MUCKAMORE ABBEY HOSPITAL INQUIRY

WITNESS STATEMENT

Second Statement of Aidan Dawson

Date: 26 May 2023

I, Aidan Dawson, make the following statement for the purpose of the Muckamore Abbey Hospital (MAH) Inquiry.

The statement is made on behalf of the Public Health Agency (PHA) supplemental to my statement of 16 March 2023. This is my second statement to the Inquiry. It is made for the purpose of providing further clarity and context to the role of the PHA in relation to the commissioning of services, provision for patients with mental health and learning disabilities and their families, and the PHA's role more generally within the Health and Social Care (HSC) sector.

There are 30 EXHIBITS produced with my statement.

1. Introduction

1.1 Background and function of the Public Health Agency

1.1.2 The Public Health Agency (PHA) was established as the Regional Agency for Public Health & Social Well-being under Section 12(1) of the Health & Social Care (Reform) Act (Northern Ireland) 2009. This is the same legislation which established the Health and Social Care Board, transferred the functions of the Mental Health Commission to RQIA and established the Patient and Client Council alongside the statutory duty of involvement in the HSC.

1.1.3 The PHA is a statutory body and as such has specific powers to act as a regulator, contract in its own name and act as a corporate trustee. Its functions can be summarised under three broad headings:

- Improvement in health and social well-being – with the aim of influencing wider service commissioning, securing the provision of specific programmes and supporting research and development initiatives designed to secure the improvement of the health and social well-being and reduce health inequalities in the population of Northern Ireland.
- Health protection – with the aim of protecting the community (or any part of the community) against communicable disease and other dangers to health and social well-being, including dangers arising from environmental hazards and the public health response to major incidents and other emergencies.
- Service development – working with the Strategic Planning and Performance Group (SPPG – formerly the Health and Social Care Board, 2009 - 2022) with the aim of providing professional input to the commissioning of health and social care services that meet established safety and quality standards and support innovation. Working with SPPG, the PHA has an important role to play in providing professional and public health leadership within the HSC.

1.1.4 The PHA also aims to improve the early detection and treatment of illness through provision of a range of screening programmes and, through its Health Protection service, the early detection and management of outbreaks of communicable diseases in the community. The Health Protection service is also responsible for the overall management of vaccination programmes which reduce the incidence of vaccine preventable diseases in the community.

1.1.5 In exercising these functions, the PHA also has a general responsibility for promoting improved partnership between the HSC sector and local government, other public sector organisations and the voluntary and

community sectors to bring about improvements in public health and social well-being and for anticipating the new opportunities offered by community planning at local government level.

1.1.6 The PHA hosts the regional Health and Social Care Quality Improvement (HSCQI) function which was established in 2019 in response to a recommendation in the Donaldson Report (2015) (Exhibit 1) and acts as an Improvement Institute to deliver quality improvement initiatives across the HSC.

1.1.7 The Health and Social Care Research and Development Division (HSC R&D) is part of the Agency and is located within the Public Health directorate. HSC R&D is responsible for the administration and coordination of the HSC R&D budget on behalf of the Department of Health.

1.1.8 The PHA acts as a corporate host for the Safeguarding Board for Northern Ireland (SBNI), supporting the SBNI by securing Human Resource, financial and other corporate support functions. The SBNI and its objectives and functions of safeguarding and promoting the welfare of children in Northern Ireland are entirely separate from that of the PHA. The PHA is accountable to the Department for the discharge of its corporate host obligations to SBNI but is not accountable for how the SBNI discharges its own statutory objectives and functions. A Memorandum of Understanding is in place which sets out in detail the respective obligations of the PHA and the SBNI and the PHA is represented on SBNI professional committees (EXHIBIT 2).

1.2 <u>PHA Structure</u>

1.2.1 The PHA is currently structured into four directorates – Public Health, Nursing and Allied Health Professionals, Operations and HSC Quality Improvement– each with its own director and senior staff, remit and functions. The Chief Executive and Executive Team are responsible for

implementing the strategic direction of the Agency which is set by the PHA Board in line with ministerial priorities and detailed in the Corporate and Business Plans and identifying and mitigating corporate risks that have the potential to impact on the implementation of these plans.

1.2.2 The responsibilities of the various parties are set out in the PHA Management Statement and Financial Memorandum (MSFM). (Exhibit 3)

1.2.3 Since 2009, there have been four Chief Executives in the PHA:

- Eddie Rooney – April 2009 – October 2016
- Valerie Watts – October 2016 – March 2020 (Mrs Watts was appointed by the Permanent Secretary as Interim CEO and continued to discharge her substantive post as CEO of HSCB until her retirement in March 2020.)
- Olive Macleod – March 2020 – July 2021
- Aidan Dawson – July 2021 – present.

1.2.4 PHA is a small organisation relative to the size of Trusts. There are some 340 staff employed across the main site in Linenhall Street in Belfast and satellite offices in Ballymena, Derry/Londonderry and Armagh. There is a strong tradition of cross-directorate working both on internal projects and programmes and as part of wider HSC initiatives.

1.2.5 Formal cross-Agency management team meetings (referred to as AMT) take place weekly. These meetings are for corporate decision-making and provide the opportunity for senior leaders to share information about the work of their directorates; discuss and agree the approach to new areas of work; and horizon scanning.

1.3 Covid-19 Pandemic

1.3.1 The PHA played a central role in the HSC management of the Covid-19 pandemic. As with all HSC bodies, the Agency had to adapt its functions and working practices in order to accommodate the needs of the system in responding to the pandemic. All directorates were impacted and for the period of the pandemic, the majority of staff were working on Covid-19 response.

1.3.2 A new temporary directorate of Contact Tracing was established during Covid-19 and the PHA headcount eventually increased by approximately 400 staff. At various points in time the Agency moved into Business Continuity and the PHA's own staff were required to supplement the Tracing Service during the peaks of Covid-19 waves.

1.3.3 During Covid-19, much of the usual work of the Agency – as with the HSC as a whole – was paused.

1.3.4 Covid-19 represented an extremely challenging and arguably an unprecedented event in the history of public health across the world. Whilst the recognition, identification and management of incidents and outbreaks have been a function of the PHA's business since its inception, the scale and impact of Covid-19 across all aspects of society in Northern Ireland ensured that the role, support and work of the Agency was kept consistently at the forefront of public attention throughout.

1.3.5 Responding to the many challenges of Covid-19 required a full organisational approach from the Agency beginning in March 2020. The scale and pace of Covid-19 led to the Agency invoking business continuity measures shortly after the first case was identified in Northern Ireland in late February 2020 and given its lead role in managing significant elements of the Health Protection response it is not surprising to note that the Agency has been the last HSC organisation to stand down its Business

Continuity arrangements and begin the transition to Business as Usual during 2022/23.

1.3.6 The outworking of the Covid-19 response required the Agency to respond in an agile fashion at all times and lead work associated with emergent pressures and priorities including inter alia; Development of the Northern Ireland Contact Tracing Service; Establishing the NI Covid-19 Testing programme; Support for the education sector; Supporting the care home sector; Infection prevention and control; supporting the roll out of Vaccination programmes; coordinating planning approaches to surge management; coordinating the NI Research and Development response to Covid-19; Managing the impact of Covid-19 on screening services; mobilising Health and wellbeing improvement initiatives to support wider public health measures such as vaccination programmes; and leading a fully integrated and timely public communications programme.

