1 We have determined that to promote the HPSS as a developing, "people-friendly" organisation the experience of the people who work in the organisation must be positive. The quality of care provided to service users, their families and carers goes hand in hand with the quality of the working lives we provide for everyone who works in the HPSS. To improve the working lives of our staff we need to transform working and training practices and sustain a healthy balance between work and our lives outside it.

3.2 A modern HPSS requires modern employment practices. It is well documented nowadays that "the healthy workplace" is about much more than merely addressing Health and Safety issues in Employment. "Healthy" is used in the broadest terms and incorporates employee friendly policies, equality of opportunity, dealing with issues of stress, mental health, bullying/harassment and the development of effective Occupational Health services.

Challenge

3.3 Achieving "quality of life" for many people is dependent on finding a balance between the demands of employment and the responsibilities of home life. While a number of policies have been developed within the HPSS with a view to improving the working environment and its flexibility, it is widely acknowledged that a more comprehensive range of flexible working arrangements need to be developed and supported. The recently published document "Opportunity 2000 Models of Flexible Working" - now known as "Opportunity Now" – provides wide-ranging examples of flexible working arrangements which can help managers to achieve their objectives in a way that also supports employee need.

3.4 The HPSS knows how to provide round the clock care – now it has to make services more accessible and respond to rising public expectations. Offering greater flexibility in working patterns can help in the delivery of better care and will also benefit staff. However, to enable the HPSS to improve its general reputation and become an employer of choice, staff must also feel that they are valued. This will be achieved where staff believe that there is equality of opportunity in promotion and training and where issues which contribute to stress in the workplace are addressed. Quality of working life is an increasingly important factor that influences staff to remain in their jobs and staff who are committed to their place of work, are more likely to recommend others to join them.

Meeting the Challenge

Key Priorities: -

To create an "employee friendly" workplace
To provide a healthy workplace for all staff;
To maintain a safe working environment.

An Employee Friendly Workplace

3.5 The government has recognised that to help recruit and retain skilled staff, to reduce absenteeism and increase morale, employers must try to help employees find a balance between the demands of employment and the responsibilities of a home life. Caring for children, elder-care and care for dependants are just some examples of the commitments staff have outside the world of work. Managing these demands positively can help keep staff in the HPSS who may otherwise leave. "Opportunity Now" presents a wide range of flexible working models that provide tangible benefits for both the employer and the employee. We need to involve staff and managers in the development of policies. To ensure that policies are put into practice a full training programme for managers will be required and auditing the effectiveness of the policies will be essential.

A Healthy Workplace

3.6 It is the duty of a responsible employer to work with staff to act against the causes of preventable ill health and to play a part in providing a supportive, safe and healthy work environment. To build a better quality of life for HPSS staff we need to create better health at work and take clear action to achieve it. To this end, the HPSS needs to develop an effective and comprehensive Occupational Health Service that will take the lead in assessing the health needs of staff and will take action to promote good health and reduce ill health among staff, caused, or made worse by work. This will best be achieved through the development of a strategy on Occupational Health Services for HPSS staff. Among the issues that the strategy should address are the identification of best practice, roles and responsibilities, education and training needs and the role, aims and minimum standards of an Occupational Health Service in the HPSS.

A Safe Workplace

3.7 The skilled and dedicated people who work in the HPSS spend their lives caring for others, yet too often they are victims of violence and intimidation, bullying and harassment. "Violence" means any incident where staff are abused, threatened or assaulted in circumstances relating to their work and as such will not be tolerated. There is no single solution to preventing

violence against staff working in the HPSS. Preventing violence at work must start with a full assessment of the risks. This must be followed by the development of strategies to reduce identified risks. Establishing procedures for dealing with violent situations will give staff confidence in how to cope effectively. Similarly, bullying and harassment within the workplace is a serious issue. It can undermine a person's physical and mental health and in doing so can effect their work performance. Obviously, the employer has a duty of care to provide a safe a healthy working environment but employees also have a duty to ensure their behaviour does not have an adverse impact on colleagues. The HPSS must have effective policies in place for dealing with bullying and harassment. The development of a Staff Charter will promote the rights of staff in this area and help staff to feel valued within the organisation.

Strategic Issues: -

Promote and support the development of a wide range of working patterns to enable staff to balance work with their other responsibilities.
Address the "long hours" culture that exists in parts of the HPSS.
Produce a strategy document that will guide the development of an effective and inclusive Occupational Health Service to be accessible by all staff in the HPSS.
Ensure that policy documents addressing safe working conditions are developed and issued in all local management areas.
Develop a Staff Charter that will promote the rights of staff in relation to violence, bullying and harassment.

SECTION 4

Equality and Fairness

4.1 The Northern Ireland Act 1998 places new duties on all public authorities to promote equality of opportunity and good relations and has considerable implications for how the HPSS conducts its business. The Act creates a statutory obligation on public authorities in carrying out their functions to:-

> have due regard to the need to promote equality of opportunity between certain groups (persons of different religious beliefs, political opinions, racial groups, ages, marital status or sexual orientation, between men and women, between persons with a disability and persons without and between persons with dependants and persons without); and
>
> have regard to the desirability of promoting good relations between persons of different religious beliefs, political opinions or racial groups.

4.2 The Act also sets out a detailed procedure for the enforcement of these duties, which include a requirement on all public authorities to submit equality schemes to the new Equality Commission. The main vehicle through which the HPSS will fulfil its statutory obligations is through its equality schemes.

Challenge

4.3 Within the HPSS it has been regarded as very important that sound equal opportunities principles should be applied to everything we do. The traditional equal opportunities approach has however, tended towards the letter of the law rather than the promotion of a good equal opportunities culture. It has for too long been confined to the personnel department, often taking the form of paper policies and statistical exercises.

4.4 The key equality principles for the HR strategy are based on the effective implementation of the full range of equality legislation and, most importantly for the HPSS, on the implementation of the statutory duty of equality of opportunity under the Northern Ireland Act 1998. The HPSS plays a key role in delivering services to the community, it is a major employer of men and women and forms many links with external agencies. It should therefore be seen to take a lead role in the integration of equal opportunity policies into all policy development, implementation, evaluation and review processes.

Meeting the Challenge

Key Priorities: -

To promote equality of opportunity within the HPSS;
To ensure equality is sustained throughout the HPSS by ongoing monitoring;
To ensure the equal and full protection of all part-time workers.

Promoting Equal Opportunities

4.5 There is a statutory duty under the Northern Ireland Act 1998, and other legislation, to promote equality throughout the HPSS. However aside from the legal reasons there are moral and economic reasons for having a good equal opportunities policy and promoting equality of opportunity within the organisation. The HPSS operates in a very complex and demanding environment where the only constant is change. To help meet these challenges we need to ensure that we make the best use of the skills, expertise and talents of our staff. This will best be achieved where all eligible staff have equal opportunities for employment and advancement in the HPSS based on their ability, qualifications and aptitude for work. As a catalyst to stimulate awareness and interest in good equal opportunity practice we need to integrate a full equality approach into training strategies and programmes. We need to fully integrate equality into the procurement and review of service delivery and into resource allocation. When developing key policies, not just those promoting equality of opportunity, their likely impact on the promotion of equality must be assessed and adequate consultation must ensue with service users/those affected. The successful promotion of good equal opportunities practices will generate cost and we will need to allocate specific resources, including staff, to maintain a working environment where staff feel confident that the HPSS is indeed and equal opportunities employer.

Monitoring Equality of Opportunity

4.6 Despite the recognised merits of equal opportunities policies there are barriers to translating them into daily practice. Problems can persist which include prejudices, existing work practices, attitudes, stereotyping and behavioural problems. Monitoring arrangements will have to be put into place/maintained to help identify problem areas and to assist management and staff in overcoming them. There will need to be continuous monitoring of existing policies and procedures, and quality assurance of any proposed new operational policies to ensure the rigours of the Northern Ireland Act 1998 and the HPSS equal opportunities policies are met. We need to ensure that questions of equality and non-discrimination are not sidelined. Employers must engage directly with equality issues.

Protecting Part-time Workers

4.7 In recognising that a modern HPSS requires modern employment practices it is necessary that we challenge traditional working patterns and promote a variety of working arrangements that meet the needs of staff and benefit users. Research evidence, however, suggests that staff who work part-time can become marginalised in terms of their contribution to care and their own career development. It is important to prevent such an undervaluing of skills and experience and therefore policies need to be put in place to address directly the situation of part-time staff. Part-time staff should have the same opportunities to update and develop skills as full time staff. They should be involved in meetings and not distanced from decision making within teams. It is vital that mixes in working patterns are not allowed to undermine continuity of care for service users. Effective handover and communications procedures must be in place. The existence of part-time posts at all levels - up to the most senior - will capture the contribution of staff whose ability and skills would otherwise be lost. Such a structure would enable careers to be progressed.

Strategic Issues: -

Ensure policies that actively promote equality of opportunity for all staff (including part-time workers) are developed/maintained and are consistent with the legislative requirements and HPSS equal opportunities policies.
Integrate a full equality approach into training strategies and programmes.
Develop procedures to assess and consult on the likely impact of policies on the promotion of equality.
Develop a system for analysing, monitoring and evaluating the application of equal opportunity policies and procedures by all managers and staff.
Develop a set of standards to ensure staff are valued and rewarded according to the contribution they make to patient/client care and meeting the needs of the service, and not according to their working patterns.

SECTION 5

Education and Training

5.1 The skills, experience and commitment of the workforce determine the quality of care provided by the HPSS. Our workforce is generally highly educated and well trained. This, combined with the experience gained in providing care, represents a high investment in expertise and skills by both the staff themselves and the HPSS and ultimately by the taxpayer.

5.2 This accumulation of knowledge and skills is a critical valuable resource in planning to meet the future needs in terms of promoting health and well being. But like any other valuable investment it presents a challenge to ensure that it is protected, maintains its value in meeting the needs of service users and enhances the career prospects of staff.

Challenge

5.3 The delivery of the more flexible, responsive, person-focused service that will be needed in the future will have a major impact on the workforce. Particular attention will need to be paid to how staff are skilled and trained, how their skills are maintained and developed and how different disciplines work together to enhance the user's experience. There is the emphasis on primary care, the modernisation of secondary care, the shift away from institutional care to care in the community and there is the organisation's responsibility to deliver on clinical and social care governance. This means that there will be a greater need for many professional staff to adapt, to learn new skills and to work in changed environments as new roles emerge and others cease to be relevant.

5.4 The HPSS must demonstrate that it is fiercely committed to helping its people to succeed. We must dedicate ourselves to giving staff the support and resources they need by investing in their training, education and overall employability. Staff, for their part, need to be responsive to the opportunities provided for their continuing development. In an environment ever changing through advances in technology and the development of clinical practice, it does not take long for skills and knowledge to become outdated. Staff must be prepared to adapt to new products and techniques. They need to be kept informed of changes to their work areas so they can update their knowledge, acquire new skills and stay abreast of what is happening in their field/profession.

5.5 Meeting the Challenge

Key Priorities: -

To develop, maintain and support a culture of lifelong learning throughout the HPSS;
To ensure that there is a business focus to all training and development programmes;
To promote learning among staff who do not hold professional qualifications.

Learning for All

5.6 It is clear that investment in post registration/post graduate/continuous professional education is at best static and is frequently under threat when resources are constrained. We must also acknowledge that there is currently little infrastructure for the promotion of learning among staff who do not hold professional qualifications (with the possible exception of management). This is unacceptable and we need support the training and development of all staff in the context of business need, and to accept that Continuous Professional Development is a "must" for all groups of staff.

Lifelong Learning

5.7 The HPSS needs to develop a culture of lifelong learning to ensure that **all** staff will be able to develop and update their skills and knowledge throughout their working lives. Improvements need to be made to the way in which we identify the knowledge and skills required by the workforce. As new skills and knowledge requirements are identified these must be incorporated into the curriculum by the education providers. There is therefore a need to develop and improve the relationship between the HPSS and the providers of education to ensure, particularly in relation to higher education, that providers remain in touch with modern service needs – improvements must include the provision of far more multi-disciplinary education and training programmes. Adopting a culture of lifelong learning will require investment but we need to recognise that failure to make the requisite investment is short sighted and will ultimately lead to a lowering of standards.

Business Focus

5.8 While individuals need wider access to opportunities for learning, there must be a clear focus for training and development activities. The Investors in People (IIP) standard requires that all training and development activities meet the business needs of the organisation and all areas of HPSS should strive to attain/retain this standard. The reward for any organisation in adopting this approach, is added value to organisational performance. It is equally important for the HPSS to develop the flexibility

for added skills which enhance the business to attract added reward, to develop and support career progression by creating genuine flexibility between jobs and to develop and support career structures that encourage and recognise specialist skills.

Strategic Issues: -

Develop a programme for the systematic examination of training and development provided for staff.
Promote lifelong learning through the creation of a personal development planning system.
Ensure education providers incorporate the skills and knowledge requirements of the HPSS into the curriculum.
Develop structures that reward skills development, support career progression and recognise specialist skills.
Ensure Continuous Professional Development is provided for staff.
Create an infrastructure for the promotion of learning among staff who do not hold professional qualifications.

SECTION 6

Employee Relations

6.1 The promotion of effective and harmonious employee relations is a key component in the development of a successful Human Resource Strategy for the HPSS. The HPSS needs, and wants, to meet its responsibilities as a good employer and in doing so commands widespread respect and commitment from the workforce. Better employee relations are fostered where there is effective employee involvement and genuine partnership arrangements. This requires leaders to adopt modern and effective leadership styles that seek to support staff and involve them fully in the change process.

6.2 Against a background of changing service needs the HPSS must be able to recruit retain and support a fairly paid, well trained and highly motivated workforce who are free from uncertainty over employment security. Recent research commissioned by the TUC confirms that one of the principles needed for trades unions and management to work successfully together is a commitment to employment security.

Challenge

6.3 Both the employers and the staff in the HPSS are firmly committed to the aim of improving the health and social wellbeing of service users. This shared goal will be achieved in a working environment where staff are involved and feel valued. A proactive, collaborative approach involving the Department of Health, Social Services & Public Safety, HPSS employers and the recognised trade unions and staff organisations in developing a policy of fostering good industrial relations is therefore essential to improving the working environment.

6.4 The HPSS is facing considerable change in the near future and during times of transition and change it is difficult to maintain a "business as usual" working environment. Restructuring within any workplace affects staff morale as apprehension grows over perceived risks/threats to jobs. In the past managers have felt powerless to offer guarantees on jobs and have expanded the use of fixed term and temporary contracts, which added to staff's feelings of vulnerability.

Meeting the Challenge

Key Priorities: -

To improve the current mechanisms for negotiating within the HPSS;
To develop policies and practices to manage change;
To introduce employment security policies to the HPSS.

Improve Negotiating Machinery

6.5 The Regional Joint Council machinery was abolished in April 1995 and was replaced with a Regional Consultative Forum and some 28 separate local negotiating units. While there have been some examples of good industrial relations practice at local level under these arrangements, situations have also arisen where, because of the number of local negotiating units, there has been unnecessary bureaucracy and duplication of work. We need therefore to review the existing industrial relations arrangements at local level, and to build on examples of best practice. We acknowledge the need for regional negotiating and will jointly develop appropriate regional consultative and negotiating mechanisms.

Managing Change

6.6 There is widespread recognition of the changing environment the HPSS is now operating in, which has in part come about as a result of the rapid evolution of the government's health policy. To manage change effectively requires an investment in leadership skills. Staff will feel valued where they are involved in improving care and providing better services. Effective involvement happens only where leaders at all levels in an organisation are committed to an open, participative working style. With an emphasis placed on co-operation, true partnership can provide a positive framework for the management of change. While a partnership approach is directly related to the HR Strategy it is not just about Human Resources – it is about engaging the whole process and will for example embrace policy formulation in the widest sense. It is about drawing together the different employer and staff perspectives. Future reorganising and restructuring processes need therefore to be supported by the appropriate regional negotiating machinery and need to be managed in such a way as to avoid uncertainty and insecurity over contractual employment and industrial relations issues.

Employment Security

6.7 One of the most prized benefits of employment to every employee is security. Modernising the HPSS will mean adapting to new technology and new working patterns and consequently all jobs will continue to be subject to change. Employment security policies recognise change and

acknowledge that individual jobs will not necessarily be secure. They do however provide a strong commitment from the employer to securing employment. This is achieved by requiring people to work flexibly and to change jobs as business requirements dictate. The effectiveness of an employment security policy is determined by the organisation's investment in re-training staff and through genuine flexibility between jobs. The more flexible staff are prepared to be, the greater their employment security will be. Employment security policies create the right environment in which to manage change by recognising staff's concerns and providing the necessary support to overcome them

Strategic Issues: -

Develop appropriate regional negotiating and consultative mechanisms.
Undertake a comprehensive review of industrial relations procedures.
Define the core competencies and qualities required by leaders key to the management of change.
Develop open, participative leadership skills through a programme of training and development.
Employers to develop Partnership Agreements with staff and their representatives
Facilitate the management of change through the adoption of employment security policies, with the aim of reassuring employees and committing them to the change process.

Annex 1

Steering Group Members

ERIC BOWYER	NEWRY AND MOURNE HSS TRUST
JIM COOPER	N.I.P.S.A.
PATRICIA GORDON	MATER INFORMORUM HSS TRUST
STUART MCDONNELL	NORTHERN HSS BOARD
JOHN MCGRATH	D.H.S.S.& P.S.
PATRICIA MCKEOWN	U.N.I.S.O.N.
EAMONN OAKES	M.S.F.
MYRTLE RICHARDSON	CRAIGAVON AREA HOSPITAL GP HSS TRUST
MAUREEN SCOTT	R.C.N.
CALVIN SPENCE	B.M.A.
ELAINE WAY	FOYLE HSS TRUST

Department of
Health, Social Services
and Public Safety
www.dhsspsni.gov.uk

QUALITY 2020

A 10-YEAR STRATEGY TO PROTECT AND IMPROVE QUALITY IN HEALTH AND SOCIAL CARE IN NORTHERN IRELAND

November 2011

Minister's Foreword

As Minister of Health, Social Services and Public Safety, the guiding principle for me, and I know for the vast majority of people working in health and social care, is to protect and improve the quality of our services. The strategy set out in this document is designed to provide a clear direction over the next 10 years to enable us to plan for the future while ensuring this principle is preserved, whatever the challenges we may encounter.

Clearly we face challenges in the immediate future on the financial front, but there are many other factors that we must also grapple with in the longer term which require that we plan now so as to be able to best address those challenges and maintain high quality services.

The people using Health and Social Care (HSC) services must be at the heart of everything we do. We will be measured by how we focus on their needs through delivering high quality as they deal with pain and distress. This means the services we provide must be safe, effective and focused on the patient.

HSC services in Northern Ireland are already internationally recognised for excellence in a number of areas, and these services are provided by thousands of staff who apply great skill with compassion to ensure the best possible outcomes and experiences of care for their patients and clients. Their continuing determination to deliver high quality care, whatever the constraints, is fundamental to achieving the right outcomes.

This strategy, therefore, has the great advantage of building on an already strong foundation. It gives a clear commitment to sustainable improvement and high standards, safe services and putting people first.

Edwin Poots, MLA
Minister of Health, Social Services and Public Safety

A VISION FOR QUALITY

Quality

Every day hundreds of thousands of people, old and young, are treated and cared for by highly skilled and dedicated professionals in our health and social care services. Some in their homes, some in hospitals, some in community settings, some because they are ill, some because they need care and support, some who need protection. Most of these people are in distress or pain. Some need urgent treatment. Some have to live with chronic conditions over many years. All of them deserve and seek one thing above all: to know that the service provided is of high quality.