1.3.7 This resulted in the Agency periodically providing additional staffing support to critical functions through a strategy that included recruitment of new staff (PHA staffing complement increased from 320 in March 2020 prior to the Covid-19 to a headcount of 522 in June 2022 with additional temporary staff on a bank arrangement) together with the repurposing of its staffing teams. For example, approximately 125 members of PHA staff were trained across the Covid-19 period to undertake contact tracing on a full time basis or on a part time basis alongside their day to day role within the organisation

1.4 Relationship with Health and Social Care Board

1.4.1 The 2009 Reform Act also established the Health and Social Care Board (HSCB). The HSCB itself was dissolved in 2022 and its functions transferred to the Department of Health under the auspices of the Strategic Performance and planning Group (SPPG). The relationship between HSCB and PHA has been described as symbiotic. Improving

public health and wellbeing is a central tenet of the provision of health and social care services and PHA provided the professional and public health and nursing input to the HSCB in the discharge of its functions. HSCB retained its own social care professional staff.

1.4.2 The PHA Director of Public Health and the Director of Nursing and AHPs sat on the Board of the HSCB and contributed to the corporate decision making of the HSCB. Other PHA staff would have attended such meetings to provide professional input to support decision making as and when necessary.

2. Policy

2.1 Roles and Functions

2.1.1 The Department of Health (the Department) is responsible for developing policy in respect of health and social care and wellbeing. The HPSS (Quality, Improvement and Regulation) (Northern Ireland) 2003 Order, established the right of the Department to make (or commission) standards for health and social care services and also introduced the statutory duty of quality which makes Trusts and commissioners responsible for the quality of care they deliver and commission.

2.1.2 The PHA is responsible for implementing policy relevant to its role and functions as set out in the MSFM. The PHA also provided professional input, guidance and advice to the HSCB in the discharge of its functions. PHA also plays an important role in informing policy development through membership of a number of working groups across a range of policy areas where expertise in health protection, improvement and service development is required.

2.1.3 Given the wide range of policy areas aligned with the PHA's role and remit it is impossible to list all of this work. It is important, however, to note some key policy developments in learning disability, safety and quality, and

nursing. Similarly, there are some key strategic developments that provide important context to PHA's work.

2.1.4 The HSCQI Hub is a Directorate hosted within the PHA established by the Department in April 2019. The Directorate includes legacy Safety Forum staff who transitioned to the HSCQI Hub when it was launched by Department in April 2019. The Legacy Safety Forum was in existence from 2007 – 2019.

2.1.5 The HSCQI Directorate contribute to the overarching PHA Annual Business Plan and report progress on objectives through the PHA Business Plan reporting process.

2.1.6 HSCQI also report to the HSCQI Leadership Alliance who set the direction and oversee the HSCQI workplan.

2.1.7 Membership of the HSCQI Leadership Alliance is constituted as follows:

- The Chief Executives of the six HSC Trusts.
- DoH representation
- Primary care representatives
- Chief Executive of the Public Health Agency.
- Chief Executive of SPPG.
- Chief Executive of the RQIA.
- Chief Executive of the Business Service Organisation.
- Expert Service user/carer rep
- Director of HSCQI
- The Alliance is currently chaired by the Chief Executive of the Belfast HSCT

2.2 The Bamford Review of Mental Health and Learning Disability

2.2.1 In October 2002 the Department initiated a major, wide-ranging and independent review of the law, policy and provision affecting people with mental health needs or a learning disability in Northern Ireland.

2.2.2 The **Bamford Action Plan** 2012-15 was published in March 2013 (Exhibit 4). The Action Plan represented the Northern Ireland Executive's continued commitment to the development of mental health and learning disability services in Northern Ireland, and to the promotion of independence and social inclusion.

2.2.3 The Bamford Action Plan 2012-15 contains 76 actions under the five main Bamford delivery themes:

- Promoting positive health, wellbeing and early intervention;
- Supporting people to lead independent lives;
- Supporting carers and families;
- Providing better services to meet individual needs; and
- Developing structures and a legislative framework.

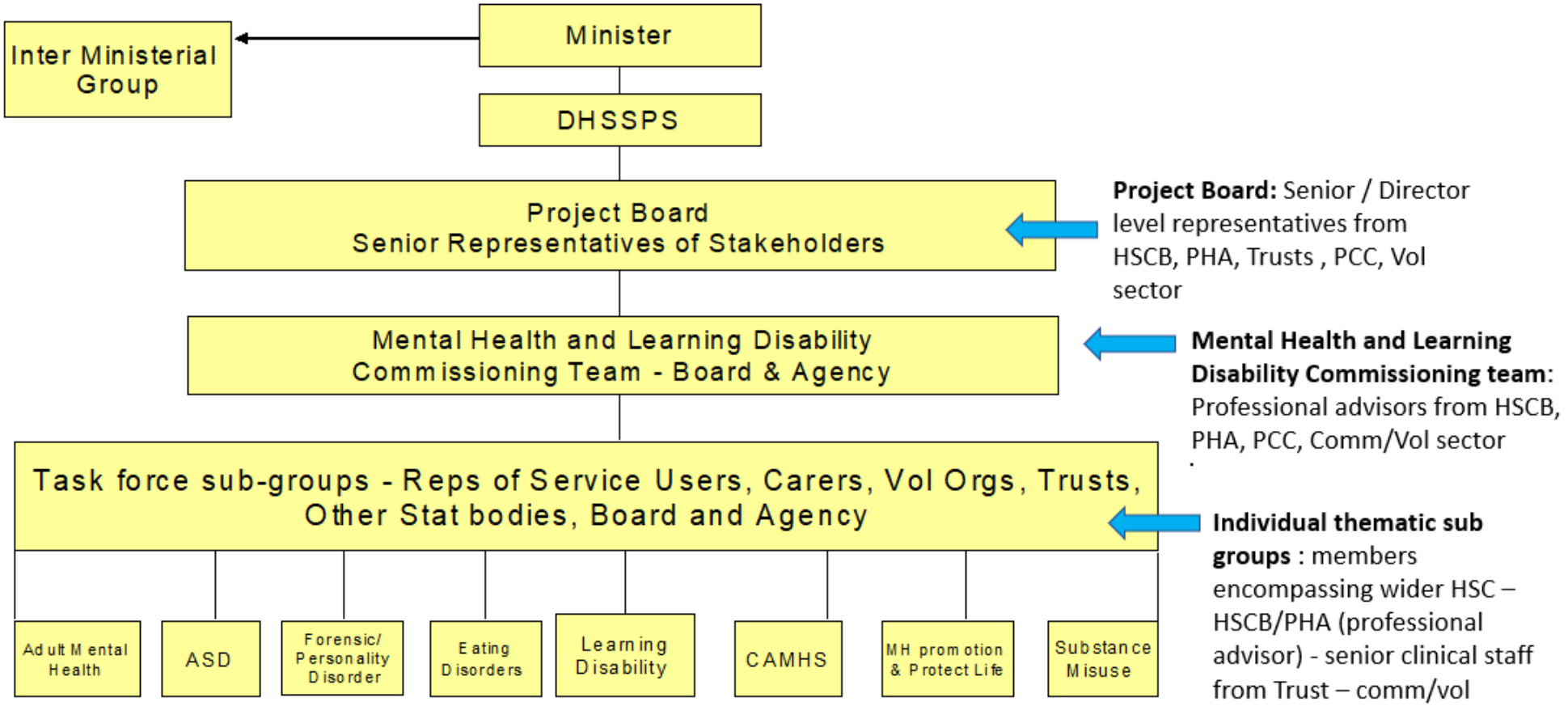
2.2.4 The DHSSPS had lead responsibility for the implementation of the Action Plan.