But what is "*quality*", a word so often used but so little understood? The dictionary definition is "*degrees of excellence*". We know that quality can be high, low or somewhere in between. We also know that to make quality high normally requires a range of things to be present. Usually no one factor can define it. Whether it is holidays (facilities, food, comfort, service, etc) or cars (economy, power, safety, reliability, etc), the excellence is derived from how that product or service performs across a range of factors.

So how should we define quality for health and social care in Northern Ireland? One of the most widely influential definitions in healthcare was produced in the United States by the Institute of Medicine in 2001. It proposed six areas in which excellent results would lead to high quality or excellence overall: safety, timeliness, effectiveness, efficiency, equity, and patient-centredness.

> *"No one wants luxury; people just want to be safe and given the proper care."* - a carer

The European Union describes high quality healthcare as care that is "*effective, safe and responds to the needs and preferences of patients*." Many other countries, including England, Scotland, Australia and the Republic of Ireland, have likewise focused on three key components, although not to the total exclusion of the others in the list of six above. Many countries have chosen to subsume those elements of timeliness, efficiency and equity under the heading of effectiveness. For Northern Ireland this 10-year quality strategy takes a similar approach defining quality under three main headings:

- **Safety** – avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

- **Effectiveness** – the degree to which each patient and client receives the right care (according to scientific knowledge and evidence-based assessment), at the right time in the right place, with the best outcome.

- **Patient and Client Focus** – all patients and clients are entitled to be treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Everyone expects the best care possible when they or a family member falls ill or needs social care support. In Northern Ireland this is provided by health and social care services, for the most part free at the point of use, and funded by the taxpayer at a cost of around £4 billion a year. It is different in one important aspect from the National Health Service (NHS) in Great Britain in that it provides integrated health and social care services.

It is a highly complex, sophisticated and increasingly technological service involving a wide diversity of some 70,000 people working together in multidisciplinary teams, providing services day and night, in all weathers, often dealing simultaneously with conditions that are very common as well as those that are very rare. They work in a compassionate and professional manner through more than 15 million engagements each year (hospital admissions, in-patient appointments, consultations, etc) with patients, clients, families and carers at times when they are suffering and vulnerable.

For all these people it is a fundamental expectation that the service provided will be as **safe** as possible. The fact is of course that in such a highly complex and stressful environment things will go wrong. The reasons are many and varied. Thankfully it is only in a tiny proportion of cases that things do go wrong. But a high quality healthcare service needs to protect and improve by learning from all such occasions and so minimising the chances of them happening again. There can never be room for complacency. Safety will always be an aspect of quality that needs to be guarded.

Equally, a high quality service should mean that the services provided are the right ones at the right time in the right place. In other words they are **effective** in dealing with the patient or client's clinical and social needs. Too often there is evidence that wasteful procedures or inefficient systems are being employed and internationally recognised best practice is not used where it can be.

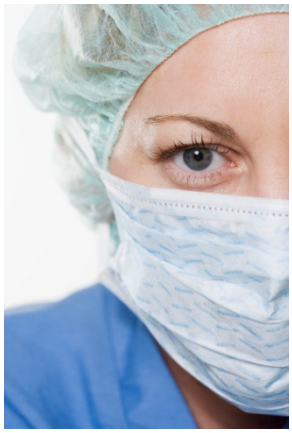
Thirdly, and just as importantly, services must have a clear **patient and client focus**. People are not just an element in a production process. There is abundant evidence that such an approach delivers improved health and wellbeing outcomes. There is also more than enough evidence, particularly in recent reports within the UK alone (and internationally), that when the dignity of the person is not respected, or people are not effectively involved in decision making about their health and wellbeing, or indeed listened to when they complain or raise concerns, quality suffers and declines.

Undoubtedly the amount of money available for health and social care services affects the quality of care, but other factors such as behaviours, attitudes and the way services are designed, are also very relevant. There is much evidence to show

that money is not the only determinant of high quality. When some say "*we cannot afford higher quality at this time*" they overlook the fact that low quality, so often the result of inappropriate behaviours and attitudes, costs more.

Over the last decade, health and social care services in Northern Ireland have taken important steps forward in improving quality. The consultation paper *Best Practice – Best Care* (April 2001) made proposals for setting standards, ensuring local accountability and improved monitoring and regulation. New legislation in 2003 introduced a statutory Duty of Quality for Boards and Trusts. This also led to the establishment of the Regulation and Quality Improvement Authority (RQIA) as an independent body, one of whose main functions is to promote improvement in the quality of health and social care services. *Safety First* (March 2006) produced a framework for sustainable improvement.

In 2009 the HSC Reform Act introduced a new statutory Duty of Involvement for all the main HSC bodies. This required them to involve people at a personal and public level in making decisions about service design and delivery. Together these initiatives have made a positive impact on safety, effectiveness and patient/client focus. The object of this strategy is to build on that foundation so as to widen and deepen the impact over the next decade in terms of protecting and improving quality in health and social care.



As we face the next 10 years, with all its challenges and uncertainties – not least funding – this is when we most need a strategy to protect and improve quality across all health and social care.

Purpose of a quality strategy

How will a new quality strategy help to protect and improve quality and achieve excellence in the three areas described above? Fundamentally a strategy is simply a plan to achieve a result over the long term. In this case a period of 10 years has been selected to deliver results for quality because much of what needs to be done simply cannot be achieved overnight but will take time, regardless of money. The strategy is intended to provide a clear direction for all of us, taking account of the strengths and weaknesses of the present system, so that we can better tackle the future challenges and opportunities faced.

It will provide a vision of what we can achieve, a mission statement of how to get there, and specific goals and objectives to make that vision become a reality over the 10 years. It will give us the long-term perspective needed to plan and design future services and deliver outcomes to the highest quality possible.

There are already many examples, often recognised internationally, of high quality or excellence within health and social care in Northern Ireland. Such examples, based on recent evidence, include the focus on early years and early interventions, the treatment of cancer and head injuries, neurosurgery, innovative mental health facilities, the new health and care centres with their one-stop approach to treatment

and care, and many others. But even more importantly, there are also thousands of individual staff who apply great skill with compassion, giving patients and clients the best possible outcome and experience of care at times of personal crisis. They show an unshakeable determination to deliver high quality care, whatever the constraints.

Consequently, this strategy has the great advantage of building on an already very strong foundation, while still recognising that no system is beyond improvement. There is a clear imperative to remain committed to continuous improvement, to maintain high standards and to achieve even higher degrees of excellence – in other words, to protect and improve quality.

How the strategy was developed

This strategy was devised by a project team convened by the Department. Over 100 people, some employed in health and social care and some users of these services, came together at four workshops to discuss priorities for safety, effectiveness and patient/client focus. The outputs from each workshop were referred to an international reference group made up of 18 highly respected professionals and academics for quality assurance. The essence of what was discussed at the workshops was also brought by the Patient and Client Council (PCC) to a wider public cross-section of almost 100 people in the community for comment, and focus group meetings were held with over 150 frontline staff working in health and social care at 10 venues around Northern Ireland. In all, some 350 people, from many different backgrounds, have contributed significantly to the development of this quality strategy (quotations from some of them are included in this document).

> *"We are already world leaders in some areas but in Northern Ireland we never talk enough about our successes."* – a community nurse

The strategy was then published for public consultation in January 2011 and attracted 46 responses from a wide range of health and social care, voluntary and charitable organisations, as well as individuals. There was very broad support for the strategy and many helpful comments and suggested amendments, many of which have since been incorporated in this final version of the strategy. This consultation process, building on the highly inclusive development process, has further strengthened the integrity, purpose and focus of the strategy, reinforcing the underlying support for its implementation. It has also fundamentally confirmed that protecting and improving quality really is the first priority for all those concerned with achieving the best health and wellbeing outcomes.

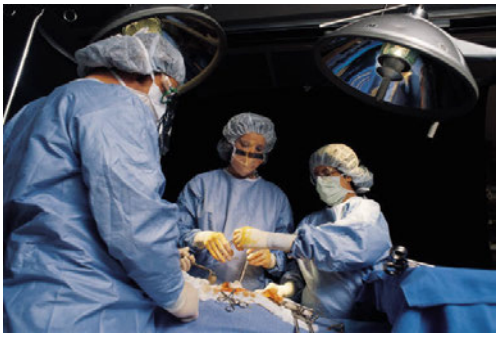
Principles, values and assumptions

The strategy identifies a number of **design principles** that should continue to inform planners and practitioners over the next 10 years. A high quality service should:

- be holistic in nature.

- focus on the needs of individuals, families and communities.
- be accessible, responsive, integrated, flexible and innovative.
- surmount real and perceived boundaries.
- promote wellbeing and disease prevention and safeguard the vulnerable.
- operate to high standards of safety, professionalism and accountability.
- be informed by the active involvement of individuals, families and communities, HSC staff and voluntary and community sectors.
- deliver value for money ensuring that all services are affordable, efficient and cost-effective.

In delivering high quality health and social care this strategy also identifies the need to promote the following **values**:



- **Empowerment** - supporting people to take greater responsibility for their own health and social wellbeing, and putting people at the centre of service provision.
- **Involvement** - ensuring that service users, their carers, service providers and the wider public are meaningfully involved, and if necessary supported, at all stages in the design, delivery and review of services at an operational and a strategic level so that, as far as possible, services are personalised.
- **Respect** – showing respect for the dignity of all people who use the service, their carers and families and for all staff and practitioners involved in service delivery.
- **Partnership** - engaging collaboratively across all disciplines, sectors and specialisms in health and social care, including the voluntary and independent sectors, to ensure an integrated team-based approach, and working with people in their local communities.
- **Learning** - promoting excellence in service delivery and founded on evidence-based best practice to achieve improvement and redress.
- **Community** - anchoring health and social care in a community context.
- **Continuity** - ensuring a co-ordinated and integrated approach to health and social care in all health and social care sectors, and ensuring continuity of care across the system.

- **Equity and Equality** - fairness and consistency in service development and delivery.

While it is impossible to predict exactly what will happen over the next 10 years, the strategy also identifies eight strategic **planning assumptions** (which will be adjusted as circumstances change). These are:

- **Political** - health, social services and public safety will continue to remain the responsibility of a devolved Administration.

- **Structural** - the present Departmental and HSC organisational structures will remain broadly unchanged but delivery structures will continue to evolve.

- **Economic** – very significant resource constraints and challenges will continue to impact on services requiring a robust focus on efficiency and effectiveness of service design.

- **Social** - an ageing society will have greater need for health and social care; general demands and expectations on quality including involvement will continue to rise; there will be an increased focus on safeguarding vulnerable people and groups; there will be continued challenges in addressing the impact of obesity, deprivation, drugs and alcohol.

- **Technology** - the effective use of information and technology in health and social care will increase in importance.

- **Rights** - the need to promote and protect human rights and equality will increase in a diverse society.

- **Environment** - the pressure to minimise waste of all kinds and maximise the use of sustainable resources will increase.

- **Service Delivery** - there will continue to be advances and changes in the science underpinning treatment and care, as well as emphasis on prevention and self-managed care and a continued move towards caring for people in their own homes.

A strategic Vision for quality

Ultimately every patient and client, and their families and carers, wants to receive the best care at the time they most need it to achieve the best outcome possible. In order for this to be a reality for all the people of Northern Ireland, the 10-year quality vision for health and social care is:

"To be recognised internationally, but especially by the people of Northern Ireland, as a leader for excellence in health and social care."

This is a bold statement and will require continuous improvement, concerted effort, commitment and determination if it is to be achieved by 2020. It must be acknowledged that many aspects of current services and many of the people working in health and social care are already world-class and worthy of celebration. So the strategy starts from a strong position. But high quality cannot be assumed to remain constant against the challenges that inevitably lie ahead. There is always room for learning, innovation and improvement.

This vision statement is intended to inspire and motivate all of us and give a shared sense of purpose and direction. As Abraham Lincoln said "*Far better to aim high and just miss the target, than aim low and just reach it*."

"We need to identify who is best at providing high quality and see what they are doing. It is not good enough to settle for second place; we must aspire to be the best." - a GP

Mission statement

In terms of <u>how</u> the vision is to be achieved, the strategy mission statement is:

"In order to become an international leader for excellence in health and social care, the inherent motivation of staff to deliver high quality must be supported by strong leadership and direction at all levels, along with adequate resources, in order to:

- ***focus on improved health and social wellbeing for all;***
- ***provide the right services, in the right place, at the right time;***
- ***develop effective partnerships and communication between those who receive and those who provide services;***
- ***create a culture of learning and continuous improvement that is innovative and reinforced by both empirical and applied research;***
- ***devise better ways of measuring the quality of services; and***
- ***protect and enhance trust and confidence in the service provided."***

Succeeding in this mission will depend crucially on good leadership and partnership working. Excellence is something that should be obvious not only to professionals working within health and social care but to individual patients and clients and their families. There will be a need to embrace change positively and find innovative ways of dealing with problems with highly motivated, skilled and engaged staff and volunteers.

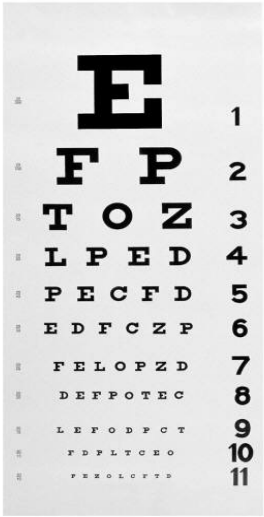
STRATEGIC GOALS AND OBJECTIVES

Setting strategic goals

The mission statement summarises how we can realise the vision of being an international leader in the excellence of health and social care. But it is the specific actions taken during the life of this 10-year strategy that will drive that positive change. To that end the strategy identifies five strategic goals to be achieved by 2020. Achieving them will help make the vision a reality.

1. **Transforming the Culture** - This means creating a new and dynamic culture that is even more willing to embrace change, innovation and new thinking that can contribute to a safer and more effective service. It will require strong leadership, widespread involvement and partnership-working by everyone.

2. **Strengthening the Workforce** - Without doubt the people who work in health and social care (including volunteers and carers) are its greatest asset. It is vital therefore that every effort is made to equip them with the skills and knowledge they will require, building on existing and emerging HR strategies, to deliver the highest quality.



3. **Measuring the Improvement** - The delivery of continuous improvement lies at the heart of any system that aspires to excellence, particularly in the rapidly changing world of health and social care. In order to confirm that improvement is taking place we will need more reliable and accurate means to measure, value and report on quality improvement and outcomes.

4. **Raising the Standards** - The service requires a coherent framework of robust and meaningful standards against which performance can be assessed. These already exist in some parts, but much more needs to be done, particularly involving service users, carers and families in the development, monitoring and reviewing of standards.

5. **Integrating the Care** - Northern Ireland offers excellent opportunities to provide fully integrated services because of the organisational structure that combines health and social care and the relatively small population that it serves. However, integrated care should cross all sectoral and professional boundaries to benefit patients, clients and families.

These five goals are developed in more detail below. Pairs of objectives for each goal are described in terms of why they are important, the actions to be taken, who might take the lead in each case, and, crucially, what will be the expected outcomes. Fundamentally, this sets out the difference this strategy can make for the future quality of health and social care.

TRANSFORMING THE CULTURE

Objective 1: We will make achieving high quality the top priority at all levels in health and social care.

Why is it important?

An emphasis on high quality will improve the experience of all those who use and work in health and social care services. It will also make those services safer for all.

What will be done?

- The delivery of high quality services will be central to the commissioning process.
- A consistent regional definition of what constitutes high quality in every service will be established and accountability for its delivery made part of governance arrangements.
- The use of best practice and improvement methods will be promoted and adopted across the health and social care system.
- Staff and service users' awareness of their individual roles and responsibilities in ensuring high quality outcomes for health and social care will be maximised.
- A culture of innovation and learning that creates more quality-focused attitudes and behaviours among HSC staff will be promoted.

"Often it's the little things that make a big difference to people's lives and make our own job worthwhile." – a social worker

How will we know it is working?

- The number of adverse incidents and near misses reported will increase steadily reflecting a stronger reporting and learning culture – serious adverse incidents will decline in number.
- Increased evidence of more effective complaints resolution and learning.
- Improved levels of satisfaction by both staff and the public.
- Quality, embracing safety, effectiveness and patient/client experience, will be a standing top item on the agenda of all boards and top management teams within the health and social care system.
- Waste caused by inappropriate variations in treatment or care will reduce.

Objective 2: We will promote and encourage partnerships between staff, patients, clients and carers to support decision making.

Why is it important?

There is already a body of evidence from around the world that involving patients and clients in decisions about their care and treatment improves the outcome and their satisfaction with the services they receive and at the same time reduces demands on services. Workshops conducted in the preparation of this strategy also confirmed that this is an important issue for a wide range of service users.

What will be done?

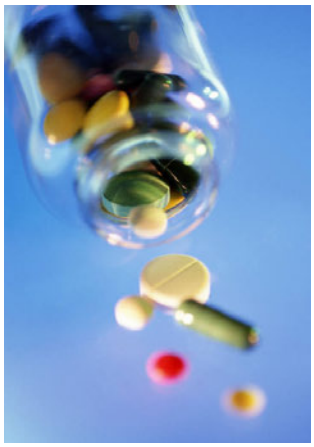
- Best practice standards will be established for informing patients, clients and carers based on what has been successful elsewhere.

- Regular patient and client surveys as well as other creative approaches to getting feedback, such as 'patient/client narratives' will be conducted in collaboration with the PCC.

- Effective and meaningful partnerships to support shared decision-making for HSC staff, patients, clients and carers will be created, including the voluntary and independent sectors.

- Patients, clients and carers will be involved in the design and delivery of education and training to all staff working in health and social care.

- The needs and values of individuals and their families will always be taken into account.



How will we know it is working?

- There will be clear evidence of user involvement arising from effective implementation of Public and Personal Involvement (PPI) Consultation Schemes at all levels of decision making in health and social care from individual care to corporate management.

- There will be baseline information and regular monitoring on how involvement changes over time.

- Evidence on compliance by HSC bodies with all relevant equality and involvement standards.

STRENGTHENING THE WORKFORCE

Objective 3: We will provide the right education, training and support to deliver high quality service.

Why is it important?

No matter how good our systems and procedures are, they all rely on staff who are motivated, skilled and trained to implement them. This is fundamental to the delivery of safe and effective services. Increasingly these systems and procedures must include personal and public involvement in their design and operation.

What will be done?

- Opportunities for continuous learning by staff will be resourced and planned in order to continuously improve quality.
- Increased knowledge and skills in the principles of PPI will be promoted among all HSC staff.
- Arrangements will be made to involve service users and carers more effectively in the training and development of staff.
- A customised Healthcare Quality training package for all staff working in health and social care (with mandatory levels of attainment dependent on job responsibilities) will be developed, with possible links to regulation and dovetailed with existing and emerging training and development strategies across HSC.
- Better use will be made of multidisciplinary team working and shared opportunities for learning and development in the HSC.
- Regular feedback from staff and service users and carers will be sought alongside commissioned research on quality improvement.

"We need constantly to look for simpler and faster ways of disseminating learning to staff who need to know, to improve quality." - a hospital doctor

How will we know it is working?

- HSC service organisations will be recognised as employers of choice.
- Evidence for improved outcomes for patients and clients will be published.
- Increasing levels of competence among HSC professionals will be evidenced through professional revalidation and appraisal.
- There will be evidence from research of reducing errors in service delivery arising from "human factors".

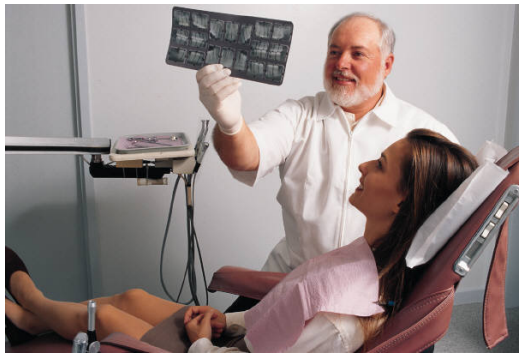
Objective 4: We will develop leadership skills at all levels and empower staff to take decisions and make changes.

Why is it important?

Strong leadership is the key to effecting change and we believe that giving frontline staff autonomy to take more decisions locally, provided this is balanced with clear accountability, is the best way to secure improved quality and productivity.

What will be done?

- Top management teams will be expressly accountable for quality improvement within their organisations.
- Each HSC organisation will produce an annual quality report and be responsible for making improvements year-on-year.
- Staff will be actively supported through service change programmes.
- Change champions will be trained and supported in the latest improvement techniques.
- A renewed emphasis will be placed on generating robust and relevant research to support innovation and quality improvement, building on links with local research organisations.



How will we know it is working?

- Evidence of increased authority being delegated to frontline decision makers wherever practical.
- Evidence of health and social care staff at all levels driving quality improvements.
- Every organisation or team will be involved in making their work safer, more effective and patient/client centred.

MEASURING THE IMPROVEMENT

Objective 5: We will improve outcome measurement and report on progress for safety effectiveness and the patient/client experience.

Why is it important?

Safety, effective treatment and a good experience of the care received, whether in hospital or the community, and whether provided by the public, voluntary or independent sectors, lies at the heart of a high quality service. We need to compile good baseline data and be able to measure that this is happening and let everyone have this information in as accessible a way as possible.

What will be done?

The HSC Board, Public Health Agency and Trusts will work with the RQIA, PCC and others to:

- Devise a set of outcome measures, with quality indicators, focused on safety, effectiveness and patient/client experience.
- Agree a set of effective quality performance targets, involving service users to drive improvement.
- Monitor quality improvement year-on-year and compare our performance with the rest of the UK, the Republic of Ireland and internationally.
- Publish a regional annual quality report that is widely available.

"We expect healthcare leaders and healthcare professionals to be intolerant of defects or errors in care and constantly seeking to improve, regardless of their current levels of safety and reliability." - a doctor

How will we know it is working?

- There will be a set of effective and measurable quality targets agreed within the first year of the strategy implementation.
- All HSC organisations will meet quality performance targets.
- There will be evidence of steady improvement in the public's reported experience of health and social care.

Objective 6: We will promote the use of accredited improvement techniques and ensure that there is sufficient capacity and capability within the HSC to use them effectively.

Why is it important?

Within the large and complex health and social care system there is always scope for improvement. To achieve best outcomes it is important to review what happens and look for improvements with the aid of skilfully applied accredited techniques.

What will be done?

- A set of improvement methods and techniques for use in the HSC will be agreed and HSC staff will be trained and resourced to use them.
- Capacity and capability will be built up within the HSC to achieve the desired results.
- Audit techniques to measure how standards are being met will be further developed.
- Research and innovation will be encouraged.
- Benchmarking with other health and social care organisations outside Northern Ireland will be conducted to ensure that there is up-to-date information available on best practice.

How will we know it is working?*

- The number of avoidable deaths will decrease steadily.
- The number of healthcare associated infections will be reduced year-on-year.
- All HSC facilities will meet established standards for cleanliness.
- There will be 95% or higher satisfaction ratings from the public with the safety of care in the HSC.
- There will be 95% or higher satisfaction ratings from staff with the safety of care in the HSC.

(* These indicators will be further refined and developed during the implementation planning process.)

RAISING THE STANDARDS

Objective 7: We will establish a framework of clear evidence-based standards and best practice guidance.

Why is it important?

It is essential that we work to agreed standards that represent best practice and are clearly understood by staff, users and relatives alike. Standards should be authoritative and concise and help achieve high quality in the most cost effective way.

What will be done?

- Information on national and international standards will be gathered and standards developed, where necessary, to deliver best practice.
- A coherent regional framework for standards and guidelines will be established.
- A Web-based system will be established to allow easy access to the framework of standards and related information.

"Even though there is always change I think it is important that we ensure we are not seen to be stagnant, but an evolving organisation, always striving for the best." – a public health consultant

How will we know it is working?

- Standards will be evidence-based and effectively applied.
- Standards will be kept up-to-date and easily accessible to all.
- The meeting of standards will demonstrate measurable improvements in the quality of services, becoming safer, more effective and more patient/client-centred.

Objective 8: We will establish dynamic partnerships between service users, commissioners and providers to develop, monitor and review standards.

Why is it important?

Increasingly standards should span both health and social care sectors and be developed by partnerships that include all those involved in providing and receiving a service. They should also be monitored periodically and reviewed if they are to continue to be fit for the purpose they were designed.

What will be done?

- An advisory group, representative of HSC organisations and including service user and carer representation, will be set up to harmonise processes in relation to the application of standards.
- A new structure will be created for drafting and agreeing standards and guidelines that gives meaningful inclusion to those affected by them.
- A performance management mechanism will be put in place to ensure standards are achieved by means of audit and compliance measurement within set timescales.

- An incentives mechanism will be created to better ensure compliance with quality standards in all health and social care settings.
- The use of Service Frameworks will be extended.
- Surveys of the public will be conducted to seek feedback on compliance with standards.

How will we know it is working?

- Quality targets published in Priorities for Action will be met.
- All parts of health and social care will be able to demonstrate compliance with the standards.
- Information on standards, and associated compliance information, will be easily accessible on-line.
- New standards will only be introduced after full and effective consultation.

INTEGRATING THE CARE

Objective 9: We will develop integrated pathways of care for individuals.

Why is it important?

Northern Ireland already has an integrated health and social care system, but in order to be truly effective there should be seamless movement across all professional boundaries and sectors of care. This has implications for the timely transfer of information and how data is held. Improvements in this area will make a significant contribution to raising the quality of care and outcomes experienced by patients, clients and their families.

What will be done?

- More effective and secure information systems will be established to record and share information across HSC structural and professional boundaries (and with other relevant Departments and agencies as appropriate).
- Service users will be given a greater role in, and responsibility for, information transfer (e.g. patient held records, patient smart cards, etc).
- Barriers to integrated multidisciplinary and multisectoral working will be identified and removed.
- Annual targets for use of personal care plans will be established.

> *"The first premise, indeed the whole point of a health service, is to deliver what its customer needs. In other words – put the patient first."* – a service user

How will we know it is working?

- Patients, clients, carers and HSC staff will collaborate in developing individual care pathways.
- Patients and clients will be able to move between different sectors and specialties within health and social care without undue delay or the transfer resulting in avoidable information errors or resultant harm.
- Patient and client information will be available to staff and carers when it is required.
- There will be evidence of consistent quality of care experienced by patients and clients across all settings.

Objective 10: We will make better use of multidisciplinary team working and shared opportunities for learning and development in the HSC and with external partners.

Why is it important?

It is increasingly recognised that the effectiveness of treatment and care given to patients and clients is enhanced by a holistic approach that encourages co-operation between all those involved at every stage. Failure to address this can produce an "us" and "them" mentality, which has the potential to be detrimental to outcomes and wasteful of resources.

What will be done?

- All disciplines should contribute to a single assessment through a shared assessment framework – NI Single Assessment Tool, and for children, Understanding the Needs of Children in Northern Ireland (UNOCINI).

- More integrated treatment and care teams will be established with innovative management approaches.

- Universities will further develop inter-professional education at undergraduate and postgraduate levels in health and social care.

- Pre-registration and post-registration training will be reviewed to enhance the use of multidisciplinary teams.

How will we know it is working?

- There will be a significantly more effective skills mix on teams.

- There will be increasing evidence of joint working across professional disciplines to improve quality.

- In-house organisational training will give primacy to multidisciplinary learning.

MAKING IT HAPPEN

Managing, advising and reporting

Implementing any new strategy requires good governance arrangements and structures to deliver results at every stage of the process. This is especially true of any strategy that covers a period as long as 10 years.

There are three important elements to implementing this strategy.

The first is **management**. A programme board, chaired by the Chief Medical Officer, will be responsible for overall control and will report on progress on the implementation of the strategy to the Minister. The board will include senior Departmental policy and professional representatives, senior executives from health and social care organisations, including the voluntary and independent sectors, and people who use health and social care services. Many others will be involved in working on individual projects reporting to the programme board in order to meet the objectives set out under each of the five goals. A senior official within the Department will be responsible for co-ordinating and overseeing the work of these project teams and will report to the programme board.

> *"We need to involve patients and their carers in both the design and implementation of the quality strategy."* - a patients' representative

The second is **advice**. A Quality Advisory Forum will meet twice a year and include a wide range of "stakeholders", e.g. patients, clients, carers, trade unionists, relevant professional bodies, academics and HSC frontline staff (not senior executives) and representatives from the voluntary and independent sectors. The Forum will facilitate comment on regular six-monthly reports provided by the programme board and comment on progress against the objectives set. It will be able to suggest changes, voice concerns to the programme board and thus provide transparent accountability. This will help to reinforce the consensual and inclusive approach that has characterised the development of the strategy.

The third is **reporting**. It is proposed that each health and social care organisation will publish a freestanding Quality Report every year. These reports will state clearly the progress made in each organisation towards meeting the goals of the strategy and also comment on the improvement made to the quality of services commissioned, delivered or promoted within the previous 12 months by that organisation. The reports will make use of new "quality indicators" to be developed by the quality programme. The purpose of this report is to increase accountability against the Duty of Quality that health and social care organisations are required by law to meet. Furthermore, quality should be given the top position on the agenda for meetings of all senior management teams and boards within these organisations.

Engagement and Involvement

The relationship and exchange of information between the Department and health and social care organisations and the wider public will be important in driving this strategy forward. A new Quality Interface Group will be established with representation from all HSC bodies, and patient/client representation, to consider all proposals for new best-practice guidance, guidance under development and the dissemination and evaluation of guidance on all quality issues concerning safety, effectiveness and patient/client focus.

The Department will set up and manage a dedicated Quality Website to provide access to all relevant policy documents and guidance circulars. While this will be provided primarily for health and social care services, it would be available to everyone and the Department would take active steps to bring such guidance to the notice of a wide range of interests, including patient, client and carers' groups and the independent sector. The object would be to make information easily accessible and include links to related websites nationally and internationally.

The Implementation process

This strategy provides a clear vision of **where** we want to get to over the next 10 years in terms of quality healthcare; a high-level mission statement of **how** we plan to get there; and, most importantly, **what** we need to achieve in concrete terms to deliver that vision - the strategic goals.

Achieving those goals will require a detailed, rigorous and inclusive implementation planning process which is to be carried out over the next six months. We have established an implementation planning team drawing on a diverse range of interests including service users, commissioners, providers and led by a senior official in the Department. That team will finalise an implementation plan and submit it for Ministerial approval by February 2012 to enable the detailed work to follow that will secure those strategic goals, and thus our strategic vision.

It will obviously be necessary to keep the strategy under review so that it remains fit for purpose, not least because the nature and scale of challenges to be faced in the future are always subject to change. If we are not ready to adjust our plans to deal with changing circumstances, then we are likely to be blown off course and fail to realise our objectives.

It will also be essential that the people served by health and social care services, and those who work in the system, are kept fully informed of progress being made. Annual reports on progress in protecting and improving quality in health and social care will be widely accessible.

CONCLUSION

The 10-year Quality Strategy

This strategy is designed to protect and improve quality in health and social care over the next 10 years. During this period, services will undoubtedly face many great challenges. Some of those are already clear, such as funding for health and social care services, but some will only become clear as time passes.

In any event, there is a clear need to be prepared and ready to tackle those challenges strategically and effectively if the quality of services, so important to peoples' lives and wellbeing, are to be protected and improved. This is especially so because health and social care services are large and complex and can take time to change in ways that are safe and effective.

"The quality of services is inextricably linked to raising awareness and earning commitment." - a hospital doctor

This strategy will aid our preparedness and readiness and provide an enduring framework within which policy and service design can better develop.

The Department will give leadership in its implementation. But leadership will also be required in all parts, and at all levels, of the Health and Social Care service, as well as through partnership with patients, clients, carers and communities.

Produced by:
Department of Health, Social Services
and Public Safety,
Castle Buildings, Belfast BT4 3SQ
Telephone: (028) 9052 8321
Textphone: (028) 9052 7668
www.dhsspsni.gov.uk
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Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

HSC Health and Social Care

HSC Collective Leadership Strategy

Health and Wellbeing 2026: Delivering Together

Foreword from Transformation Implementation Group

Evidence has shown that where a culture of Collective Leadership thrives it yields benefits for staff, leads to improved quality of care, results in a better experience for those who use our services and brings greater sustainability of those services. At no time has the need for Collective Leadership been more important.

Within our Health and Social Care system, we face considerable challenges and there is no doubt that our services and staff are under extreme pressure. Redressing this position will not be easy but over time we are determined to make it better for those who use our services and those who work in the HSC. *Delivering Together* has provided us with the roadmap for transformation but we recognise that leadership is key to achieving success.

In implementing this HSC Collective Leadership strategy, together we can improve the health and wellbeing of the people of Northern Ireland by harnessing our strengths and working collaboratively and effectively across traditional boundaries as one system.

Our vision is for a culture which values leaders, regardless of hierarchy or experience, location or discipline. It is one in which people strive for continuous improvement, are enabled to be innovative and take some risks along the way. We want to see staff flourish and take pride and joy in their work. This strategy provides a framework to achieve that ambition and we give our personal commitment to creating the conditions to make that happen.

We want to thank the many staff members across the HSC who helped to develop this strategy. They have set the bar high and it is for all of us to live up to their expectations.

Members of the Transformation Implementation Group

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Context

The NI Executive have endorsed the need to transform how we design and deliver health and social care services to meet the increasing demands and changing external pressures. *Health and Wellbeing 2026: Delivering Together* sets out the direction for transformation and how services can deliver better outcomes for our population. It identifies 18 key actions, one of which is to:

'Develop an HSC-wide leadership strategy, to consider a five year approach and plan for development of collective leadership behaviours across our system' **Health and Wellbeing 2026: Delivering Together, (Oct 2016)**

The case for change is not in itself new and has been made repeatedly by experts, our people who work across health and social care, our patients, clients and carers. The political summit hosted by the Expert Panel in February 2016 secured a political mandate for the need for change and the principles to underpin it. The advent of a new outcomes based approach in the draft Programme for Government puts an onus on us all to work together, across traditional boundaries, to deliver the best outcomes for the people of Northern Ireland.

Whilst there are many leadership frameworks, the collective leadership model has been adopted as it is informed by considerable research and, in particular, by two major programmes of study conducted within the National Health Service. The first is a study of cultures of quality and safety in the English National Health Service (Dixon-Woods et al., 2013). The second involved analysis of NHS national staff survey data from 350+ organizations surveyed each year from 2004 to 2011 (Dawson et al., 2011). The data from these surveys were linked to national patient satisfaction surveys, mortality data, data on quality of care, financial performance, staff absenteeism and staff turnover.

The research suggests that all leaders (from the front line to the top) in the best performing health care organisations prioritised a vision and developed a strategic narrative focused on high quality, compassionate care and support (Dixon-Woods et al., 2013). The research evidence suggests that high performing health care systems around the world are characterised by a culture of collective leadership as opposed to command and control. It also shows that it is compassionate leadership behaviours combined with a strong focus on quality improvement that create cultures where people who work across health and social care are able to deliver high quality, continually improving, compassionate care and support.

Widespread engagement locally with people at all levels who work in health and social care organisations and those who use our services has endorsed the use of the collective leadership model. These stakeholders have influenced the development and contributed to the final content of this strategy.

Collective leadership consists of four key components:

- Leadership being the responsibility of all
- Shared leadership in and across teams
- Interdependent and collaborative system leadership
- Compassionate leadership

This strategy sets out how we will achieve a collective leadership culture across the wider health and social care system.

Figure 1: Four components of Collective Leadership

Our Challenge

We recognise that now is the time for us to work more collaboratively and collectively across the system to deliver world class health and social care services to the population as a whole. This will require harnessing and integrating the strengths of different parts of the system across organisations and sectors as well as working beyond what is traditionally considered to be the health and social care sector.

Our health and social care system faces a number of challenges which will require us to have a consistent approach to leadership across all organisations.

Increasing Demand

We are working in a complex, rapidly changing environment with increasing demands on our health and social care services which we know will continue into the future. We require leaders who have the knowledge, skills and abilities to promote the collective leadership that will deliver and sustain the changes required to deliver a world class service.

Working across boundaries

We need to work across traditional boundaries to address the ever increasing complexity and demands on our services. For this transformation to be effective we need to increase the prevalence of collective leadership and reduce or eliminate any silo based leadership approaches, both within our organisations and across the wider health and social care system. Our success will be measured by our ability to recognise the interdependence of our collective efforts and the need for our leadership community, which will include service users and carers, to work collaboratively to build the health and social care system for the future.

Pressure on our people

Our people have told us that the pressure on our system from increasing demand and challenging targets is impacting on their ability to deliver the quality of services they wish to provide for our population. One of the most significant challenges is for us to create a consistent approach to leadership, building an environment where our people are supported, engaged, enabled and empowered to offer the quality of the care they aspire to deliver.

Leadership culture

We have a workforce of highly capable, committed and enthusiastic people, including skilled and dedicated leaders. Because our system is changing we will require a shift towards a new leadership culture, a culture that recognises service users and carers also as leaders and moves away from command and control to collective leadership responsibility which:

- Values both formal and informal leadership
- Takes risks and learns from mistakes
- Supports continuous improvement
- Recognises that leadership comes from all levels, as referenced in Delivering Together *"Rather than concentrating power at the top, I want all those working in health and social care to feel able to effect change and improvement in care. This means developing leadership at all levels, a truly collective leadership model"*
- Enables effective and meaningful personal and public involvement, leading to co-production and a commitment to 'no decision about me, without me'

Collective leadership offers us a real opportunity for creating a culture of high quality, continually improving, compassionate care and support. There is consistent evidence that collective leadership in health and social care is necessary for overcoming the challenges we face and we recognise that it will require us as leaders, both formal and informal, to have courage, commitment and determination.

Our Ambition

Our ambition is to create a health and social care leadership community in which all take responsibility for nurturing cultures of high quality, continually improving, compassionate care and support. Our leadership culture will be the outcome of the collective actions of formal and informal leaders working collaboratively to deliver our common purpose of world class health and social care services.

The delivery of our strategy will require commitment from everyone who works in health and social care, service users and carers working with us, as well as our political leaders. Our commitments at a local and regional level will be that:

- We use our strategy as a guide when we are undertaking all things concerning leadership, improvement and collaborative working so that we engage across the system with one voice
- We take responsibility and hold each other accountable for the values and behaviours required to create our collective leadership culture
- We model in all our interactions the compassionate leadership and attention to people development that establish continuous improvement cultures
- We will share learning and spread best practice to support a continuous improvement culture

Realising our ambition will require a change in both behaviour and mindsets, our strategy will provide a framework for developing the capabilities and desired culture of collective leadership

Our Change

"It is people not strategies that bring about change and it is relationships not systems which make it work" Systems, Not Structures - Changing Health and Social Care, Expert Panel Report (Oct 2016)

There are many good examples already within health and social care of collective leadership and this strategy will ensure that it spreads to become the consistent approach across our system. To deliver the transformation that is set out in Delivering Together 2026, we need everyone to be prepared to lead - not just in their own work area but to lead with others in order to fulfil the core purpose of health and social care - high quality, continually improving, compassionate care and support for all in Northern Ireland.