2.2.5 Implementation of the Bamford Action Plan was monitored (Exhibit 5) through the Inter-Departmental Senior Officials Group and Ministerial Group on Mental Health and Learning Disability -figure 1: this also identifies the HSC 'Bamford Taskforce' within the HSCB/PHA this element of Bamford was constituted within the HSCB/PHA Mental Health and Learning Disability Commissioning team (figure 2 below).

Figure 1 – overall Bamford Structure

Figure 2 – The HSC 'Bamford Taskforce': within the HSCB/PHA this element of the Bamford structure was constituted within the HSCB/PHA Mental Health and Learning Disability Commissioning team. This was sub-divided into x9 subgroups

Mental Health/Learning Disability Taskforce - Project Structure



NB. It should be noted that in addition to the specific Learning Disability Sub-Group many of the other sub-groups eg Forensic, ASD etc will have Learning Disability issues explicitly included in their terms of reference

2.3 Regional Learning Disability Health Care and Improvement group

2.3.1 The Nursing and AHP Directorate in the Public Health Agency leads the Regional Learning Disability Healthcare and Improvement (LDHCI) Steering Group.

2.3.2 This LDHCI Steering Group superseded a previous group named 'Directed Enhanced Services (DES) and Health Facilitation Regional Group for People with Learning Disabilities which was chaired by PHA Regional Lead Nurse for Mental Health and Learning Disability, and reported to AMT and to Bamford Service Team for Learning Disability (Exhibit 6).

2.3.3 This group was in place from 2014 – 2020 to take forward key areas of work through 3 Regional Sub-Forums:

- Regional Health Care Facilitators Forum
- Regional Health & Wellbeing Improvement
- Regional General Hospitals Forum Learning Disability

2.4 Service Framework for Learning Disability (2012)

2.4.1 Service Frameworks were introduced as part of the Department's drive to improve the quality and safety of services provided across key programmes of care. They attempted to introduce a holistic approach to the planning, design, delivery and monitoring of services and were developed using a multi-agency, multidisciplinary approach. Providers, commissioners and regulators were expected to use the Frameworks as part of reporting on the safety and quality of care delivered.

2.4.2 When launched by the Department, the PHA and HSCB were required to nominate a lead professional to oversee and report on the implementation of the Framework. The Director of Social Care (HSCB) was the lead for this Framework.

2.5 Transforming Your Care (2011)

2.5.1 Transforming Your Care (TYC) included recommendations to expedite the resettlement of patients from sites such as Muckamore Abbey Hospital. It also recommended that the Public Health Agency promote the health of this population and one outcome has been the creation of a passport for hospital staff which holds helpful information on how to communicate with service users. This was launched in 2019 and PHA was central to its design, development and implementation.

2.6 Making Life Better (2013)

2.6.1 Making Life Better is the current strategy for public health in Northern Ireland. PHA is responsible for providing short-term funding to a range of projects under the strategy and over the most recent five-year period from 2018-2023, 97 programmes have received over £425k of funds to provide programmes for people with a learning disability (Exhibit 7).

2.7 Programmes and Projects

2.7.1 As well as direct involvement in policy initiatives, PHA has worked on a number of projects and programmes to improve outcomes for people with learning disabilities. Some of these are outlined below for information.

2.7.2 Regional Workshops – with Mencap NI (2021)

A series of workshops were delivered across Northern Ireland in January and February 2021, in association with Mencap NI, the Community Development & Health Network and the Public Health Agency, through the

regionally commissioned Elevate Service. Elevate is funded by the Public Health Agency and supports the community, voluntary and public sectors to develop skills, knowledge and expertise in community development, as a way to address health inequalities. The workshops focussed on supporting people with a learning disability and sharing of resources on best practice to service providers. Resources included guidance for engagement, accessible communication, reasonable adjustments, capacity & consent & supported decision making and understanding health inequalities.

2.7.3 Regional Health & Social Wellbeing Improvement Forum

The PHA's Health Improvement Team was previously involved a regional Health and Social Wellbeing Improvement Forum for Learning Disability which was a subgroup of the Regional Learning Disability Health Care and Improvement Steering Group, led by Nursing Directorate within the Public Health Agency.

The subgroup included staff from Health Improvement Teams across the Health and Social Care Trusts and co-ordinated actions and shared good practice. The group maintained an Annual Action Plan.

2.7.4 Regional HSC Hospital Passport

The *HSC Hospital Passport* was developed by the PHA and the Regional General Hospital Forum for Learning Disability for people with a learning disability to complete (with or without help) and present to staff every time they have contact with a general hospital. It was launched in September 2019, and is now in use across all Health & Social Care Trust Hospitals in Northern Ireland. (Exhibit 8)

It gives staff important information on the person and how they prefer to communicate, their medical history and any support they might need while in hospital. Staff can then make any reasonable adjustments in order to provide the best possible care for people with a learning disability.

The electronic version of the version of the Hospital Passport allows patients or carers to type their details directly into the document before saving, printing off and bringing to hospital.

There are also Guidance Notes to help those completing the *HSC Hospital Passport.* The publications were distributed through all Health & Social Care Trusts and (HSCTs) and the community and voluntary sector across Northern Ireland (Exhibit 9).

2.7.5 Regional Lifeline Service

Lifeline is Northern Ireland's crisis response helpline for people experiencing distress or despair. Lifeline is available 24 hours a day, 7 days a week, every day of the year.

Calls to Lifeline are free and available to people of every age, gender, race, religion, disability and sexual orientation living in Northern Ireland who are experiencing distress or despair.

In 2022/23 Lifeline supported 109 callers recorded as having a learning difficulty - this equates to 1.83% of Lifelines callers.

2.7.6 Physical Activity programmes

The PHA works closely with Physical Activity Co-ordinators in the Health and Social Care Trusts, to ensure activities and resources are provided and accessible to all residents, including people with a learning disability.

Services are usually part-funded through the PHA - in some cases this includes activity and resource costs and in others partial /full funding of a Physical Activity Co-ordinator.

Activities are designed to support people with a learning disability, sensory disability and / or physical activity to meet the Chief Medical Officer's guidelines on physical activity.

Workforce training has included DRUM based exercise training, chair-based activity training, walk leader training and Chi-Me training to Health & Social Care Staff, for use within Learning Disability settings.

There are also a number of bespoke staff-led walking groups for adults with a learning disability.

2.7.7 ‘Just Ask’ Programme

“Just Ask” is a Relationships and Sexuality Education (RSE) programme that works specifically with young people with a learning disability, a learning difficulty and autistic people, their families and carers.

Just Ask offers participants the opportunity to discuss topics which are often described as ‘sensitive’ in a safe environment.

The focus of this programme is to develop understanding around self/identity, boundaries, personal space, permission, consent and the choices around these topics.

The Public Health Agency holds a current contract with Informing Choices NI to deliver the “Just Ask” regional programme, which includes interactive one to one sessions and group activities for individuals as well as interactive sessions with parents and carers of young people.

2.7.8 I Can Cook It! – Skills Building Programme

Community Food and Nutrition teams, based in the Health & Social Care Trusts have been involved in the design and delivery of a bespoke version of the Regional ‘Cook It!’ programme, for adults with a mild to moderate learning disability. This programme is called ‘I Can Cook it!’.

The Community Food and Nutrition Teams have previously delivered tutor training to enable Cook It! Facilitators to deliver the I Can Cook It! programme to individuals with a mild to moderate learning disability across a range of settings. Activity in this programme has been affected by Covid-19 restrictions. The training programme is also under review at present and active training of facilitators was last implemented in 2019.

The Community Food & Nutrition Teams do not deliver these programmes directly – their role has been to train up facilitators who can roll out the programmes across local communities.