Now is the time to create a consistent approach to leadership, working collectively to deliver a world class health and social care service.

We must:

- Develop collective leadership capabilities at all levels
- Create the desired collective leadership culture

Collective leadership capabilities at all levels

We must continue to invest in our people including service users and carers working with us, and provide the environment to enable them to do what they do best – provide excellent, high quality, continually improving care and support. This means providing opportunities for them to develop their collective leadership capabilities so that leadership at all levels becomes a reality.

To enable the growth of collective leadership across our system we need to:

- Recognise that leadership is the responsibility of us all and we all need to develop our leadership skills, behaviours and capabilities
- Develop shared leadership within and across teams
- Develop system leadership by working collaboratively and effectively across boundaries to problem solve and co-create the future
- Create a consistent approach of compassionate leadership

Such collective approaches must be deployed effectively at the right time and place. Collective leadership does not replace the necessity for strong governance arrangements to ensure clear accountability and decisive leadership but overall, the shift in culture must be away from command and control to collective responsibility. Underpinning such collective leadership must also be the core values of health and social care.

Our leaders at all levels need to develop strong networks, supportive alliances and trusting relationships within and across organisational, professional and geographical boundaries.

Desired Collective Leadership Culture

Organisational culture can be defined as the values lived by its employees every day, 'the way we do things around here' – and we know at times this may not be the same as our stated values. We must recognise that if we want to provide users of our service with respect, care and compassion, all our leaders and people must afford all their colleagues the same respect, care and compassion.

A collective leadership culture is the product of our collective actions and our formal and informal leaders must act together to achieve organisational goals. This will require new levels of awareness of self and others, new mind-sets as well as new skills and may require personal changes in our individual behaviours.

The cultural characteristics of collective leadership that we need to embrace and integrate into everyday ways of working are:

- Prioritising an inspirational vision and narrative – focused on quality of care and support

- Commitment to effective, efficient performance and accountability - clear aligned goals, objectives and outcomes with helpful feedback
- Supportive people management and employee engagement - compassionate leadership
- Continuous learning and quality improvement
- Genuine team working and collaboration across boundaries
- Modelling in our everyday behaviour the values of the organisation

Collective leadership creates the foundation of a strong, supportive organisational culture.

Our Approach

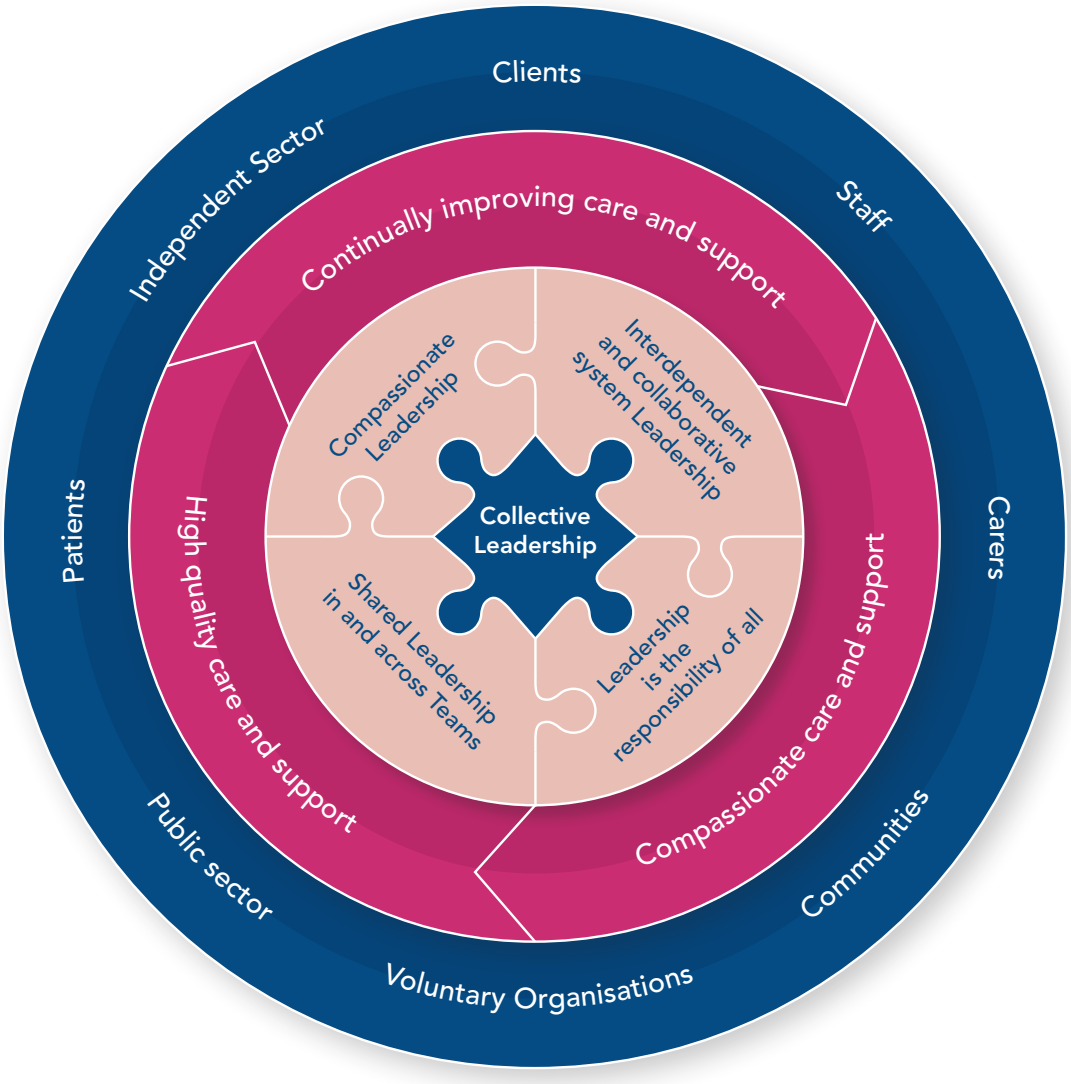
Our collective leadership strategy will be critical to ensuring that our health and social care organisations have the leadership they need to nurture cultures that:

- Deliver high quality, continuously improving, compassionate care and support, now and for the future of our population
- Equip and encourage those working in health and social care roles to deliver continuous improvement in local health and care systems
- Support those who work within our organisations to flourish, gain satisfaction, take pride and experience joy in their work

To enable this change in our culture the four components of effective and sustainable collective leadership are:

- Leadership is the responsibility of all
- Shared leadership in and across teams
- Interdependent and collaborative system leadership
- Compassionate leadership

Figure 2: HSC Collective Leadership



Whilst the model of collective leadership is new we have many excellent examples of this occurring across our health and social care system. These are illustrated by the following case studies.

Leadership is the responsibility of all

Collective leadership requires us to share leadership responsibility across all levels. It is a fluid approach enabling anyone with expertise for a particular task or situation to take responsibility when there is a need. Leaders in formal roles must create the conditions in which power, authority and decision making are distributed to all levels within and across our organisations. In developing leadership at all levels we need our people to be informed, enabled and empowered to deliver high quality, continually improving, compassionate care and support.

South Eastern HSC Trust

My name is Andrew Patterson, I am a Band 3 working in the Phlebotomy Team based in the Ulster Hospital. I was given the opportunity to take part in the Trust's Leading in Safety, Quality and Experience programme. This is where my leadership story began. Although banding plays a part in leadership, I realised that we are all leaders, we all have expertise in our own fields and we all have the potential to take on responsibility no matter how small when the need arises. Through the training I received I was able to take on responsibility for the service that I was providing and improve it to deliver the best possible results for those accessing our service, whether patient or staff. This led to a 43% reduction in the amount of blood sampling being carried out, freed up capacity in labs, a reduction in phlebitis and antibiotics prescription, results back in time to facilitate discharge and decision making and a reduction in the work load being handed onto JHO's out of hours. Alongside this we managed to save £4,367 in a three week period.

Since stepping up to the mark I have further developed myself not just in the area of leadership and education but also as a person. When someone invests in you, develops you, informs you, enables and empowers you to lead in this way it just doesn't benefit them.... It benefits you as a person. You become happier in your work, you feel a sense of ownership in your work, your passion is reignited, you feel proud of what you do and you know that your work really does matter.

Northern Ireland Ambulance Service

Over the past two years the Northern Ireland Ambulance Service has developed 12 new care pathways for patients which provide safe alternatives to ED and which mean patients with a chronic condition or a specific need – like palliative care support - can access that help more appropriately than being conveyed to the Emergency Department. Referrals can now be made to Falls teams, Minor Injury Units, Frail/Elderly Services, Palliative Care services, Respiratory services. A modernisation team drawn from Operations and Ambulance Control meant leadership came from within these services. The programme started with staff focus groups to ask front-line staff what services they thought their patients would benefit from. A feedback model of 'you said, we did' was used to show how this influenced conversations with hospital and community services to develop new pathways. This collaborative approach, coupled with a commitment from the modernisation team to spend time working in Ambulance Control, on the front-line, or shadowing front-line staff, meant that there was consistent attention paid to the observations and insights from those working in front-line ambulance services. There has been a lessons learned process carried out to ensure deep learning from how this process was led well and how to build and develop this in the future. Frontline staff commented:

- "Cross directorate working has been strong"
- "I like how much engagement there was with front-line staff"
- "When I sent in emails with ideas these were responded to and I got feedback."

Patients engaged through surveys and structured telephone calls to continue to help us learn and improve the pathways: Patient stated:

- "They couldn't have gotten a better service. Very happy with contact/treatment and referral pathway."
- "Very grateful for the referral and immediate action. The staff were lovely."

Northern Ireland Medical and Dental Training Agency

My name is Dr Anna O'Kane and I am a GP Trainee and ADEPT Clinical Leadership Fellow for 2016/17. ADEPT is the 'Achieve, Develop, Explore Programme for senior Trainees' established by the Northern Ireland Medical and Dental Training Agency in 2015. It enables senior doctors and dentists in training to take a year out of their training programme to work in an apprenticeship model with senior clinical leaders in host organisations across HSCNI.

As a GP trainee the fellowship has given me insight into the strategic and organisational aspects of General Practice as well as the wider HSC, the challenges that it faces and the value of true integration of care and meaningful co-production. I believe that this leadership training will offer real system benefits in connecting services, understanding how different people, teams and organisations interconnect and interact. By taking a collaborative leadership approach, I hope to use my skills by influencing for results, developing capability within the system, and enabling teams to deliver care across traditional boundaries.

I have gained immensely from the practical experience of being involved in a range of strategic projects focused on improving General Practice, and have particularly enjoyed and benefited from the opportunity to learn from inspirational leaders across our system. ADEPT has made me appreciate that whilst there are some inherent qualities suited to leadership roles, effective clinical leadership requires continual personal reflection, learning and growth in response to challenges and experience; and that it is essential all HSC staff feel encouraged and empowered to develop and use their leadership skills to the best of their ability and for the wider benefit of the system. I feel very privileged to have had this opportunity and believe it will enable me as a future GP to better influence and affect change to improve patient care and experience. I now feel a much greater connection to the HSC as a wider system as opposed to being a member of an individual specialty or trust area, as well as a greater sense of personal responsibility and confidence in my ability to actively contribute to improving our system.

Shared leadership in and across teams

Collective leadership requires us to develop shared leadership within teams and across teams based on open and supportive communication, candid and mutual feedback and agreed, shared and challenging goals. This will build communities of teams and create a culture that values differences and enables decision making at the closest point of contact to our users by teams rather than individuals. In our teams, we need to create a cohesive, optimistic and effective environment that stimulates and supports innovation, continuous learning and quality improvement. Every team must include among its objectives a commitment to improving the effectiveness with which they work with other teams and organisations to ensure the delivery of the best possible care and support for the population.

Northern HSC Trust

The Northern Trust focused on the design, implementation and evaluation of a virtual renal review clinic model for patients with Chronic Kidney Disease (CKD).

The Virtual Renal Clinic Project was led by a consultant nephrologist and included specialist nursing, community nursing, booking office and service management. This team worked together to agree a protocol for identifying CKD patients who would be suitable for telephone review with a renal nurse specialist rather than a face to face consultant review appointment. A pilot was established whereby suitable patients were offered a transfer to nurse telephone review, and a total of 60 patients were moved across. The feedback from patients was strongly positive, with a particular focus on avoiding a stressful and time-consuming trip to hospital. The evaluation showed a safe and effective service, less resource-intensive than a consultant review clinic, delivering excellent patient experience and a reduction in the renal outpatient review backlog.

The success of this initiative was largely due to the collaborative approach taken from the outset: clinical leadership from the consultant nephrology team, a willingness from the nurse specialist to try new ways of working, support and flexibility from community and admin services, and project and QI support from divisional management. The result is a safe and robust model for nurse-led virtual clinics which delivers good outcomes and excellent patient experience.

Western HSC Trust

The Western Trust developed an Infant Mental Health Strategy in 2011 that brought attention and focus to the importance of early intervention. As part of the natural development of the strategy it was important to grow leadership to promote and develop the culture of early intervention and also to lead and nurture innovation. There was a view that whilst important, the emphasis was only on very young children. The creation of a broader focus on Emotional Health and Wellbeing of all children and young people enabled a collective leadership approach to emerge. The collective leadership approach has generated broader interest and commitment across services thus enabling the strategy to permeate into the organisation at every level.

Bringing together a range of leaders from a range of professions and specialities was a challenge. Significant time was taken to agree the overarching vision and subsequently signing up to working together to ensure that there was quality and improvement across the whole system. The collective leadership challenge was significant and took time to embed. This was time well spent. The founding principle was that to succeed the contribution of everyone must be valued.

The leadership group has consolidated and grown in numbers and strength over the past 12 months. It has agreed a programme plan that is founded on the agreed vision and articulates what it hopes to achieve over the next 12 months. All of the leaders are leading by example and encouraging creativity and innovation. The secret has been collective ownership of the strategy and a commitment to work collaboratively to ensure there is positivity, energy and enthusiasm for every action undertaken. The group meet regularly and undertake work that spans all programmes and directorates ensuring key programmes are available to all.

Belfast HSC Trust

Delivering safe, high quality and compassionate care at all levels is the first order priority for the Belfast Health and Social Care Trust.

We are working to develop a culture of excellence in safety and quality; engaging, inspiring and supporting our workforce to deliver improved outcomes and experience for those who access care. By getting this right, we'll have collective leadership within and across our areas, and with other organisations in the wider HSC family; prioritising overall care outcomes rather than just the success of our part of it.

It is clear from the views of our staff, service users and research that a new way to think about leadership is required, one which enables local teams to take control and have the permission to drive improvement. This has shaped a broad programme of work focusing on creating the conditions – the structures, processes and behaviours – we need to deliver our first order priority. Our culture change programme covers all aspects of our corporate objectives and includes a relentless focus on safety and quality outcomes, supported by ways of working that nurture innovation and shared learning, and improved decision making and collaboration through a network of high performing teams.

Here's a snapshot of some of our work to date:

- Building the will and capability for safety and quality – delivery of a range of QI programmes, support materials and project based work involving staff from across all professions and levels. This is aligned to our Trust QI strategy and plan.
- Building the capability and confidence for collective leadership – including our Medical Leadership Development (consultant medical staff and above) and Leading with Care programmes (successful at tiers 3 and 4, and now being rolled out to all staff at Tier 5)
- Living our values – engaging staff in dialogue about our Trust values and objectives, and what these mean in our day to day working lives.
- Collective leadership in action – originally looking at improving the unscheduled care performance and experience of service users, IMPACT is a multi-disciplinary, collective leadership approach to service improvement which is now being rolled out in other service areas.
- Challenging our ways of working – looking at how our leadership structures can be enhanced to deliver more local accountability, partnership working, and better individual and collective decision making closer to the point of care.

The Trust is currently aligning and developing its enhanced leadership and decision-making structures, embedding collective leadership as a key enabler to the delivery of safe, high quality and compassionate care within teams and across teams. It is about continuously learning within teams, across teams, organisational boundaries and enabling better decision making, and the drive for quality improvement closer to the point of care.

Interdependent, collaborative system leadership

In our changing landscape of health and social care, our leaders must work effectively across boundaries. As system leaders we must create:

- A compelling shared vision for transforming the health and wellbeing of our population across Northern Ireland
- A shared commitment to work together for the medium and long term (not only the short term)
- Frequent contact between leaders who need to work together to build trust and make real progress in order to deliver a world class service
- A shared agreement to surface and resolve conflicts quickly, fairly, transparently and without blame, and a commitment to collaborative problem solving
- A commitment to establish shared learning for improvement rather than blaming for mistakes
- A clear commitment to support and value each other's organisations, mutually supporting system success in transforming the health and wellbeing of our population
- Equal partnerships between those who work in health and social care and the people they serve, through a co-production approach

Public Health Agency

Public Health Agency (PHA) worked in partnership with Age NI and local HSC Trusts to achieve a shared vision for improving nursing services in older peoples' settings using a co-design partnership approach with users. Peer educators from Age NI led on the co-design function of the initiative to identify what really matters to older people in care settings.

The production of a regional report 'What Matters' sets out the achievement of a number of products which have been very well received including a DVD and training resources which were co-produced in partnership through meaningful collaboration with HSC Trusts, PHA, users, Age NI and education providers. This successful collaboration has resulted in the PHA securing a significant nursing award from Burdett to undertake additional work with the organisations, based on the recommendations from the report.

A Lived Experience Perspective, Eileen Shevlin

I have been a member of the Service Delivery Board (SDB) within the Recovery College of the South Eastern Trust since its inception in 2014. Our college embraces a shared leadership approach with our vision built on the values of hope, control and opportunity. This means that the Board consists of an equal number of professionals, service users and partner organisations who are strategically responsible for the ongoing development of the college, monitoring quality and advising on how resources should be prioritised within the college.

The experience of working in this way, where all people are recognised for their unique skills and talents, has transformed relationships and the way we do things, as everyone is valued equally and everyone feels that they have a contribution to make. This is true co-production with our shared leadership approach recognising the equal importance of both learned experience and lived experience.

Personally, it has given me the opportunity to rediscover the skills that I thought I had lost forever due to my mental health. I could dip my toe in the water of a working environment again where Compassionate Leadership meant that I felt safe to be authentic, honest and open as well as demonstrate that I had leadership skills without being in a position of power. This co-productive way of working has given me great hope for my future and for the future of others, by recognising that everyone has their own skills and strengths from the strategic leaders, to the people at the front line and those who use the service.

The strength of the collective leadership approach adopted by our Recovery College means professionals and people with lived experience are proactively engaged, are empowered to make decisions and own the drive for better outcomes. At its heart is a culture of co-production and mutual learning with a commitment to 'no decision about me without me'.

Working together in this way has transformed the culture and relationships between managers, staff, people with lived experience and third sector organisations, with leadership seen as our shared responsibility.

For me it has opened many doors and created opportunities which I have grabbed with both hands. Wellness for me has always involved returning to the workplace using the skills that I had spent my life developing. Now, thanks to co-production and using a collective leadership approach I have a fabulous new CV and I feel ready to return to work and use those skills again.

Compassionate leadership

As leaders, whether formal or informal, we will create our desired culture of strong, visible collective leadership focused on high quality care and support which is continually improving and recognised through our behaviours. Creating a consistent approach to compassionate leadership in practice is:

- Attending: paying attention to our people – being present and listening with intent
- Understanding: finding a shared understanding of the situation
- Empathising: using emotional intelligence and engaging with our people
- Helping: taking intelligent action to help

Our leadership community will be characterised by authenticity, honesty and openness, curiosity, decisiveness and appreciation.

Department of Health and Public Health Agency

The Family Nurse Partnership (FNP) Programme is an intensive, preventive, one to one home visiting programme for young, first time mothers from early pregnancy until their child reaches two. Its main aims are to improve pregnancy outcomes, child health and development and the economic self-sufficiency of the family. FNP aims to introduce a new approach to nursing, working with the parents to help them build up their own skills and resources to parent their child well, but also to think about their own future aspirations.

The FNP programme is based on positive psychology and strengths based practice and collective leadership. At all levels of the organisation it is the responsibility of all to practise strengths based working, building on the client's and nurse's strengths and resilience to build a hopeful and positive future for the family and new baby. It is a shared leadership by all of the FNP team. Family nurses and clients manage incredible change and challenge in their lives. Every day, FNP teams support clients to navigate and overcome often unimaginable difficulties and uncertainty. They do this by drawing on past experience, skills and evidence, staying calm, being brave, and trusting their instincts – and each other. The FNP teams practise kindness compassion when working with young families and others. The building of respectful relationships between clients, nurses, stakeholders and supervisors is key to the success of the programme. The central team, supervisors and family nurses all role model compassion and self-awareness to enable and empower clients to develop their sense of self efficacy and confidence. This creates a parallel process between Supervisor and Nurse and Nurse and Client. Collaborative working with other professionals and agencies, building on a strengths based approach, remains central to the effectiveness of the programme.

The family nurses are supported by frequent restorative supervision by the supervisors, psychologists and safeguarding nurse. Supervision supports nurses to remain compassionate and strengths focused. Emotionally nourishing nurses through supervision processes, good leadership and an excellent learning programme will spread in a positive way to the young mothers, children and families. The FNP teams take time to be compassionate with each other and model this self-care to others.

The young clients and the family nurses are actively encouraged to help us develop and improve the programme. With leaders at all levels the FNP teams have a responsibility to listen to, be curious, understand, respect and value different views. The central team, supervisors and family nurses strive to find a shared understanding on how to improve the quality of the programme and ensure the high quality implementation and compassionate care.

Southern HSC Trust - Deirdre's story

Deirdre is a Health Visitor Team Manager in the Southern HSC Trust and took up post in 2012 having previously worked in the team for a number of years. This is Deirdre's story, as told by her team members.

"When our last Team Manager moved on to a new post in 2012, there was one team member that we all knew would be the right person for the job, and thankfully she succeeded in obtaining the post. Right from the start Deirdre was faced with many challenges. Our actual numbers of staff had been gravely depleted through general staff shortage, sick leave and maternity leave and even more stressfully – by a very dear and much-loved colleague who was diagnosed with a rapid terminal illness and died in November 2015.

Naturally our entire team was devastated but throughout all of this very challenging time, our Team Manager, Deirdre, was exceptional, continuing to motivate our small team with great compassion and professionalism. Deirdre ensured we all had time to visit our friend one last time, and had Carecall attend our team meeting to help us cope with our emotions and understand the way we may all face situations with different coping strategies, so we could better understand and support each other in our own ways. Despite her own personal grief at the loss of her dear friend and colleague of many years, Deirdre sought to help each one of us with great compassion and insight and offered each one of us, as individuals, her time.

Despite her own over-burdening managerial duties, Deirdre is not afraid to roll up her sleeves and help our team by practically carrying out home visits and hands-on duties. She keeps in touch with what's happening on the ground, yet excels in all her managerial duties leaving our team with the full knowledge and confidence in her ability and skills, to feel very well supported.

Deirdre is not a 'soft touch' but a quiet, very unassuming, yet inspiring role model in every way. She has the knack of helping us to feel special and valued in all that we do, aiding team cohesion and certainly staff morale. Deirdre has continued to work tirelessly and relentlessly to ensure that all of our team are mentally, emotionally and physically well. She always arrives in with a smile on her face, instantly inspiring and empowering us all to face the work challenges of each day. Her flexibility with the team and genuine compassion is often breath taking given the personal challenges of her own role on a day-to-day basis."

NHS England have already begun to put in place practical actions needed to develop and strengthen collective leadership across their system.

This case study provides an early illustration of the outcomes achievable through the implementation of a collective leadership approach.

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

The Trust had already standardised its approach to QI and recognising the role leadership has in creating culture, believed the next step was to develop an aligned leadership strategy. This had huge support from the Board.

Our change team is one of the things we are most proud of. We developed a set of criteria in order to recruit to it. To apply, individuals had to:

- have the sponsorship and support of their line manager
- meet the criteria
- commit to attend 6 workshops
- undertake cultural audit work between the workshops

All of this was in addition to their "day jobs".

Applicants were shortlisted and assessed by a panel that consisted of execs, non-execs, heads of nursing and quality and directors of operations. The Board was also fully engaged in the process. We deliberately recruited a diverse section of people in terms of grades, roles, skills and experience. We tried to select a team that was representative of the workforce.

We originally planned to recruit 12 change champions but from a strong field we actually recruited 15 people from a pool of 30, one of the team is a patient/volunteer representative. Being in the change team is a development opportunity.

The impact has been huge. At the end of Phase 1, Discovery, the change team gave a presentation of their findings to the Board and received a standing ovation. The Board wanted to know how things really were, and the change champions felt they were doing something really valuable. We took the views of over 900 staff into account and, in itself, the cultural audit has proved to be a very positive engagement activity.

The change champions then worked with the Board to determine priorities and develop next steps. They gave further presentations and then sought feedback from the clinical directors and the council of governors. This work was then translated into an action plan which was agreed at the board meeting in July. The action plan set out our quick wins 'just do it' actions and things we need to take to the next phase: Phase 2: Design.

Our next steps are roadshows from our diagnostic phase – the 'cultural audit' - are now underway with a series of open meetings and attendance at existing team meetings being held. In these sessions, the findings of the cultural audit are being shared, staff are being invited to feed back on the findings and recommendations and shape the new culture. These sessions are being delivered by the change champions who are working in pairs and supported by a member of the executive team at each session.

We are now developing the design phase and looking to recruit more change champions alongside the current team.

Some of the outcomes that we are able to report are:

- following the CQC inspection, nearly 80% of our services received ratings of 'good' or better
- against a background of continued and sustained growth in emergency admission, our OPM length of stay reduced from 10.3 days to 6.2 days
- reduced spend of agency staff by £3.4m
- results from the National Staff Survey have improved:
  - 77% of staff recommend the Trust as a place to work (66% in 2016)
  - 89% of recommend the Trust as a place for treatment (83% in 2016)
  - Overall impression of Trust, mainly good 94% (88% in 2016)

The Actions

This strategy sets out our commitment to develop and implement a consistent collective leadership approach across our health and social care system in line with Health and Wellbeing 2026: Delivering Together. We recognise that this will not be easy and will require continuous effort. The outcome of implementing this strategy will be the development of collective leadership capabilities at all levels and the creation of a collective leadership culture that will deliver high quality, continually improving, compassionate care and support for our population.

To realise our ambition to deliver a world class health and social care system we must work together to deliver the following actions.

What are we going to do?	Date
Phase 1	
Establish and embed a core set of values and associated behaviours.	March 2018
Develop a framework that outlines the critical collective leadership capabilities needed by all our people who work in health and social care.	June 2018
Design and implement a system to monitor the outcomes and review the implementation of the collective leadership strategy.	June 2018
Embed the collective leadership framework into all leadership development activities consistently, including and ensuring talent management and succession planning.	March 2019
Develop a framework that will support and enhance team working in and across the system.	March 2019
Establish a programme of work that will modernise selection and recruitment arrangements within health and social care and is aligned to the Regional Workforce Strategy.	June 2019
Collaborate with education providers and professional bodies to introduce the principles of collective leadership into undergraduate and postgraduate training.	June 2020
Phase 2	
Embed the phase 1 actions across health and social care organisations	March 2024
Evaluate the outcomes identified in the strategy of - collective leadership capablities at all levels - a collective leadership culture within health and social care organisations.	2018-2026

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Health and Social Care

Designed by the Public Health Agency.

Health and Wellbeing 2026: Delivering Together

10/17

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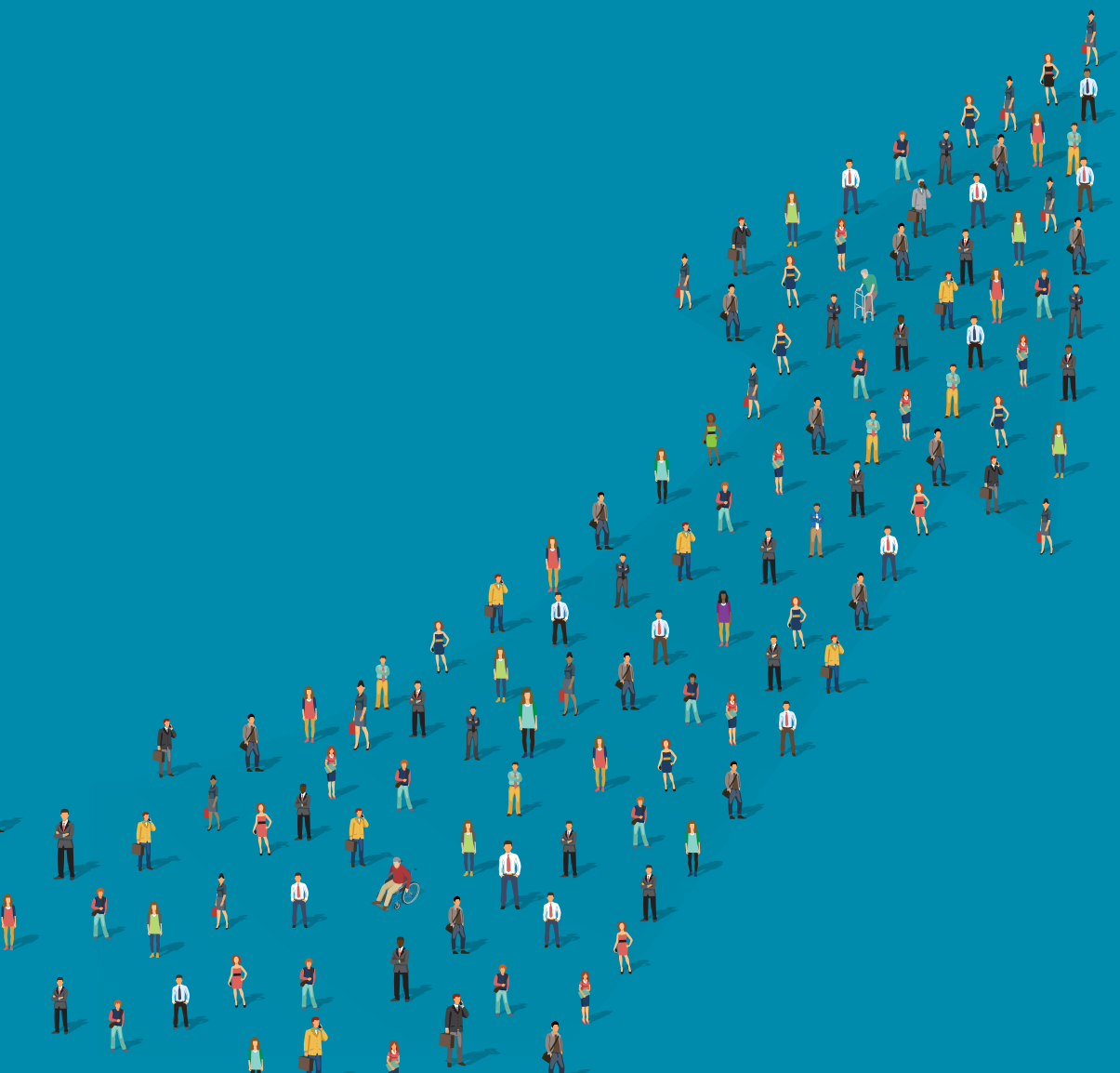
Co-production Guide

Connecting and Realising Value Through People



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Section 1:

What do we want to achieve?

1.1 Our Task

The **Delivering Together** Transformation Implementation Group (TIG) asked for the development of a practical guide to support the application of co-production across our health and social care (HSC) system. This guide has been developed using the principles of co-production in partnership with people who have experience in using health and social care services, Carers, HSC staff, Managers, Personal Public Involvement (PPI) leads, the Health and Social Care Board (HSCB), the Public Health Agency (PHA) and the Patient Client Council (PCC). They were partnered by community and voluntary sector representatives, local government representatives and policy makers from the Department of Health (DoH). Together they have brought their extensive knowledge and experience of co-producing to inform this guide. It is this system wide partnership approach that has given the guide its genuine authoritative footing in providing direction on how co-production can be an enabler of transformational change.

Transformational change in this guide means harnessing the collective efforts of policy makers, people who use services, carers, staff, staff representatives and local communities who all ***work together in partnership to improve health and wellbeing outcomes*** for the people of Northern Ireland. It places **people** at the centre of decision making and aims to connect people together in representative networks so that they can meaningfully influence, shape and participate as real partners in the commissioning, planning, delivery and evaluation of services.

Recognising that co-production is a developmental and incremental process the guide acknowledges that it will take time to fully embed and reflect the principles of co-production in HSC systems. The guide however sets out an ambitious mandate and outlines the key steps required for the adoption and implementation of co-production across all HSC organisations. It represents an opportunity to co-ordinate and integrate all the work undertaken through PPI, patient experience, service user feedback, peer networks, expert patients, peer advocacy, public consultation and community development, into an integrated approach.

The guide requires all HSC organisations to review the extent of partnership working across its services and to develop an integrated plan in order to strengthen co-production between people who use services, staff, their representatives, local communities and multi-agency partners.

1.2 Co-Production Parameters

Uniquely the DoH and its 'Arm's Length Bodies' are the only public bodies in Northern Ireland which have a statutory duty to involve and consult its stakeholders, therefore the guide augments and builds on the requirements set out in current PPI policy[1].

Our goal is to support transformational change through a co-productive approach and promote the opportunity for all sections of the Northern Ireland community to partner with health and social care staff in improving health and social care outcomes. This will be done within existing statutory requirements. The extent to which decisions will be co-produced will be dependent on Executive and Ministerial priorities, adherence to legal and regulatory requirements, professional standards, and HSC organisational financial accountabilities.

It is also important to note that patient and public safety is paramount and there are a range of circumstances where Health and Social Care services within its statutory and legal duties may not co-produce decisions in order to safeguard people and families who are physically, psychologically and socially vulnerable. In this context it is incumbent in line with legislation, statutory, policy and professional requirements that HSC services and professionals are open and transparent about why this is so, and provide information on how people(s) best interest will be reflected and protected throughout decision making processes which impact their lives.

1.3 Our Purpose

To meet the challenges of a 21st century population, we need to be ambitious in how we plan to transform our services to meet the needs of our population, in a safe and sustainable way, so they can ***enjoy long, healthy, active lives*** and to enable those with long term and life limiting conditions to live as well as possible.

Delivering Together 2026 Section Four 'the Approach' identifies partnership working as one of the five enablers in the delivery of HSC transformation. Figure 1 sets out the core requirements and the guide has been developed in recognition that' *"Our Health and Social Care system belongs to all of us and we all bring valuable insights to how it can improve. We must work in partnership - patients, service users, families, staff and politicians - in doing so we can co-produce lasting change which benefits us all"*

1 https://www.health-ni.gov.uk/topics/safety-and-quality-standards/personal-and-public-involvement-ppi
2 Delivering together The Approach Section Four https://www.health-ni.gov.uk/sites/default/files/publications/health/health-andwellbeing-2026-delivering-together.pdf

Figure 1

Co-production will empower patients, service users and staff to:

• **design the system** as a whole to ensure there is a focus on keeping our population well in the first place and ensuring that when people need support and help they receive safe and high quality care;

• work together to **develop and expand specific pathways of care and HSC services** which are designed around people and their needs, including setting outcomes to measure impact;

• be partners in **the care they receive** with a focus on increased self management and choice, especially for those with long-term conditions.

Delivering together commits health and social care to:

- Adopt the co-production and co-design model for development of new and reconfiguration services.
- Maximise the lived experience (patient & carer) voice across the system.
- Engage staff particularly staff who are closest to those who use our services in co-design and in the co-delivery of services.
- Build and strengthen partnerships working with other providers of care, including those in the community and voluntary sector and in other government sectors in support of Programme for Government (PfG) priorities.

1.4 Let's Talk About Language

Some of the language and concepts of coproduction are often misunderstood and interchangeably used. It is therefore necessary to set out a number of key definitions of terms used through this guide in order to support understanding.

Definitions used in this document have been developed to reflect and expand on The Executive Office of the Northern Ireland Civil Service (NICS) Policy Champion's Network Guides, *'A Practical Guide to Policy Making in Northern Ireland'* published in 2016 and *'The Good Practice Guidelines for Effective Stakeholder Engagement (2nd edition)'*.

The language and definitions also align with the strategic direction of ***Delivering Together***.

When we talk about co-production, we are referring to a concept that requires the complete application of the six principles and the key implementation steps outlined in Section 3 in addition to the core concepts of co-design, co-delivery and co-creation. A number of terms used throughout the guide to describe the full range of actions associated with ***co-production*** have been defined in order to assist understanding.

Definitions

People

The term **'People'** used throughout this guide refers to citizens across all lifespan groups who use services, their families, carers policy makers, HSC staff, Trade Union Side, local communities, communities of interest, communities of practice, multi-agency and community and voluntary sector partners.

Co-production

A highly **person centred approach** which enables partnership working between people in order to achieve positive and agreed change in the design, delivery, and experience of health and social care. It is deeply rooted in connecting and empowering people and is predicated on valuing and utilising the contribution of all involved. It seeks to combine people's strengths, knowledge, expertise and resources in order to collaboratively improve personal, family and community health and wellbeing outcomes. Co-production is not just a word, it is not just a concept, it is a genuine partnership approach which brings people together to find **shared solutions**, In practice co-production involves partnering with people from the start to the end of any change that affects them. It works best when people **are *empowered*** to influence decision making and care delivery processes.

Co-design

A **partnership approach** which seeks to establish a *representative co-design team* of people, who come together to **design care pathways, develop new and revise existing services models**. The work of co-design teams is governed by person centred values, a shared ambition and commitment to generate solutions in line with the quadruple aim outlined in Delivering Together 2026.

Co-delivery

A partnership approach which aims to **empower multidisciplinary** teams to deliver **integrated care** solutions for their population. It also involves developing and integrating expert patient, peer and community led services into the delivery of health and social care.

Citizen Powered Health and Wellbeing

This is a population health approach which seeks to create the conditions in which people can be empowered, to take a more active role in their own health and social wellbeing. It crucially involves addressing the wider determinants of health and social wellbeing and requires a shared understanding of need. Based on population need stratification, it requires targeted resources in support of prevention, early intervention, recovery and personalised support for those with long term and life limiting conditions.

Lived and Learned Experience

Throughout the guide the terms 'lived experience' and 'learned experience' are used. **Lived Experience** is used to describe the direct experiences, perspectives and views of patients, clients, service users, peer advocates, and carers of their own health and social care needs and that of the services they received. **Learned experience** includes all those staff who are directly involved in leading, managing and providing health and social care.

Being Representative

One of the key objectives of co-production is to avoid unrepresentative perspectives and opinions and to create from the outset equal opportunities for people to influence and shape the design and delivery of health and social care. This means ensuring a representative balance of the people who use services, carers, staff, trade union staff and as appropriate other partners in co-design and co-delivery teams. It is also important in line with Section 75 responsibilities that particular attention is paid to including under representative/hard to reach groups.