2.7.9 Home Accident Prevention

The Public Health Agency leads on a Regional Home Accident Prevention Strategy and Action Plan (Exhibit 10). Within the Action Plan the Public Health Agency works with all 11 Councils to commission and deliver a regional Home Safety Check Scheme (HSCS). This service has been running for over 10 years.

This scheme is available to families with under 5s, over 65s and other vulnerable groups. People with a learning and/ or physical disability are included in the vulnerable category.

The scheme does not include additional disability specific equipment for clients with a learning disability, however the Home Safety Officer will make a direct referral to the Occupational Health Teams or other Specialist Teams in the Health & Social Care Trusts – if the client is not already engaged with these services.

The Home Safety Officers would also refer to NIFRS as appropriate for a fire safety check / equipment for all beneficiaries of the Home Safety Check Scheme.

In addition, the Home safety Officers have been trained on working with clients with autism and dementia.

2.7.10 Accessibility to Cancer Screening

Commissioned service

The PHA has responsibility for commissioning, co-ordinating and quality assuring a range of screening programmes, including breast, cervical and

bowel cancer screening. Population screening programmes save lives, reduce illness, reduce disability and enable choice.

The PHA commissions a service to raise awareness of and promote the three cancer screening programmes throughout Northern Ireland. The service is targeted at those impacted by health inequalities (Section 75 groups, including learning disability, along with those living in socially deprived areas).

When delivering sessions to those with learning disability, the service provider considers the needs of the specific group and tailors session content to make it accessible. They take an informal approach during sessions, using active learning and props (e.g. breast models which allow participants to feel for lumps) to support learning and make the session content accessible for those with lower levels of health literacy. In 2022/23, 206 people with learning disability attended a cancer screening awareness session.

In addition to this commissioned service, some individual screening programmes have taken steps to make the service more accessible.

Easy read resources

The Breast Screening Team co-produced an easy read leaflet for breast screening (Exhibit 11). The team worked with a PHA nursing colleague who was undertaking pilot work on breast screening and learning disability in the Southern Trust. Representatives from the Telling It Like It Is project (a group of adults with a learning disability who are keen to have their voice heard in Northern Ireland) fed into leaflet development. The leaflet is available via Health Care Facilitators and Health Promotion Leads in each Trust. It is also available on PHA & NI Direct websites.

Videos showing what happens at cancer screening are available on the PHA & NI Direct websites. There is also a link on the PHA website to a

video on breast screening for those with learning disability. The video was produced by Avon Breast Screening and Biggerhouse film, in collaboration with women with learning disabilities.

Easy read leaflets are being developed for bowel and cervical cancer screening. Links to easy read leaflets for bowel and cervical screening produced by Beyond Words are included on PHA website professional resources website.

Invitations to screening

There is a system in place to ensure eligible residents of Muckamore Abbey are invited for both breast and bowel screening.

2.8 Nursing Models of Care

2.8.1 In 2019, the Chief Nursing Officer initiated Phase 9 of Delivering Care, a review of the role of the registered nursing for learning disability workforce in Northern Ireland. The overarching aim was to examine the current role of a Registered Nurse Learning Disability (RNLD) and make recommendations to support the future role within health and social care settings across Northern Ireland. It would also enable people with a learning disability, their families and carers to be supported, to achieve and maintain good health and to live long, healthy, and fulfilled lives. A draft paper of Phase 9A (In-patients) has been completed but before final sign-off the CNO has commissioned NIPEC to progress further work on LD population needs and workforce requirements.

2.8.2 The RNLD Strategic Development Group was established in 2022, led by NIPEC, commissioned by CNO, and is taking forward specific recommendations made in the Review of Learning Disability Report (draft and unpublished at present). The group will define the roles that registered nurse for learning disabilities should be delivering in line with evidence-based practice to meet the needs of the population in Northern Ireland. This will include the development of a proposed model to ensure the availability

of a suitably skilled and resourced registrant workforce across primary, secondary and specialist health and social service in Northern Ireland.

2.8.3 This Task & Finish Group will also consider and contribute to the new Delivering Care Framework.

3. Commissioning

3.1 Background

3.1.1 The Reform Act required that the HSCB, in consultation with the PHA, prepare and publish an annual Commissioning Plan (Examples at Exhibit 12- Exhibit 17. The Plan set out the services to be commissioned in that year and the costs of same. Until the HSCB was dissolved in 2022, the process for the commission of HSC services was, broadly, as follows:

- The Department issued an annual Commissioning Plan Direction to the HSCB and PHA. The Direction set out the Minister's (or Department's) strategic priorities and any specific standards and targets to be delivered by the HSC.
- In line with the requirements of the Reform Act, the Department also issued Indicators of Performance Direction which were designed to improve the performance of HSC Trusts.
- PHA provided professional input into the development of the Commissioning Plan by HSCB and once drafted, the Plan was submitted to the PHA Board for approval before formal submission to the Department.
- In implementing the Plan, PHA nursing, medical and AHP staff were members of integrated commissioning teams for services including learning disability. These teams used the content of the Plan and the budgets available to commission services directly from HSC Trusts. These teams were responsible for needs assessment, programme planning, commissioning and quality and performance review.

- Performance management was the remit of the HSCB, but PHA input into the process by providing public health, medical and nursing advice on the performance reviews as members of the Multi-Disciplinary Commissioning Teams.

3.2 MHLD Commissioning

3.2.1 The Bamford Review reports represented the Department's strategic direction on MHLD. In 2009 a Commissioning Team for MHLD was formed. The Team was chaired by the HSCB and included representation from PHA senior staff in terms of medical, nursing, AHP, service improvement and planning expertise. The Team led the implementation of the Bamford recommendations and progressively migrated into two Improvement Boards – for mental health and learning disability.

3.2.2 Some examples of changes introduced in the commissioning of learning disability services because of the Bamford recommendations include models of nursing that were shifted in response to care in the community and resettlement programmes. This resulted in the development of community learning disability teams, and new roles for nursing staff in social care, primary care, ID CAMHS and Forensic services.

3.3 Impact of Covid-19

3.3.1 As a consequence of Covid-19, the 2019/20 Commissioning Plan was carried forward into 2020/21 and again into 2021/22. (Exhibit 18-19)

3.4 Dissolution of HSCB

3.4.1 As a result of the dissolution of the HSCB in April 2022 and the establishment of SPPG within the Department the arrangements regarding commissioning are currently in transition. Moving forward it is envisaged that the new Integrated Care Planning system (ICP) will provide the planning framework by which the

commissioning of services will be designed and delivered. PHA will play a key role in ICP – including providing the population health expertise required in developing plans.

4. Safety, Quality and Learning

The following section outlines the key processes that the PHA is engaged with in pursuit of Safety, Quality and Learning throughout the HSC sector.

4.1 The PHA has primary responsibility for providing professional and clinical leadership across the SAI process and are accountable for overseeing the dissemination and application of regional learning across the health and social care system in partnership with SPPG Directors.

4.2 It is important to note the responsibilities of PHA as outlined above are governed by the PHA Chief Executive through the Director of Public Health and the Director of Nursing, and AHPs.

4.3 Early Alerts

4.3.1 The Early Alert (EA) process is overseen by the Department of Health and Alerts are notified to SPPG for information and then forwarded to the appropriate PHA professionals (Exhibit 20). Prior to 2020 these would also have been circulated individually to all the directors within the PHA. Since 2020 they are circulated via a Daily Report to all Directors and members of professional groups across SPPG/PHA. All EAs are then reviewed at the weekly Incident Review Group (IRG) to assess whether they can be closed from an SPPG/PHA perspective or if a SAI should be requested. On occasion further information may be requested if deemed necessary. The purpose of EAs is largely to make the Department and Minister aware of any issues which may require urgent attention or action by the Department.