Shared Decision Making to Enable Partnership Working

Decision making in HSC is governed by a wide range of legal, professional and policy mandates. In the case of HSC organisations the specific responsibilities of their Chairs, Boards and Chief Executives as well as of the sponsoring Department are set out in the management statements between the Department of Health and each of these HSC organisations. Set within PPI legislation, co-production creates the opportunity for people to work in genuine partnership and to take shared responsibility for improving health and social care outcomes. This requires a commitment to create opportunities for shared decision making to enable partnership working which involves sharing information and developing collective evidenced based solutions. The principle of shared decision making is deeply rooted in prompting equality of opportunity for people who use services and those who provide them to **influence decisions about health and wellbeing**. As co-production develops shared decision making should become the accepted approach in the design of services. Whilst recognising that shared decision making does not mean everyone has the same authority, co-production seeks to **empower partners** to take **shared ownership** for the delivery of health and social care outcomes. This does not remove or dilute statutory accountability, however leaders act as catalysts in facilitating transformation by empowering people to work together to generate improvements in care outcomes.

Section 2:

Why Co-production is Important

2.1 The Co-production Ambition for 2026

As outlined in the draft PfG, our ambition is to enable people to ***enjoy long, healthy, active lives*** and one of the critical building blocks in achieving this aim is to move towards the creation of a 'Citizen Powered Health and Social Care System'. This requires the mobilisation of people into representative networks. **We want a system that partners and organises health and wellbeing with people, for people, and by people.** Therefore the only way to understand what matters to people is to work as partners with them. This requires a commitment to create (through genuine partnership) working opportunities for people to influence the decisions and shape the direction of health and social care.

A citizen powered health and social care system helps to support the building of people's social capital and recognises that the infinite talents and resources of people who use public services are often overlooked and sometimes diminished by the predominance of professional structures. There is a tendency to see **what's wrong, not what's strong,** alongside the unconscious willingness of people to slip into a passive role as recipients of services. **Therefore building social capital methods into the design and delivery of care is a critical aspect of co-production**.

It involves strengthening the commitment and connections between people and their respective social and community networks. Doing this not only addresses the immediate needs of people, but also enables collective action in tackling the wider determinants of health and wellbeing at both strategic and local levels. Inevitably this requires a commitment to embed community development and social enterprising approaches as we implement co-production. This is essential in generating new and innovative solutions with people.

As a system we will:

- **Value** and embed co-design and co-delivery as a core practice in improving health and wellbeing;
- **Value** the contribution and experience of people who use services by creating the conditions for them to ***enjoy long, healthy, active lives*** through the provision of personalised, evidenced based care and support.
- **Value** the outcomes that matter to people, families and their communities.
- **Value** evidence, quality improvement and innovation in achieving sustainable person, family and community centered outcomes.
- **Value** our staff and the wider workforce in the co-design and co-delivery of care systems.

Co-production enables us to genuinely create a system which enables people to play an active role and become invested in improving personal and collective health and wellbeing outcomes. To achieve success, a whole system approach is required. In the next ten years we will work to have a system which will have:

1. **Connected people together as part of the care system.** People working through representative groups and networks and it is usual practice for people to co-design and co-deliver innovative health and social care solutions. Participation has balanced representation and co-design teams routinely consist of people who use services, staff who provide care and as appropriate other partners. Health and social care leaders at all levels are champions of co-production and have created the conditions for partnership working.

2. **Embedded a population health and wellbeing approach**. Population health data, and predictive technologies will be used to anticipate need. This approach enables the development of a shared understanding of need and how actions can change health and social care outcomes for individuals and communities.

3. **Built social capital** as evidenced by more people designing their own health and social care wellbeing solutions. Personalised budgeting, community development peer, expert patient, and social enterprising approaches have demonstrated how improvements can be delivered in health and social care.

4. **Empowered and enabled integrated multi-disciplinary team working.** Teams are self-managing and take responsibility for quality improvement and care outcomes for their respective area of practice and localities.

5. **Utilised enabling technologies.** People are enabled to personalise their health and wellbeing goals, track and analyse their own health data. Enabling technologies support the personalisation of knowledge, self-management and the interactions between people and their health and social care team.

6. **Enabled people to provide real time feedback** on their experiences of health and social care. People's feedback (staff, service users and carers) is utilised to identify areas of excellence and also for service improvement by putting things right when their experiences have not met agreed standards.

7. **Quality assurance systems** fully reflect the principles and practice of co-production. People become partners in the quality assurance process across health and social care services.

2.2 The Benefits of Co-Production

Much has been written locally, nationally and internationally about the benefits of co-production for society, communities and for individual people. As detailed in **figure 2** adopting a co-productive approach is at the heart of improving people's experience of care. Co-production, done well can improve care outcomes, it can enable systems to become more effective, efficient, and is rewarding for the staff who provide care.

Figure 2

The Heart of Experience

Co-production demonstrably improves people's experience of care. This is achieved through relationship building, valuing people's contribution, partnering with people in making decisions about their lives, and creating the conditions for co-design/co-delivery of health and social care services.

Think Outcomes

Co-production creates the conditions for people to be empowered to take active responsibility for their health and wellbeing. It gives equal weight to the biological, psychological and social models in the design and delivery of care. Co-production recognises that outcomes are significantly improved when people are enabled to contribute to and work in partnership in order to ***enjoy long, healthy, active lives***.

Optomising Resources

Co-production is a strengths based approach which aims to harness the expertise of people and creates opportunities for partners to pool their resources, their talents and expertise. Services can become more efficient, innovative and cost effective.

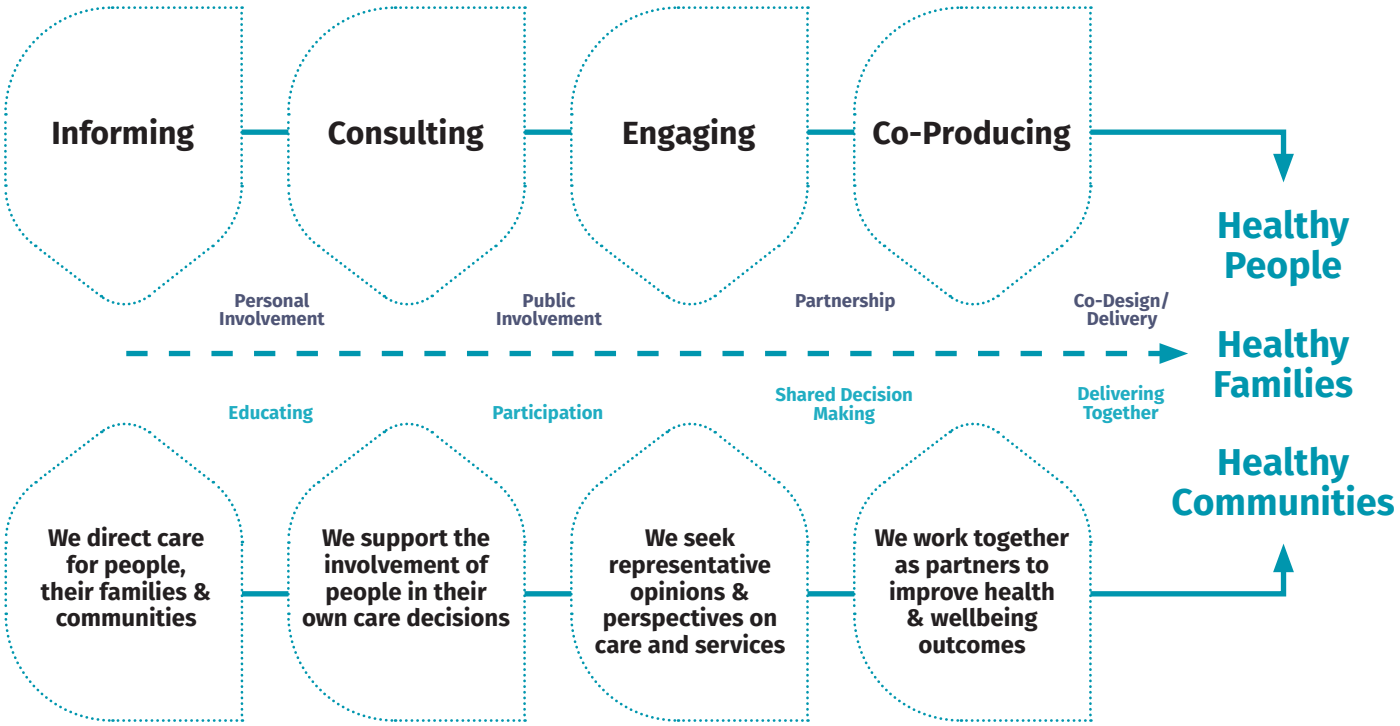
Staff Experience

Co-production is only possible when the staff who provide services are proactively involved as partners in the development and design of health and social care solutions. The evidence shows that when staff are empowered by their organisations and take responsibility the outcomes of care improve.

2.3 The Co-Production Pathway

Co-production has become an increasingly popular methodology in policy making, public health, services delivery organizations and in community sectors. It is important to **recognise** that the evolution of engagement and involvement to co-production in health and social care holds the promise of improving outcomes, it is not always clear what counts as or what is meant by "co-production", what it entails in practice, or what is actually being co-produced. This is because involvement, engagement and co-production approaches are all part of a continuum as outlined in the co-production pathway figure 3. This ranges from involvement, to co-design and co-delivery. The other reason why there is so much variation in approaches is often influenced by the context, culture and beliefs about when co-production is appropriate.

Figure 3



Whilst co-production may challenge conventional forms of engagement and involvement; common to all these approaches is a **desire to improve the interaction between people who use services and staff who provide care**. The real value of co-production is its ability to **create the space** to bring together different and representative perspectives in order to co-design innovative solutions which improve outcomes for people, their families and communities.

Locally, nationally and internationally 'co-production' is seen in current policy agendas both as the next logical step to personal and public involvement by offering a new way of incorporating people's expertise in more substantive and meaningful ways into the design and delivery of health and social care services.

One of its distinctive features involves bringing people into the decision-making process by working across organisational boundaries. This helps to reduce knowledge gaps and addresses power imbalances between different participants. Blurring boundaries erases artificial distinctions between 'recipients' and 'providers' of services. The process of co-production must take into account the participant's understanding of involvement and co-production; the differences between involvement and co-production; and how the power disperses between partners can be equalized through the process of co-design and co-delivery.

The power of co-production is best understood through the shared narrative that evolves when people find ways of working together to generate better outcomes and recognises the ***'sum is greater than all of its parts'.***

Figure 4

What co-production is and is not

✓ Co-production IS:	✗ Co-production is NOT:
Partners respecting each other and valuing each others perspective and contribution	Just giving people a chance to speak but not using the information.
Working together from the very start to identify and achieve an end result that is collaboratively agreed on.	Confrontation and 'winning and losing'.
Listening to each other and understanding where everyone is coming from and the particular challenges they face.	A quick fix.
At times deferring to the other on grounds of practicality, economics, ethics, equality of civic rights, requirements under section 75.	Consultation i.e. having a plan and then going out to tell people about it OR even having a plan, asking people's thoughts and about it and incorporating these thoughts into a revised plan.
Valuing, learning from and building on the different skills, assets, experience and expertise that different people bring to the process.	One partner simply trying to persuade another to come around to their way of thinking.
Working in ways that best meet the needs of all partners.	Listing problems and expecting someone else to solve them.
Sharing ownership for developing solutions that are evidence based, work and are deliverable.	A new way to get your personal agenda on the table at the expense of someone else's.
Breaking down barriers between professionals/ providers and people using public services.	A new forum for public service staff to tell people what is going to happen, or for people to lobby the public sector.
Committing jointly to support and develop the capacity and understanding of all people involved in the process.	
Trust, support and information sharing.	
Taking shared ownership when solutions don't work first time and taking a joint problem solving approach to move forward.	
Talking with and not to.	

Section 3:

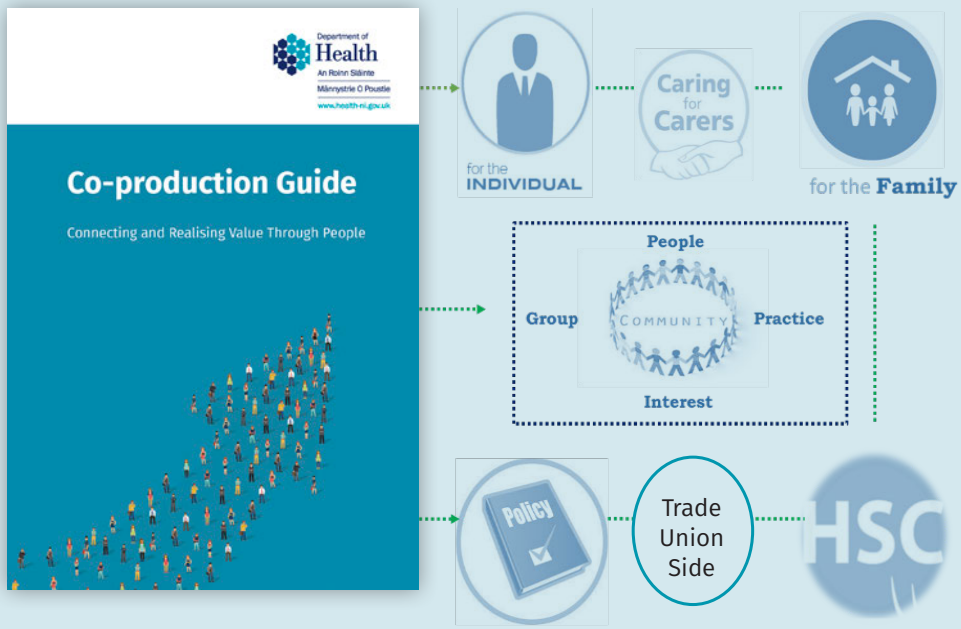
Guide on ‘How To’ Co-produce

3.1 Who can use this Co-Production Guide?

As outlined in figure 5 the Guide has been developed for all those involved in the design and delivery of health and social care specifically with:

1. people who use services their families and/or Carers,
2. local communities, community groups, communities of practice and community of interest.
3. Policy Makers, system Leaders, staff who deliver care and TUS.

Figure 5



It aims to provide guidance on the core principles and practice which underpin co-production and should be of specific use to:

The co-production principles outlined in this guide have been tailored in section 3 to support the embedding of co-production into policy making, strategic planning and care delivery. The Guide is specifically intended to complement existing PPI policy and other key areas of transformation identified in ***Delivering Together***, which includes but is not limited to:

- HSC Leadership Framework;
- Improvement Institute;
- HSC Community Development Framework;
- e-Health Strategy.

- HSC Organisations
- HSC Board Members and Executives
- PPI staff and forums

- Carers
- Primary Care Services
- Local communities
- Communities of Interest
- Community and Voluntary Organisations

- Patient Client Council
- Policy makers and transformation work-stream leads
- People with lived expereince and peer networks

- Staff at the point of care delivery
- TUS
- Operational Managers, Team and Clinical Leads

3.2 The six principles of co-production

The following six principles will enable the implementation of co-production across all HSC organisations. Building on existing PPI infrastructure and using practical steps outlined in this guide each HSC organisation will embed co-production in its strategic, and operational planning.

Valuing People

Co–production is a person centred process which is dependent on building reciprocal relationships between people. It is based on developing mutual respect, openness and accepting collective ownership for outcomes. It recognises that people possess a wealth of different knowledge and expertise about needs, what matters, and what has to change in order to deliver better outcomes. This means we will:

- acknowledge that everyone on the co-production team is an asset with individual skills, strengths and experiences to contribute;
- find ways to use and develop these assets; value everyone's contribution; and build on citizen's ability to participate; and
- work together to develop confidence and strengthen capacity, making sure the voices of everyone co-producing on a project is heard and understood.

Building Representative People Networks

A core principle of co-production is to move towards balanced meaningful participation, engagement and shared ownership. It is about developing effective collaborative partnerships in order to co-design and co-deliver services. It is dependent on developing representative and sustainable networks, with people from all sectors including those who have been marginalised and are hard to reach. The ***principle of representative*** means that co-design and co-delivery groups should reflect a balance of people who use services, staff who provide services and as appropriate other external partners. This requires detailed stakeholder mapping using the **'ARE IN'** principles:

- **A**uthority: People with the ability to act to influence change and enable it to happen when a solution has been developed by the group.
- **R**esources: People who know what we have capacity to do/not do (e.g. finance/HR/access/influence).
- **E**xpertise: In the topic (social, economic, technical, professional etc.)
- **I**nformation: That others need (data etc)
- **N**eed: Service users, carers, staff and others who will be affected by the outcome

Mapping stakeholders in this way will help strengthen existing networks; enable the development of new networks; and to bridge networks where gaps exist. It also creates a real opportunity to maximise social capital through the development of peer led/community networks.

Building People's Capacity

Co-production is dependent on creating the circumstances for shared decision making and power from boardroom to point of care services. This requires investment in:

- building people's knowledge;
- training people in PPI, co-production, quality improvement, population health and community development approaches; and
- harnessing the efforts and work of: local PPI forums; co-production teams; peer networks; Integrated Care Partnerships (ICPs); thematic/communities of interest; quality improvement teams; and other community networks into a logical representative approach.

Reciprocal Recognition

HSC organisations will need to dedicate resource to support co-production, invest in building the capacity within their organisation, mentor/coach/ support people with lived experience and release their staff to become involved in the co-design and in the co-delivery of services. Co-production requires the contribution of all participants to be valued and a commitment to learn together, and resolve different perspectives with respect. As appropriate co-design and co-delivery contributions may include non-monetary and/or monetary rewards.

Cross Boundary Working

Co-production also creates the conditions for a multi-agency approach to the improvement of outcomes for local communities. This is about mobilising all the assets of the community, voluntary sector, and all relevant government organisations. This creates opportunities to pool resources and assets in working towards shared goals and better health and social care outcomes.

Enabling and Facilitating

Co-production requires staff, leaders and managers to become facilitators and enablers of change. Effective facilitation is established by empowering all involved to have solution focused approaches and promotes joint responsibility for achieving positive outcomes. This means we also focus on outcomes and review by considering '*how much did we do, how well did we do it and is anyone better off?*' The system facilitates change and empowers people to have the confidence and opportunity to live their lives in the way they want to and to take control of their own future health and wellbeing.

3.3 Practical Guide for Policy Makers

This section is to help policy makers think about their role in enabling co-production in their organisations. Policy makers have a crucial role to play in creating the conditions for shared decision making to become a reality. This requires cultural change, commitment and collective leadership in order to engage people from the start in policy making processes and in the co-production of strategy.

'People with lived experience have said 'if you want us to step up, you have to learn to step down a bit'

Using the six principles:

Valuing People

People value the opportunity to be involved in shaping the key policies that affect their lives. For this to be meaningful policy makers should work to maximise the opportunities across the system for early involvement and engagement of people in the formulation of HSC policy. Make time for partnership working at all levels and facilitating the necessary background work order in to ensure people's voices and contribution are representative, valued, understood and reflected in the policy making process.

Building Representative Network

Policy makers will enable the active development of representative networks to support the drafting, design and evaluation of policy and strategy. This will include drawing representatives from these networks including unrepresented groups into the policy and strategy formulation process. Policy makers will proactively develop relationships within, across and outside their own department, in order to generate evidence based solutions.

Building People's Capacity

Through sharing knowledge and attending training programmes, policy makers will strengthen people's capacity to participate in the co-design of policy, strategy, and service improvement. There must be opportunities for reflecting and integrating people's experience and evidence into the development of new ways of working. This includes all partners understanding legal and statutory decision making processes as part of the progression towards shared decision making.

Reciprocal Recognition

Recognising and rewarding people's contribution particularly the lived experience and communities' contribution is a fundamental principle of co-production. In line with the reciprocity guidance, secure ring-fenced funding and/or other opportunities for reward to support the time people give to being involved in co-production work.

Cross Boundary Working

The draft PfG requires the wider public sector to work together to deliver better population outcomes. Policy makers should consider opportunities to collaborate and co-design policy widely to address need and ways to pool resources to deliver on agreed programmes of intervention.

Enabling and Facilitating

Policy makers have a critical leadership and enabler role in creating the condition for whole system collaboration (co-design). Policy makers can act as facilitators in the shaping of policy and in enabling collective agreement on the strategic shape and direction of services. Occasionally it may be important to source an independent person to facilitate the process of co-design.

Key Outcome

Community is more actively engaged in health and social care services design and delivery.

3.4 Practical Guide for Board Members and Executives

This section outlines the roles and responsibilities for HSC Boards and Executives (Non Executives, Chief Executives and Directors) leading the development of people powered health and wellbeing approaches through co-production, both within and across their respective organisations. For co-production to be successful it requires Boards, senior executive leaders to lead and have co-production embedded in the organisation's core business and its culture.

Valuing People

In creating the strategic and organisational conditions to enhance the role and contribution of people in the planning, development, delivery and evaluation of all the organisations activities and services. This involves leading from the front and valuing people's contribution by progressively sharing decision making and promoting co-design and co-delivery.

Building Representative Network

Through supporting the development of representative networks across all programmes of care. This includes investing time and resources in building relationships with local communities and groups of people who use services. It also involves investing in peer support, expert patient services and progressively creating self-managing teams who are empowered to co-produce with those who use services.

Building People's Capacity

Building the capabilities and capacity of the workforce to co-produce at all levels. Consider re-energising the role of the Board to overseeing the development of PPI/co-production in the organisation. This involves investing in co-production training across all parts of the organisation. It also involves open and transparent sharing of information in order to facilitate effective co-design and co-delivery with all relevant partners.

Reciprocal Recognition

Ring-fencing funding to enable the development of co-production across the organisation. This includes establishing systems that reward and recognise the contributions people make. It also involves learning from the experience of people who use services and staff who provide care by formally recognising how their contribution has changed the delivery of services.

Cross Boundary Working

As part of transitioning HSC systems of care, Boards and Executives will need to strengthen the organisation's community development role in addressing population health needs. Reach out and invest in multi-agency and community sector partnerships in order to deliver of better outcomes.

Enabling and Facilitating

Facilitating a change in organisational culture which embeds co-production at the heart of the organisation's strategic planning processes. This involves leaders providing oversight and enabling all those involved in service planning, development and improvement to reflect the principles of co-production in their practice.

Key Outcome

People are active participants in co-design and co-delivery of services. There are measureable and objective improvements in people and staff experience, care outcomes and there is evidence of increased productivity across all services.

3.5 Practical Guide for People with Lived Experience & Peer Networks

This section outlines the roles and responsibilities of people with lived experience in participating in service development and in leading co-production. Lived experience includes: direct experience of a health and social care need, carers, advocates and all peer support networks. Fundamentally co-production is a ***deeply person centred approach*** and is based on ***'No decision about me without me'***. It recognises the knowledge of people with lived experience **is of equal value** to staff experience and knowledge. Individuals and peer led/support groups therefore have a fundamental partnership role in formulating their own needs, developing their own personalised support plan, shaping and influencing policies, strategies, and in the co-design and co-delivery of services.

Valuing People

Recognise the value placed on their personal experience and knowledge and will value the worked experience of staff and in partnership with them and other partners work to break down barriers, create mutual understanding of needs, develop shared goals and improve outcomes for all.

Building Representative Network

Have a lead role in developing and building representative peer networks, and in working with other partners who participate in delivering, advocating or enabling better health and social care outcomes. This also involves working in partnership with others and representing lived experience on regional and local co-design/co-delivery working groups.

Building People's Capacity

Avails of training and development opportunities alongside staff in co-production on how HSC systems works. Will also co-deliver training and development for staff, and other partners in seeking to create understanding of the personal, psychological, and social economic needs. People with lived experience will have a leadership role in supporting the development of peer led and expert patient models and services.

Reciprocal Recognition

As a basic principle recognise that everyone has expertise, skills and strengths. Share ownership and accept responsibility with others for shared decisions. This will include advocating for positive change in service delivery models with peers across HSC systems. As outlined in the recognition section of this guide the contribution of people with lived experience will also be recognised, valued, and, where appropriate, remunerated.

Cross Boundary Working

Work with others and across organisational boundaries and through their representative networks influence other government departments, local government and all communities in working together to deliver better outcomes.

Enabling and Facilitating

Be leaders and facilitators of change and an advocate for co-production, supporting and enabling HSC staff and peers to work together to solve problems. Develop with others new and creative solutions which deliver evidence based outcomes.

Key Outcome

The experience of the health and social care system is more person centred, your contribution has enabled change and as a result health and wellbeing outcomes have improved.

3.6 Practical Guide for Operational Managers, Team and Clinical Leads

This section outlines the role and responsibilities of Operational Managers, Team and Clinical Leads in developing and leading co-production within and across their respective organisations. Operational Managers, Team and Clinical Leads have a key role in translating co-production into operational practice and showing leadership by facilitating their staff and people with lived experience to work in partnership to deliver improvements in personalised care and to design solutions which enables better outcomes for people who use their services.

Valuing People

Will champion co-production and demonstrate their organisations commitment by building lived and learned experience into the design of care pathways, service development and in the auditing and evaluation of services. Organisations will need to be accessible and visible in supporting, mentoring and in acknowledging the value of people's contribution.

Building Representative Network

Support the strengthening and development of partnerships working between staff, people with lived experience and their respective communities. Scope partners, map assets and enable the development of peer/lived experience networks. Create the conditions to support networks in the decision making process.

Building People's Capacity

Create time for staff to participate in co-design/co-delivery programmes. Develop training needs analysis, facilitate training in PPI and co-production methodologies. Embed co-production principles in team meetings, supervision, revalidation and continuing professional development processes. Create opportunities for people with lived experience to become involved in the development of care pathways and services. Ensure all participants are given the information they need to meaningfully contribute.

Reciprocal Recognition

Value and learn from the contribution of others, recognise and reward people in line with the principles in this guide. Link all co-design and delivery work to enable better outcomes.

Cross Boundary Working

Lead and build the necessary cross-government or multi-sector partnerships in generating solutions for improving people and communities outcomes. Proactively build connections and contacts beyond 'usual' boundaries, invest in and pool resources with others in outcome focused solutions.

Enabling and Facilitating

Develop/strengthen facilitation skills, and through effective compassionate leadership enable people with lived experience, point of care staff, and communities to solve problems together.

Key Outcome

Teams feel empowered; staff and people with lived experience feel valued; and health and wellbeing outcomes for people with lived experience have positively improved.

3.7 Practical Guide for Communities

This section helps communities as they embark on a transformational co-production process. Communities can be geographical or communities of interest. Geographical communities may reflect a location like a housing estate or a town. Communities of interest may be groups of people who come together from a shared experience or circumstance i.e. Tenants group or Men's shed. Co-production provides the opportunity for health and social care, other public services and the community and voluntary sector involved in health and social care provision to work with communities to design and produce services that are relevant to them. This transformational co-production process enables a different and deeper level of interaction and engagement of all those involved, from HSC organisations to other parts of the public sector through to local communities.

Valuing People

Proactively engage and build on the experience and knowledge of the people who use services and the experience of people and organisations that make up the local community.

Building Representative Network

Find and develop the peer supports that are available at community level. This may mean working in partnership with a number of new people or organisations, finding areas of common interest, or identifying gaps that others in your community can support or help in.

Build People's Capacity

Engage in activities and experiences which strengthen the levels of trust within communities and those community based organisations which are working to improve and sustain health and wellbeing. This includes HSC as well as other organisations i.e. councils, police etc. Refer to and use the knowledge known to the community to help determine what is relevant to their situation and circumstances.

Reciprocal Recognition

Value people's contribution in whatever form it takes. Be willing to use new ways to recognise people for their involvement through the use of schemes like time credits and time banking. Move towards working in a way which is reciprocal and uses the experience and knowledge communities have, and which introduces new communities to the process where they see positive benefits.

Cross Boundary Working

Traditional roles are re-examined and those best placed to address an issue with skills, knowledge, expertise and where necessary reallocation of finance are supported to do so. This is best done through established trusting relationships. These are built over time and will not happen overnight.

Enabling and Facilitating

As a community we are willing to learn and change alongside those within the HSC organisations and other public bodies. Move towards working more collaboratively investing our time into building relationships and shared solutions to overcome complex problems.

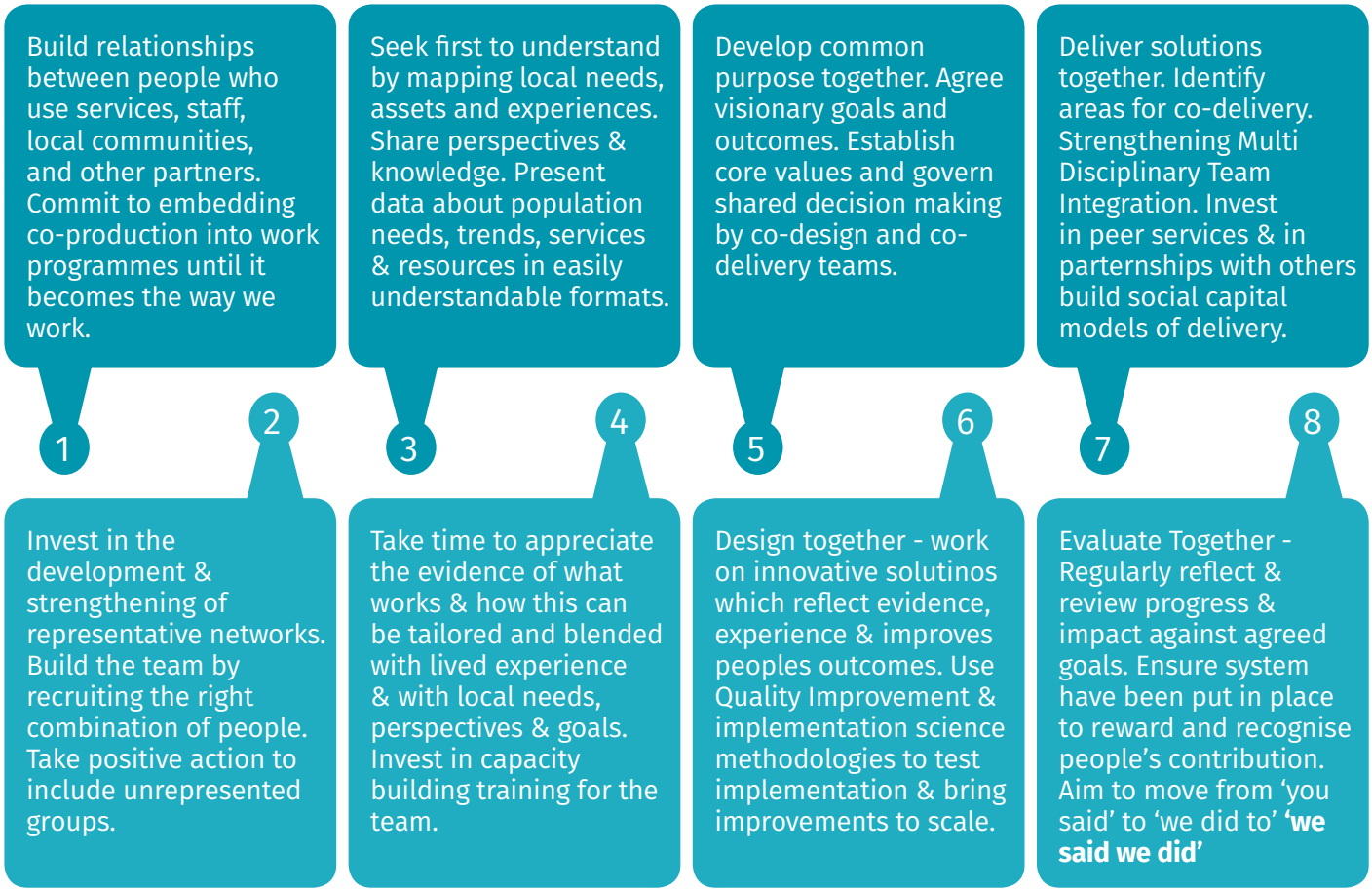
Key Outcome

Community is more actively engaged in supporting health and social care services design and delivery.

3.8 Key Implementation Steps to Effective Co-Production

To translate these prinicples outlined in section 3, figure 6 below, outlines eight key implementation steps which will enable the effective use of co-production within and across each health and social care organisation.

Figure 6



3.9 Collective Leadership

Co-production requires collective leadership at all levels. It reflects the need for distributed leadership and distributed ownership of policy, strategy and delivery within and across systems. It means system leaders:

- are accessible and visible to people who use services and the staff who provide them;
- adopt a facilitation role 'clearing the way' to enable shared decision making and real partnership working to occur, until it becomes the 'way we do things'; and
- exemplify the values and principles of co-production by ensuring they maximise the opportunities of partnership working in order to improve outcomes for all.

3.10 Reciprocal Recognition

At the heart of co-production is a commitment to value, reward and recognise the contribution of all partners, particularly people with lived experience. All the core literature on co-production recognises the principle of **reciprocity** which is defined as ensuring that people receive something back for putting something in, and builds on the premise of recognising and valuing people's contribution.

Examples of Reciprocity include mutual respect, equality of opportunity, joint learning, recognition, flexible rewards, and remunerating people for their role and contribution. This can also include benefits in kind, such as 'out of pocket' expenses, and meeting training and development costs. Depending on role or task being undertaken, rewards should be flexible and provide choice. The importance of choice cannot be overstated.

Recognise that there may be personal reasons why people do not want or are unable to accept payment for commissioned work and therefore rewards for people's time should be flexibly applied.

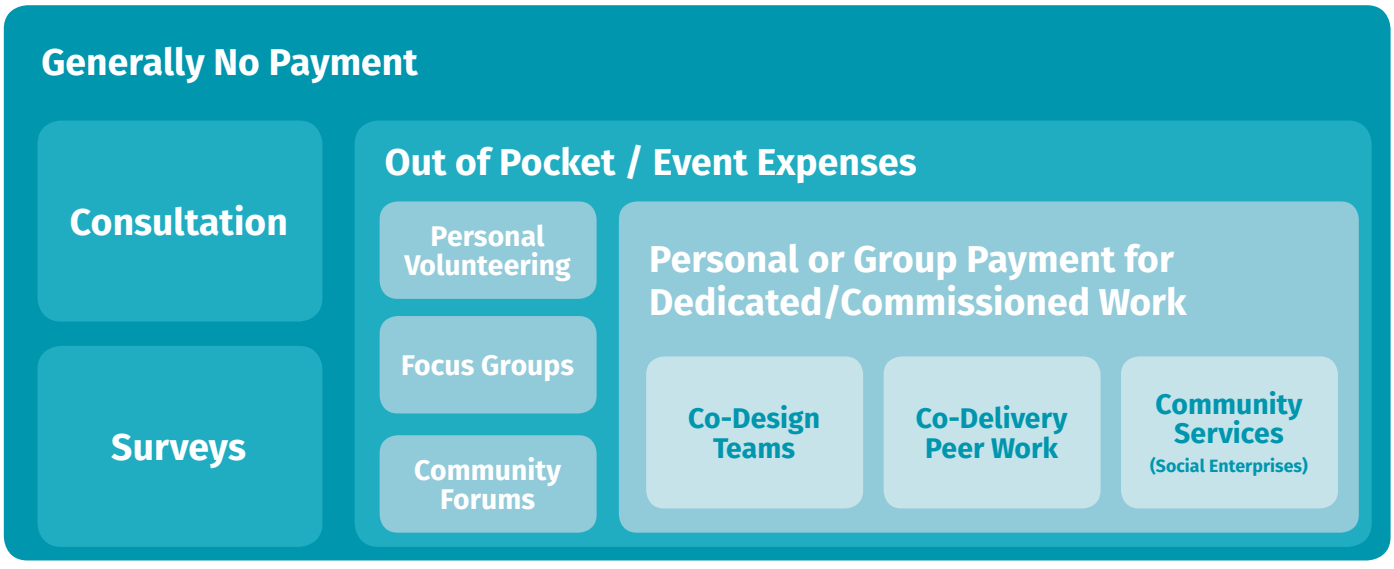
HSC organisations should plan and budget for co-production activities on an annual basis.

In the spirit of co-production, monetary and non-monetary rewards should be appropriate to the function and role required. In the same way that professional services are increasingly required to demonstrate outcomes, all peer led activities should be effectively planned and linked to outcomes.

All sessional peer led activities will be supported by a role specification which will outline the level of responsibility, skill, expertise, and experience required. It is important to note we must not substitute the important value that is associated with volunteering and good will, but aim to achieve a balance between the value of maximising personal involvement, enabling peer networking, and repaying the contribution of people with lived experience involved in co-production.

The table below is intended as a guide to reflect the principles of co-production set out in section 3. Payments should be in line with the existing HSC/NICS expenses, role specification, services commissioning, and recruitment processes.

Figure 7 (illustrative only)



3.11 Conclusion

Co-production is fundamentally an investment in relationships, which when successful leads to improved outcomes for our population. It is a crucial foundation for enabling people and communities to influence their own health and wellbeing by contributing to the co-design, co-delivery and improvement of HSC services. Recognising and harnessing the mutual strengths, capabilities and potential of people, staff and communities provides a real opportunity to achieve positive change.

Success will require a sustained commitment from leadership at all level, a willingness to inspire innovation and share:

- decision making;
- knowledge; and
- resources

to achieve transformational change. Co-production is about ***'realising value through people'***. It can move us from a culture of 'you said, we did' to 'we said, we did it together'.

3.12 With special thanks to the Co-production Working Group

This Guide has been co-produced by a group of people with a vast range of knowledge and experience in using co-production approaches and PPI standards within health and social care services. They worked professionally, tirelessly and enthusiastically as a team to reflect their learning and experiences in how coproduction can be used to improve people's health and social care outcomes.

In the months that we journeyed together working on this project, we have built strong relationships and trust with each other. We communicated well together working through issues to focus on the practical solutions to using co-production as a method of involvement for transformational change.

Their contributions have been exceptional – THANK YOU ALL

Section 4:

Essential Reading

4.1 Department of Health - Policy and Strategic Frameworks

- ☆ **Health and Well Being 2026 - Delivering Together**

  https://www.health-ni.gov.uk/sites/default/files/publications/health/health-and-wellbeing-2026-delivering-together.pdf

- ☆ **Systems not Structures**

  https://www.health-ni.gov.uk/sites/default/files/publications/health/expert-panel-full-report.pdf

- ☆ **Personal and Public Involvement Legislation**

  https://www.health-ni.gov.uk/topics/safety-and-quality-standards/personal-and-public-involvement-ppi

- ☆ **Department of Health – Personal and Public Involvement Consultation Scheme**

  https://www.healthni.gov.uk/sites/default/files/publications/dhssps/DHSSPS%20Personal%20Public%20Involvement%20Consultation%20Scheme.pdf

4.2 Supporting Literature

- ☆ **SCIE – Guide to co-production in social care**

  https://www.scie.org.uk/publications/guides/guide51/what-is-coproduction/

- ☆ **British Medical Journal – from tokenism to empowerment**

  http://qualitysafety.bmj.com/content/qhc/early/2016/03/18/bmjqs-2015-004839.full.pdf

- ☆ **Health Foundation Improving Outcomes by Helping People Take**

  Control – The Theory and Practices of Co-Creating Health.

  Improving Outcomes by Helping People Take Control The theory and practice of Co-creating Health. - ppt download.