4.4 Serious Adverse Incidents

4.4.1 Serious Adverse Incidents are notified to SPPG from the HSC Trusts and are then allocated for review to either a professional group (level 1) or a Designated Review Officer (DRO) (level 2/3). They are also circulated via the Daily Report. The corporate record for all these notifications sits with the SPPG Governance team.

4.4.2 Responsibility for administration of the SAI Process lies within SPPG's Governance and Safety Team.

4.4.3 Professional input by clinicians and others into the above processes is provided by colleagues from both the SPPG and PHA, through the role of the Designated Review Officers (DRO) and the various SAI Professional Groups.

4.4.4 The role of the PHA in SAIs is covered in the May 2010 Department of Health issued circular HSC (SQSD) 08-10-Transfer of SAI reporting to HSCB.

4.4.5 Once SAI review reports are received from the Trust they will be sent to either the relevant professional group or to the individual DROs (Designated Review Officers) and will be reviewed and discussed at the next professional group. For MH and LD there are two groups; one level 1 group (meets fortnightly) and one level 2/3 group (meets monthly) (Exhibit 21). All review reports are then discussed at these multi-professional SAI groups and any learning derived from these reviews is also identified and the best method of dissemination decided. There are 9 professional groups (see slide below).

4.5 Designated Review Officer (DRO)

4.5.1 The role of DRO is outlined in the Procedure for the reporting and follow up of SAIs (Exhibit 22) as a senior professional from either HSCB(SPPG)/ PHA who has a key role in the implementation of the SAI procedure. These will be either Social Workers or professionals from Primary care (GP's, pharmacists) within SPPG and doctors, nurses or AHPs from within the PHA.. The role of the DRO includes:

- liaising with reporting organisations where:
    - immediate action is required to be taken following notification of a SAI
    - a DRO believes the SAI review is not being undertaken at the appropriate level.
- agreeing the Terms of Reference for Level 2 and 3 RCA reviews;
- reviewing completed Learning Summary Reports for Level 1 Reviews and full reports for level 2 and 3 Reviews; liaising with other professionals (where relevant);
- liaising with reporting organisations where there may be concerns regarding the robustness of the level 2 and level 3 RCA reviews and providing assurance that an associated action plan has been developed and implemented;
- identification of regional learning, where relevant;

- surveillance of SAIs to identify patterns/clusters/trends.

4.5.2 All SAI reports are reviewed as a collective at the professional group meetings. DROs are provided with training and can access regular training updates as required. An outline of the SAI process for DRO's is provided. (Exhibit 23)

4.6 Levels of SAI review

4.6.1 Level 1: Concise internal investigation

This level is suited to less complex incidents which can be managed by individuals or a small group at a local level. Review teams should include staff from outside the direct care team.

4.6.2 A concise/compact review report which includes the essentials of a credible investigation utilising the Serious Event Audit review template will take place.

4.6.3 A learning summary to be sent to HSCB/PHA for review by the DRO.

4.6.4 All internal investigations should be supported by a clear review management plan.

4.6.5 Level 2: Comprehensive internal review (this includes those with an independent element or full independent panels).

This level is suited to complex issues, such as those involving a number of organisations which should be managed by a multidisciplinary team involving experts and/or specialist where applicable.

4.6.6 Level 3: Independent review

This level is required where the incident is complex or involving multiple organisations such as in situations of homicide. Level 3 Reviews are required where the integrity of the investigation is likely to be challenged or

where it may be difficult for an organisation to conduct an objective investigation internally due to the size of organisation or the capacity/capability of the available individuals and/or number of organisations involved.

4.6.7 In addition, on the establishment of the HSCB and PHA a number of processes were put in place for the monitoring of safety and quality issues.

4.7 Safety and Quality Alerts Team (SQAT)

4.7.1 The SQA process aimed to ensure the dissemination, implementation and assurance of safety and quality alerts. SQAT was a multi-disciplinary group that met fortnightly. The team was responsible for overseeing the implementation and assurance of Regional Learning / Reminder Letters and Guidance issued by HSCB/PHA and other organisations.

4.7.2 A lead officer from HSCB/PHA would have been allocated to any correspondence issued and updates on these were provided. This multi-professional group was chaired by the Deputy Director of Public Health (PHA) and was serviced by a governance manager (Terms of Reference at Exhibit 24). The SQA Team provided a mechanism for gaining regional assurance that alerts and guidance had been implemented or that there was an existing robust system in place to ensure implementation.

4.8 Quality, Safety Experience group (QSE)

4.8.1 A multi-disciplinary group met on a monthly basis to consider learning, patterns/trends, themes or areas of concern from all sources of safety and quality information received by the HSCB and PHA and agreed appropriate actions to be taken. This group was co-chaired by Directors in PHA and HSCB. (Exhibit 25)

4.8.2 In 2020 at the start of Covid-19 due to considerable redeployment of staff to the Covid-19 response a review of these processes was carried out in order to ensure there was still an oversight of all safety and quality processes. This led to a number of changes to these processes including the standing down of the above groups to provide both a greater and more robust oversight and accountability for all aspects of safety and quality.

4.8.3 Every notification which comes in via SPPG is noted on a **Daily Report** which is reviewed by a member of the safety and quality team (PHA) for approval for dissemination or if required immediate escalation to an appropriate director (SAI notifications are also disseminated to the appropriate professional group or DRO).

4.8.4 The weekly **Incident Review Group** (Exhibit 26) is a multi-disciplinary group from across SPPG and PHA who review on a weekly basis all notifications for any required action, identification of urgent learning and identification of themes and trends. A set of generic codes are applied to all notifications to facilitate searching of the Datix system to help identify trends. As a further layer of assurance any issues or concerns can be raised at the weekly **Safety Brief** meeting which involves members of the governance team (SPPG) and safety and quality team (PHA) and lead Directors.

4.8.5 A monthly **Safety and Quality Assurance group** meets to consider other areas of safety and quality (such as complaints and NICE guidance). This allows further discussion on themes and trends which may have been identified and allows triangulation of this information with other sources in order to produce more robust learning as required.

4.8.6 A new system for monitoring safety and quality alerts was developed in 2021. SPPG governance staff monitor the responses received and liaise with the appropriate person (lead officer) in SPPG/PHA to assess the Trusts compliance with either the SQA or learning letter issued.

4.9 RQIA involvement

4.9.1 As per the SAI procedure MHLD reports are shared with RQIA to consider in line with their responsibilities.

Learning

4.9.2 In summary the role of SAI reviews is to help identify any learning from things that go wrong i.e. what happened, why it happened and what we can learn to prevent recurrence. The process requires that the HSCB/SPPG in conjunction with PHA will

- ensure that themes and learning from SAI's are identified and disseminated for implementation in a timely manner; including for example;
    - Learning letters/ reminder of best practice letters
    - Learning newsletter
    - Thematic reviews

4.9.3 The development of letters is led by SPPG governance with input from DRO's in both PHA and SPPG depending on the learning identified. The development of Learning Matters Newsletters and Thematic reviews is led by PHA safety and quality team.

4.9.4 A review of safety and quality processes within SPPG/PHA is currently underway to bring about improvements in the methods by which learning is disseminated to make it more meaningful for staff. This work has been supported through two Project ECHO (Extension of Community Healthcare Outcomes) programmes; one for learning from acute SAIs regarding the deteriorating patient identified as a recurrent theme in a number of SAIs) and a second commenced in April 2023 into an independent SAI for mental health services.

4.10 Examples of Quality and Safety Actions undertaken in response to SAIs associated with Muckamore Abbey Hospital

4.10.1 The learning from Muckamore-related SAIs has focused a number of pieces of work taken forward within LD services regionally, including for example;

- A Mental health and Learning Disability Leadership and Governance Review.
- Creating Care Culture commissioned from the Foundation of Nursing Studies
- Commissioning of Behavioural Support Insights Programme
- Commissioning of *Safety First* an updated MAPA (Management of Actual or Potential Aggression) Programme

4.11 Complaints

4.11.1 Responsibility for Complaints relating to services is primarily that of the relevant HSC Trusts. The HSC Complaints Procedure also places responsibility on SPPG to monitor how Trusts in their provision of services deal with and respond to complaints (Exhibit 27).

4.11.2 SPPG must maintain an oversight of all Family Practitioner Services and HSC Trust complaints received and where appropriate out of hours services. SPPG must be prepared to investigate:

- Patterns or trends of concern
- Clusters of complaints against any individual clinicians/professionals

SPPG must have in place area wide procedures collecting and disseminating learning and sharing intelligence and the PHA receives a copy of closed complaints.

4.12 Process of Monitoring

4.12.1 The Regional Complaints Steering Group (RCSG) reviews complaints and information received from HSC Trusts and FPS (Family Practitioner Services) Practices (primary care). Information from all of the HSC Trusts is received on a monthly basis on a monitoring template summarising the issue of complaint and response and if any actions taken/learning identified. This information is categorised into specific areas of complaint and shared by SPPG complaints staff with designated professionals within the SPPG and PHA, who sit as members of the RCSG for review and consideration at meetings. Professionals are asked to consider if there are any areas of concern, if they require any further information, and if so, on review of same confirm if they are content or if further action is required. Membership of the RCSG also includes PCC.

4.12.2 The complaints are shared with professionals relevant to the following subject areas: - Emergency Departments, obstetrics and gynaecology, social services, Out of Hours services, allied health professions, and issues associated with patient and client experience. Complaints relating to FPS are reviewed by the SPPG's respective professional advisers and a summary of all FPS complaints are circulated on a quarterly basis to this Directorate.

4.12.3 This monitoring process ensures that complaints information is routinely linked into existing work streams/professional groups.

4.13 Quality

4.13.1 The PHA has a role in monitoring Key Performance Indicators of quality of nursing care as set out by the CNO. These are

- Reduction of Harm from Falls
- Prevention of Pressure Ulcers

- Compliance with accurately completed National Early Warning Scores (NEWS) charts
- Mixed Gender Accommodation

4.13.2 Prior to Covid-19 work had commenced on developing KPI for learning disability, however was paused as result of the pandemic. However, this work is now being progressed by NIPEC through the Learning Disability Nursing Collaborative.

4.13.3 Trusts submit their data and an annual Quality Improvement Plan report is developed. These reports were stood down during Covid-19 and a review of five years' data was carried out. As a result of this a review of KPI's has been instigated and is being taken forward through the Nursing and Midwifery Task Group.

4.13.4 The PHA also leads on the production of a joint PHA/SPPG Annual Quality Report which outlines quality initiatives taken forward either individually or jointly by the organisations. The 2017/18 and 2018/19 reports both outlined initiatives relating to Learning Disability. (Exhibit 28 and Exhibit 29)

5. AHP Professional Assurance Framework

5.1 The designated Trust AHP Lead through the agreed Trust processes (HSC Trusts and NIAS) submit an Assurance monitoring report to the PHA (Head AHP, Deputy Director) annually (taking into account the timing of the formal accountability arrangements to the Department of Health), outlining adherence to agreed standards/systems and good practice for AHPs employed within their organisation.

5.2 The PHA submits the assurance report (from the Head AHP, Deputy Director through the Director of Nursing and AHPs)) annually to the Chief Allied Health Profession Officer in the Department of Health to inform the normal governance process identifying any areas of concern and actions taken.

*note due to COVID-19 this report was not submitted in 2020 or 2021

5.3 AHP Workforce Reviews

5.3.1 The Department of Health developed a Regional Workforce Planning Framework in 2015 (Exhibit 30). AHP Workforce Reviews have been led by the Department of Health with professional input from PHA. The work of the workforce reviews has been overseen by the AHP Workforce Review Programme Steering Group. PHA EDON was a member of the AHP Workforce Programme Steering Group. PHA AHP Consultants were members of the AHP Workforce Sub-Groups.

5.3.2 Since March 2017, Project Groups comprising representatives from across the health and social care service, professional bodies, staff side representatives and the Department of Health, have been meeting regularly to consider how the Allied Health Professions are likely to develop in the period 2019 – 2029 The aim has been to understand our workforce needs, so that we can plan effectively to maintain and develop our services into the future.

6. PHA Corporate Host Functions for the Safeguarding Board for Northern Ireland (SBNI).

6.1.1 The SBNI was established in 2012 following the publication of the Safeguarding Board Act (2011) (The Act). The SBNI has replaced the Regional Child Protection Committee (RCPC) with an extended role to include the wider area of safeguarding as well as statutory child protection.

6.1.2 The objective of the Safeguarding Board for Northern Ireland (SBNI) is to safeguard and promote the welfare of children and young people in Northern

Ireland by co-ordinating the work and ensuring the effectiveness of each person or body represented on the Board.

6.1.3 The PHA acts as corporate host to the SBNI. The relationship between the Department of Health and the PHA in regard to the corporate hosting functions for SBNI is detailed in the Management Statement and Financial Memorandum (MSFM) in place between these bodies. Whilst the PHA is accountable to the Department for the discharge of its corporate host obligations to the SBNI the PHA is not accountable for how the SBNI discharges its statutory objective, functions and duties.

6.1.4 The PHA provides the SBNI with:

- a Central Support Team;
- accommodation and office facilities; and
- access to a range of corporate services: HR, training, finance, IT, legal, equality proofing and advice and support in connection with complaints handling and information mmanagement.

6.1.5 The PHA also has line management responsibility for the most senior members of SBNI staff. It is a matter for the CEO of the PHA to decide where within the PHA line management responsibility will sit, and to nominate a PHA official with sufficient seniority to act as line manager to the most senior SBNI members of staff.

6.1.6 The SBNI, through the Chair, accounts directly to the Department for the exercise of its statutory objective, functions and duties. In accordance with guidance issued by the Department, the SBNI develops a Strategic Plan and Annual Business Plans and in accordance with section 6 of the Safeguarding Board Act (Northern Ireland) 2011, produces an annual report.

6.1.7 The PHA, as corporate host for the SBNI, has no responsibility for the development of the SBNI Strategic and Business Plans, their review or approval. However, through its membership of the SBNI, the PHA Directors contribute to the SBNI through provision of independent professional advice.

6.1.8 The PHA Directors of Public Health (DPH) and Nursing and Allied Health Professionals (DNAHP) are members of the SBNI Board. The PHA Safeguarding nurse is also a member of the Board providing subject matter expertise.

7. Statement of Truth

7.1 The contents of this witness statement are true to the best of my knowledge and belief. Previously, PHA has produced the relevant documents which it believes are necessary to address the matters on which the Inquiry Panel has requested me to give evidence.