- ☆ **Welsh Government Co-producing services – Co-creating Health.** http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/T4I%20%288%29%20Co-production.pdf

- ☆ ***Scottish NHS Co-Production – Health and Wellbeing*** http://www.govint.org/fileadmin/user_upload/publications/Co-Production_of_Health_and_Wellbeing_in_Scotland.pdf

- ☆ ***Scottish Joint Improvement Team – Co-Production OPM Coproduction of health and wellbeing outcomes: the new paradigm for effective health and social care*** http://www.healthissuescentre.org.au/images/uploads/resources/Coproduction-health-wellbeing-outcomes.pdf

- ☆ **Scottish Recovery Network People Powered Health and Wellbeing – Shifting the Balance - How people with lived experience and people who work in services can have good conversations and build connections to co-produce wellbeing** http://www.coproductionscotland.org.uk/files/8014/2788/6655/4._People_Powered_Health_and_Wellbeing.pdf

4.3 Organisations and Networks with Expertise in Co-Produciton

- ☆ **Co-production Wales: Co-production Network for Wales**
  https://coproductionnetworkwales.wordpress.com/
- ☆ **Co-production Scotland – Scottish Co-production Network**
  http://www.coproductionscotland.org.uk/
- ☆ **Co-Production Northern Ireland – Community Development Health Network**
  https://www.cdhn.org/co-production
- ☆ **Kings Fund**
  https://www.kingsfund.org.uk/
- ☆ **Nesta**
  https://www.nesta.org.uk/
- ☆ **New Economics Foundation**
  http://neweconomics.org/
- ☆ **SCIE**
  https://www.scie.org.uk/co-production/

Annex A:

Examples

CO-DESIGN WITH COMMUNITIES
Daisy Hill Hospital (DHH) Pathfinder Project

CONTEXT

A need to develop plans for urgent and emergency care services in the Newry and Mourne area was identified against a background of significant public concern about challenges facing the Emergency Department (ED).

Step 1 – Build the initial team - develop relationships, trust and networks

Principles demonstrated - Building People Networks and Cross Boundary Working

Group Membership

Authority:	***Trust Directors***
Resources:	***Trust assigned Project Manager, PHA medical consultants, Trust Directors, Trust Head of Communications***
Expertise:	***Clinician and Managerial staff, GPs, Service and Professional Managers, PHA Medical & Nursing staff, NIAS, Commissioners (HSCB and SLCG representatives)***
Information:	***PHA, SHSCT, HSCB***
Need:	***Representatives from the local community, TU representative (UNISON)***

A Daisy Hill Hospital Pathfinder group (DHHPG) was formed to take forward the required development plans. The Trust Board approved adopting a co-production approach for this project. Membership of the group was wide ranging as noted above and of significance included 5 people from the local community. The latter members were selected via an open recruitment process which was facilitated by the Confederation of Community Groups, Newry and District. Essential criteria for selection included access to a local community 'network' that could be utilised to consider and provide feedback on proposals as the project progressed. The professional and managerial staff also had access to networks from their respective fields. The professional staff, while unsure as to how it would progress, embraced this new way of working with the local community. To meet the needs of the local community group members, the Project Lead met with them as required in advance of DHHPG meetings to talk through any issues, unfamiliar concepts, training needs and ideas. Tailored briefings were also provided for these members to enable everyone to be at the same starting point with regards to information and understanding – this ensured power was balanced in meetings.

Step 2 – Identify what can we do, what do we know, what are our strengths?

Principles demonstrated - Valuing People, Building People's Capacity, Building People Networks and Cross Boundary Working

A stakeholder mapping exercise was completed to identify what was available in the local area. To facilitate as many people as possible meeting with the Project Lead individually or in a small group, engagement meetings were arranged in several community settings and promoted using a variety of methods including an internet Invite Video. These meetings provided an opportunity

for people to raise concerns directly with the Project Lead and share information about local networks. All considered the meetings as positive and that many stated that they felt their views had been heard and valued. An early step was the production of additional supporting information collated through a comprehensive Health Needs Assessment (HNA). This included a range of relevant local and regional statistical data and information gained through clinical audits and a literature review. This was developed by and shared with all members of the DHHPG for consideration.

Step 3 – Co-create the Vision

What do we want to do; where do we want to be; who can help us out?

Principles demonstrated - Valuing People, Building People's Capacity, Building People Networks and Cross Boundary Working

Recognising the need for wider staff engagement, an interactive workshop attended by 100 staff and GPs was undertaken to identify their issues, concerns and potential solutions. Collectively the DHHPG considered the output from the workshop alongside information from the Health Needs Assessment, the clinical audits and the literature review to identify priorities. One was the development of a Direct Assessment Unit (DAU) at DHH as an alternative pathway to ED for stable patients. The DHHPG recognised the value of learning from others and arranged a visit to Antrim Area Hospital (NHSCT) where a DAU had been operating for several years. A delegation representing a cross section of all stakeholders from the DHHPG met with medical and nursing staff and explored a number of areas including flow between the primary, acute and community services. The visit helped to create a vision of how a DAU might operate in DHH and highlighted the significant benefits to patients.

The SHSCT was proactive in recognising the need to communicate the continued progress of the Project's work and designated a communications officer to work alongside the team. A communication strategy was developed with a monthly on-line E-Zine that all members of the DHHPG were responsible for sharing in a suitable format within their respective networks and bringing feedback back to the group to aid the wider development process.

Step 4 – Co-design the Solution

Principles demonstrated - Enabling and Facilitating, Cross Boundary Working, Valuing People and Building People Networks

The information from the Health Needs Assessment paper confirmed for members the need for an ED on a 24/7 basis and the group's focus then shifted to how best they could achieve this. To progress this vision the group agreed priority workstreams and established specialist subgroups to consider:

- ED Workforce;
- Improving Patient Flow, including Rapid Assessment/Short Stay Service; and
- Strengthening Services for the Sickest Patients.

Each subgroup contained members from the community; a range of clinical and non-clinical staff from primary, acute and community settings; and staff side representatives. They worked together, using their collective knowledge, data and networks to develop the proposed new service model, alongside the DHHPG. A final report was published in December 2017 ***http://www.southerntrust.hscni.net/pdf/DHHPG%20Final%20Report.pdf***

Step 5 – Co-delivery

This example primarily focusses on co-design but with a view to developing co-delivery as part of implementation of the model.

Step 6 – Co-evaluate

At the time of writing the co-design phase of this project has just been completed. Regarding implementation and evaluation of the proposed model, the final report commits to continuing the wider partnership approach to successfully co-deliver and co-evaluate this project. The situation regarding Daisy Hill hospital was a contentious, high profile, emotive issue. The co-production approach enabled all parties to effectively outline their positions, consider these in the context of clear evidence and information and then develop solutions in partnership.

Michael McKeown, President of Newry Chamber of Commerce, captured the impact of the process. "I have been privileged to sit on the DHHPG as a community representative. Remarkable change is taking place. Now is the time to... remove the negative. Replace the word 'save' with the word 'support'. Support Daisy Hill."

CO-DELIVERY IN MENTAL HEALTH

'You in Mind' Mental Health Care Pathway and Recovery Colleges

Step 1 – Build the initial team - develop relationships, trust and networks

Principles demonstrated - Building People Networks and Cross Boundary Working

Group Membership

Authority: PHA HSCB Trust Directors

Resources: PHA Nursing Facilitated Regional group, Trust MH service improvement officers, Trust service user and carer networks.MH Operational managers, AD Mental health.

Expertise: External ImRoc facilitators, PHA, Trust clinical staff, service user and carer/ families,Service improvement managers.

Information: All Trusts, PHA,HSCB

Need: TU Representation

When the group was formed, members outlined their initial anxieties in order to build trust – people with lived experience expressed concern about dominant professional perspectives, whilst the professional anxiety was that coproduction might undermine professional expertise. Overcoming these anxieties required all to have an agreed understanding of our values and our vision of recovery orientated practice and its practical application. This involved true partnership working and mutual respect for each other's point of view to develop relationships.

Each of the 5 areas agreed to either use existing or if required to create a new network outside of the group that could be used to engage with and inform the process as it evolved – in line with PPI statutory requirements.

Step 2 – Identify what can we do, what do we know, what are our strengths?

Principles demonstrated - Valuing People, Building People's Capacity and Reciprocal Recognition

Taking a strengths based approach, the various partners outlined the value of the different knowledge bases and networks available to them during the process and this enabled them to identify training gaps. They used the results of a regional survey of the experiences of people using or caring for someone who uses mental health services – which clearly outlined the need for 'good communication', 'shared care', 'timely information' and the importance of respectful and dignified care.

Step 3 – Co-create the Vision

What do we want to do; where do we want to be; who can help us out?

Principles demonstrated - Cross Boundary Working and Enabling and Facilitating

The consensus view on our vision was to work in a co-productive way in order to transform people's lives and make it part of the way we work on a daily basis. By doing this we wanted to create a culture where the values of hope, control and opportunity became the norm. Working in equal partnership to put co-production at the heart of mental health care by co-producing a NI Mental Health Services Framework that incorporated the 'You in Mind' mental health care pathway and the development of Recovery Colleges.

Step 4 – Co-design the Solution

Principles demonstrated - Cross Boundary Working and Enabling and Facilitating

Giving equal weight to people's lived experience with professional expertise was fundamental to promoting co-production. This influenced practice, reform of services and was instrumental in the revision of the Northern Ireland Mental Health Services Framework. The establishment of an expert by experience writing group ensured the pathway remained grounded and real for everyone involved. The group helped translate a complex range of evidence and co-production concepts into an easily understood practical guide.

The vehicle used to facilitate the establishment of Recovery Colleges was through the *'Implementing Recovery through Organisational Change Programme'* (IMROC). The Recovery Colleges have been designed using a 'hub and spoke' model and programmes are delivered within local communities through a wide range of community and voluntary sector venues and public buildings. A wide range of co-produced courses have since been developed in partnership with people with lived experience and with the active involvement of voluntary and community sector professionals.

Step 5 – Co-delivery

Principles demonstrated - Valuing People, Building People Networks, Building People's Capacity, Reciprocal Recognition, Cross Boundary Working and Enabling and Facilitating

The establishment of Recovery Colleges created a robust network of people with lived experience who are now actively involved in the design and delivery of a wide range of co-education programmes across Northern Ireland.

The 'You in Mind' care pathway and the Recovery Colleges have helped to mainstream and embed co-production, whilst also initiating a culture shift across mental health care. The co-delivery of this work has led to the establishment of peer support worker posts, five Recovery College Hubs and the appointment of Recovery College peer educators.

Step 6 – Co-evaluate

Principles demonstrated - Valuing People, Building People's Capacity, Cross Boundary Working and Enabling and Facilitating

The approach to evaluating the difference Recovery Colleges have made to people's lives is being carried out using an outcomes based accountability approach.

We consider how much we do regarding numbers of attendees and co-produced courses; how well we do it - using the 8 criteria identified by IMROC for developing a Recovery College; and finally if anyone is better off?

We consider feedback on:

- improved knowledge;
- self-reporting on improved confidence and wellbeing;
- improved connections with others in the community; and
- wanting and having opportunities to give back.

CO-DESIGN WITH COMMUNITIES
Primary Care Multi-Disciplinary Teams

CONTEXT

Delivering Together: Health and Wellbeing 2026 identifies enhancing support in primary care as a key priority. It sets out a vision for a primary care service focussed equally on mental, physical and social wellbeing which is able to intervene early to support self-management and independence. In order to deliver this, a broader primary care team is needed with a genuinely multi-disciplinary team wrapped around GP Practices.

Step 1 – Build the initial team - develop relationships, trust and networks

Principles demonstrated - Building People Networks and Cross Boundary Working

Group Membership

Authority:	***Department of Health, HSCB and PHA reps***
Resources:	***Department of Health, Trust, HSCB, PHA and GPs reps***
Expertise:	***DoF and HSCB analysts, health and care professionals***
Information:	***Department of Health, HSCB and PHA reps***
Need:	***Patient representatives, Trust, GP, HSCB and PHA reps***

A working group was formed to develop an approach to rolling out the new primary care model set out in Delivering Together. Given the very wide scope of primary care it was not possible to include all interested groups and parties round the table – instead a smaller group including a user representative, Trust and GP representatives was formed with membership from different regional agencies and from different professional backgrounds and expertise. Members of the group were expected to communicate back to their own professional networks, regional groups and organisations. The group discussed approaches to user engagement and agreed to expand the number of user representatives on the working group and create a separate service user and carer reference group to feed in a wider range of views.

Members of the service user and carer reference group were recruited from existing networks and have been meeting monthly. The group is chaired by a service user and they have been considering the principles that should underpin primary care MDT working from a user perspective.

Step 2 – Identify what can we do, what do we know, what are our strengths?

Principles demonstrated - Valuing People, Building People Networks, Reciprocal Recognition and Cross Boundary Working

A stakeholder mapping exercise was completed and a stakeholder engagement plan developed which is reviewed monthly by the working group.

An evidence base was developed through reviewing quantitative data about existing demand and service performance, commissioning a survey giving us new insight into the case mix presenting to GPs and through work to review best practice locally, across the UK and internationally. This information was reviewed and discussed collectively with all partners on the team to inform the next steps. Different members of the group have also led presentations on key elements – such as the role of social workers, or the proposed neighbourhood nursing model, or paediatric care. In addition, the working group has had presentations from others in the systems on topics which are relevant – such as primary care infrastructure or mental health.

To further enhance what we knew about the current models in place, a local best practice workshop was held. The approach to co-production was discussed and each of the 5 Trusts presented on their current multi-disciplinary approaches to working in primary care. Discussions on the key learning points, questions and issues were held in small, mixed groups of those in attendance – this included Trust staff; GPs; patient and service user representatives; and community and voluntary sector representatives.

Alongside this, a significant number of meetings were held with groupings of community and voluntary sector organisations and key professional groups to explain our approach to the work and seek their early input.

Members of the servicer user and carer reference group all completed a short profile which allowed us to assess the spread of skills, experiences and interests which were represented in that group and consider whether there were any gaps that needed to be addressed or additional training. Having drawn membership from existing groups such as ICPs, representatives had already received training in core skills. Members of the group have been provided with time to engage informally over lunch in order to help build relationships within the group.

We drew on existing regional guidance to ensure service users and carers and professionals attending workshops (such as GPs) were able to claim back travel and other costs in line with regional guidance.

Step 3 – Co-create the Vision

What do we want to do; where do we want to be; who can help us out?

Principles demonstrated - Valuing People, Building People Networks, Cross Boundary Working, and Enabling and Facilitating.

In the next stage we wanted to develop our proposals. To do this we needed to involve a wider range of perspectives into our discussions. We scheduled a series of regional facilitated workshops to do this. These are seeking to:

(i) Share what we know so far

(ii) Take views on what the future should look like

(iii) Gather suggestions for the principles that should underpin the approach to primary MDT working; and

(iv) Seeks views on the best approach to rolling out an MDT approach.

So far 3 workshops have been completed with a further 2 planned. The workshops have been held in daytime and in evenings to help ensure accessibility and have been at venues across Northern Ireland. Invitees included frontline Trust staff (doctors, nurses, social workers, AHPs and managers), ICP chairs and members, council representatives working on community planning, representatives from Trust PPI groups and from our own service and user reference group who were users of primary care services, GPs and practice or federation staff, Ambulance Service representatives, community and voluntary sector representatives, independent sector representatives, community pharmacy representatives and commissioners (LCG chairs).

Step 4 – Co-design the Solution

Principles demonstrated - Enabling and Facilitating, Cross Boundary Working, Valuing People and Building People Networks

To date the workshops have gathered views on the approach to roll-out and what elements should part of the initial model we seek to implement. Once the workshops have been completed, the working group will use this input in conjunction with the evidence collated in step 2 to make a recommendation to TIG about:

- a set of principles to underpin the work; and
- about how we should seek to roll the model out.

The exact design of the model will require further active engagement from a wide range of local partners in the areas that seek to test the model in.

Step 5 – Co-delivery

We intend to form a strong partnership with GPs, Trusts, community and voluntary sector, those with lived experience of using primary care services and staff involved in the delivery of the new model in each local area to ensure that practice on the ground can be adjusted, barriers removed and learning shared. Throughout the roll-out period it is intended that the service user and carer reference group will continue to play an active role in shaping the model we use as the 'network' for the service user reps on the Project Team.

Step 6 – Co-evaluate

DoF analysts are currently discussing the approach to evaluation with our service user and carer reference group, who are keen to shape the approach and help develop the questions we use. Proposals will then be brought back to the working group for consideration as part of our overall approach to measuring success.

We intend to co-create a continuous feedback loop that will allow us to learn from initial roll out, re-design the model with input from partners and users and support further roll-out and evaluation of the service.

Annex B

GLOSSARY OF ACROYNMS IN USE ACROSS HEALTH AND SOCIAL CARE

AHP	Allied Health Professional
ALB	Arms Length Bodies
BHSCT	Belfast Health and Social Care Trust
BSO	Business Services Organisation
CAMHS	Child and Adolescent Mental Health Services
CEC	Clinical Education Centre
CHD	Coronary Heart Disease
CMP	Condition Management Programme
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
COPD	Chronic obstructive pulmonary disease
CPD	Commissioning Plan Direction
CPO	Chief Pharmaceutical Officer
CSP	Chartered Society of Physiotherapy
DOH	Department of Health
DE	Department of Education
ED	Emergency Department
ELCOS	End of Life Care Operation System
FPS	Family Practitioner Service
FSH	Network of agencies (voluntary/community and statutory) who work with families not meeting the threshold for statutory social work support.
GAIN	Guidelines and Audit Implementation Network
GP	General Practitioner
GPSI	General Practitioner with Specialist Interest
HIA	Health Impact Assessment
HLC Alliance	Health Living Centre Alliance
HSC	Health and Social Care
HSCB	Health and Social Care Board
HSE	Health and Safety Executive
ICP	Integrated Care Partnership
IP	Inpatient
IPH	Institute of Public Health in Ireland
LCG	Local Commissioning Group
LD	Learning Disability
LGB&T	Lesbian, Gay, Bisexual and Transgender
LEP	Local Engagement Partnership

LTC	Long Term Condition – Chronic ailment from which there is no cure but will require long term treatment or monitoring
NHS	National Health Service
NHSCT	Northern Health and Social Care Trust
NIAS	NI Ambulance Service
NIASW	NI Association of Social Workers
NIBTS	Northern Ireland Blood Transfusion Service
NICE	National Institute for Health and Clinical Excellence
NICVA	Northern Ireland Council for Voluntary Action
NIFRS	NI Fire and Rescue Service
NIMDTA	NI Medical and Dental Training Agency
NIPEC	Northern Ireland Practice and Education Council for Nursing and Midwifery
NIPSA	Northern Ireland Public Service Alliance
NISAT	Northern Ireland Single Assessment Tool - for use when planning home care for older people
NISCC	NI Social Care Council
NMTG	Nursing and Midwifery Task Group
OSS	Office of Social Services
PCC	Patient and Client Council
PD	Physical Disability
PfG	Programme for Government
PHA	Public Health Agency
PPI	Personal and Public Involvement
QOF	Quality and Outcomes Framework
RQIA	Regulation and Quality Improvement Authority
RCGP	Royal College of General Practitioners
RCM	Royal College of Midwives
RCN	Royal College of Nursing
SCIE	Social Care Institute for Excellence
SEHSCT	South Eastern Health and Social Care Trust
SET	South Eastern Trust
SHSCT	Southern Health and Social Care Trust
TDP	Trust Delivery Plan
Trust	Provider of Health and Social Care Services to a particular population
TYC	Transforming Your Care
UU	Ulster University
WHSCT	Western Health and Social Care Trust