Signed: 

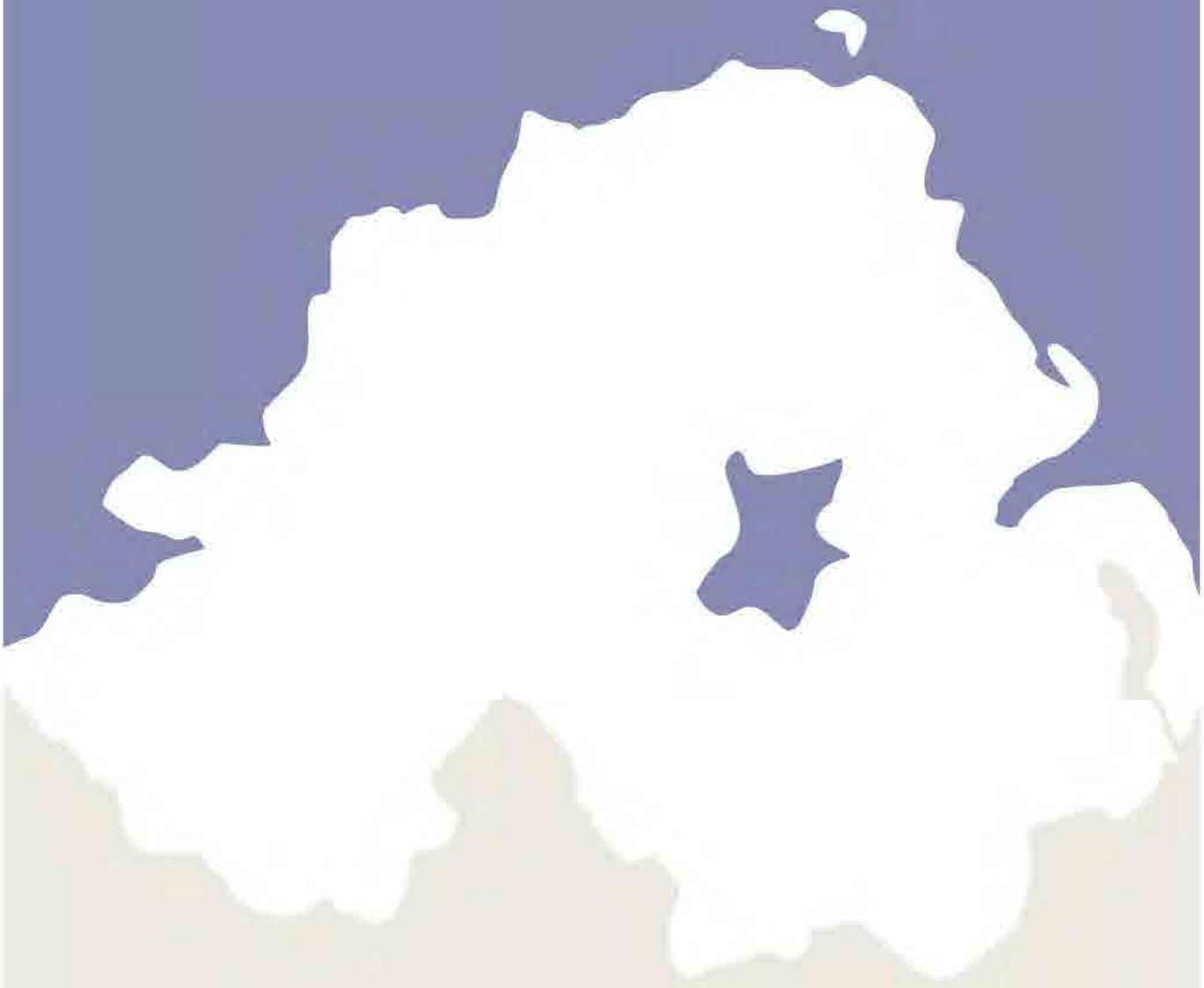
Aidan Dawson

Date: 26 May 2023

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



Review Team | Sir Liam Donaldson | Dr Paul Rutter | Dr Michael Henderson

CONTENTS

1 CONTEXT

Throughout the developed world much healthcare is of a very high standard. The range of technologies and drugs available to diagnose and treat illness greatly increased during the second half of the 20th Century, and into the 21st, offering life and hope where patients' prospects were once bleak. As a consequence, the number of people living with disease and needing years or even decades of support from care systems has expanded enormously.

The ageing population of today is a central consideration in a way that was not foreseen when modern healthcare came into being in the aftermath of the Second World War. Today, people are living much longer and developing not just one disease but several that co-exist. In old age, the twin states of multi-morbidity and frailty are creating acute and long-term health and social care needs on an unprecedented scale.

Technology has continued its rapid and beneficial advance, opening up new opportunities for diagnosis and treatment but bringing even greater numbers through the doors of hospitals and health centres. Citizens experience the benefits of an advanced consumer society and when they encounter the health and social care system, they rightly expect it to be commensurate with this. Rising public expectations are a further driver of demand for healthcare. There are other, less predictable sources of pressure on services. For example, a change in the pattern of winter viruses can bring surges in demand that threaten to overwhelm emergency departments. In response to all of this, the size of budgets devoted to health and social care has had to expand dramatically.

At the epicentre of this complex, pressurised, fast-moving environment is the patient. The primary goal of the care provided must always be to make *their* experience, the outcome of *their* condition, *their* treatment, and *their* safety as good as it gets. Health and social care systems around the world struggle to meet this simple ideal. Evaluations repeatedly show that: variation in standards of care within countries is extensive; some of the basics such as cleanliness and infection are too often neglected; evidence-based best practice is adopted slowly and inconsistently; the avoidable risks of care are too high; there are periodic instances of serious failures in standards of care; and, many patients experience disrespect for them and their families, bad communication and poor coordination of care.

The health and social care system in Northern Ireland serves a population of 1.8 million. People live in urban, semi-rural or rural communities. Responsibility for population health and wellbeing, and the provision of health and social care, is devolved to the Northern Ireland Assembly from the United Kingdom government in Westminster. As in other parts of the United Kingdom, the Northern Ireland health service operates based on the founding principles of the National Health Service - the provision of care according to need, free at the point of access and beyond, funded from taxation. However, since the advent of devolved government, England, Scotland, Wales and Northern Ireland have adopted their own strategies for: promoting and protecting health; preventing disease; reducing health inequalities; and, planning and providing health and social care services. The countries have developed different structures and functions within their systems to meet these responsibilities. Thus, they vary in features such as: arrangements for planning and contracting of care; levels of investment in public health, primary and community care versus hospital provision; funding models; incentives; use of the independent sector; managerial structures; and, the role of the headquarters function.

Various agencies, groups and strategies populate the quality and safety landscape of Northern Ireland. Quality 2020 is the flagship

ten-year strategy. Commissioned by the Minister of Health, Social Services and Public Safety in 2011, its vision is to make Northern Ireland an international leader in high quality, safe care. Quality 2020 is sponsored by the Chief Medical Officer and led by the Department of Health, Social Services and Public Safety. It has a steering group, a management group, an implementation team, project teams, and a stakeholder forum. These bring together representatives from across the statutory care bodies and beyond. Separately, a Health and Social Care Safety Forum convenes a similar group of stakeholders.

The Regulation and Quality Improvement Authority (RQIA) is the main regulator in Northern Ireland's care system. Many of the social care providers, and some healthcare providers, are registered with the Regulation and Quality Improvement Authority. However it does not register the Trusts, which provide the bulk of health and social care in Northern Ireland, or general practices. The Trusts' relationship with the regulator therefore has a somewhat softer edge than might be the case if they were formally registered, although an expanded role has been announced recently by the Minister.

Northern Ireland takes a keen interest in the work of quality and safety bodies elsewhere in the United Kingdom, and often implements their guidance and recommendations. The National Institute for Health and Care Excellence (NICE) and the former National Patient Safety Agency have been prominent in this regard.

Technical quality and safety expertise sits not in the Health and Social Care Board, but next door in the Public Health Agency. The Public Health Agency has a statutory role in approving the Health and Social Care Board's commissioning plans. Two executive directors are jointly appointed between the Public Health Agency and the Health and Social Care Board. There are therefore mechanisms through which quality and safety expertise should inform the Board's work. The Quality Safety Experience Group is jointly managed between these two agencies. It meets monthly and its primary focus is learning. It looks at patterns and trends in incidents and initiates thematic reviews.

In short, there is a good degree of activity in the sphere of quality and safety improvement. There are some unusual features of the landscape, which will emerge in some detail in this Review.

The way in which central bodies seek to achieve compliance with their policies and make broader improvement changes is based on a very traditional and quite bureaucratic management model. There is much detailed specification of what to do, how to do it, and then extensive and detailed checking of whether it has been done. This has strengths in enabling the central bodies and the government to demonstrate their accountability and give public assurances, but it can greatly disempower those at the local level. It can cause those managing locally to look up, rather than looking out to the needs of their populations.

The alternative is a style of leadership based on inspiration, motivation and trust that those closer to the front line will make good judgments and innovate if they are encouraged to do so. Perhaps the relationship needs a lighter touch, to liberate freer thinking on how to make services better for the future.

2 TERMS OF REFERENCE AND WORKING METHODS

The Review's formal Terms of Reference are available online[1]. The overall aim of the Review has been to examine the arrangements for assuring and improving the quality and safety of care in Northern Ireland, to assess their strengths and weaknesses, and to make proposals to strengthen them.

The analysis in this report is based on extensive input from, scrutiny of, and discussion with people across the health and social care system in Northern Ireland. Each of the main statutory organisations made formal submissions to the Review (including records of board meetings, policies, and plans). The Review put substantial emphasis on travelling around the system – both literally and figuratively – to see it from as many different angles as possible, and to come to a rounded view.

The Review Team visited the five Health and Social Care Trusts, the Northern Ireland Ambulance Service, the Department of Health, Social Services and Public Safety, the Health and Social Care Board (and its Local Commissioning Groups), the Public Health Agency, the Patient and Client Council, and the Regulation and Quality Improvement Authority. In each, the Review Team met with the executive team (Chief Executive and executive directors) and, in most cases, the Chair of the Board and other non-executive directors. The management team of each organisation gave a series of presentations covering the areas of interest to the Review, and Review Team members asked questions and led discussion.

During their visit to each Health and Social Care Trust and to the ambulance service, Review Team members also led focus groups discussions amongst frontline staff. In each of the five Health and Social Care Trusts, for example, the team met with separate groups of consultants, nurses, junior doctors, and other health and social care professionals. Senior managers were not present for these discussions. Participants were encouraged to speak openly, and generally did so. It was understood that no comments would be attributed to individuals. The focus groups centered on any concerns about quality and patient safety in their organisation and incident reporting, and other highly-related topics. The team also met with two groups of general practitioners.

The Review Team paid particular attention to the experiences of people who have come to harm within the Northern Ireland health and social care system. At each Trust, including the ambulance service, the team reviewed two recent Serious Adverse Incidents in detail, particularly considering the incident itself, the way in which patients and families were kept informed and involved, and the learning derived. The team later returned to two Trusts to review further incidents, this time selected by the Review Team from a list of all serious adverse incidents in the previous year. The Review Team met with people who have come to harm. Most of these meetings were in person; some were by telephone. In addition to people affected directly, the Review Team spoke to their family members and carers. We are particularly grateful to all of these individuals for giving of their time, and for graciously sharing their stories with us, which were often painful.

Finally, the Review Team met with a series of other individuals and groups that form part of the wider health and social care system in Northern Ireland, or have a strong interest in it. These were: the Attorney General, the British Medical Association, the Chest Heart and Stroke Association, the Commissioner for Older People for Northern Ireland, Diabetes UK, the General Medical Council, MacMillan Cancer Support, the Multiple Sclerosis Society, the Northern Ireland Association of Social Workers, the Northern Ireland Human Rights Commissioner, the Northern Ireland Medical & Dental Training Agency, The Honourable Mr Justice O'Hara,

[1] http://www.dhsspsni.gov.uk/tor-080414.pdf

the Ombudsman for Northern Ireland, the Pain Alliance of Northern Ireland, Patients First Northern Ireland, the Royal College of Nursing, and the Voice of Young People in Care. Other patient and client representative groups were invited to meet with the Review Team, or to make written submissions.

To inform one aspect of the Review, the Regulation and Quality Improvement Authority oversaw a look-back exercise, reviewing the handling of all Serious Adverse Incidents in Northern Ireland between 2009 and 2013. Their report was received late in the Review process, but has been considered by the Review Team and reflected in this report.

Between starting and producing its final report, the Review Team has had a relatively short period of time. It has not been possible to undertake research, extensive data analysis, large-scale surveys of opinion, or formal evidence-taking sessions. However, the documents reviewed, the meetings held, the visits made, and the views heard have given a strikingly consistent picture of quality and safety in the Northern Ireland health and social care system. The Review Team is confident that a longer exercise would not have produced very different findings.

3 THE CHALLENGES OF DELIVERING HIGH QUALITY, SAFE CARE

Patients in hospitals and other health and social care services around the world die unnecessarily, and are avoidably injured and disabled. This sad fact has become well known since the turn of the 20th Century. Awareness of it has not been matched, unfortunately, by effective action to tackle it.

There is consistency in the types of harm that occur in high-income countries. In low-income countries, harm is mainly related to lack of infrastructure and facilities, as well as poor access to care. However, in North America, Europe, Australasia, and many parts of Asia and the Middle East, analysis of incident reports and the findings of patient safety research studies shows a different, strikingly consistent pattern. Between 3% and 25% of all hospital admissions result in an adverse incident, about half potentially avoidable. Within any health or social care service, there are many potential threats to the quality and safety of the care provided:

1. Weak infrastructure - the range and distribution of facilities, equipment and staff is inadequate to provide fair and timely access to required care.
2. Poor co-ordination - the components of care necessary to meet the needs of a patient, or group of patients, do not work well together to produce an effective outcome and to be convenient to patients and their families.
3. Low resilience - the defences in place, and the design of processes of care, are insufficient to reliably protect against harm such as that resulting from errors or from faulty and misused equipment.
4. Poor leadership and adverse culture - the organisation or service providing care does not have clear goals and a philosophy of care that it is embedded in the values of the organisation and visible in every operational activity.
5. Competence, attitudes, and behaviour - the practitioners and care-providers working within the service lack the appropriate skills to deal with the patients that they encounter, or they are unprofessional in their outlook and actions, or they do not respect other team members, nor work effectively with them.
6. Sub-optimal service performance - the way that the service is designed, organised and delivered means that it does not deliver processes of care to a consistently high standard so that over time it chronically under-performs often in a way that is not noticed until comparative performance is looked at.
7. Slow adoption of evidence-based practice - the service does not conform to international best practice in particular areas of care or overall.

The amount of each type of harm varies but the overall burden has changed little over the last decade despite the unprecedented priority that has been given to patient safety within these health systems. Little is known about the level and nature of harm in primary care, though more attention is now being given to it.

Although these threats are described in relation to health, they apply also to social care. Many are strongly related to the level of resources that is available to a health and social care system. The extent to which each problem is present varies hugely across the world, within countries, and even between different parts of the same service or area of care provision.

In some ways it is reassuring to believe that the problems of quality and safety of care are somehow universal, and that no country has the answers. This is dangerous thinking. The best services in the world show that even with the all the pressures of large numbers of patients, many with complex needs, excellence can be achieved consistently across all fields of care. The Northern Ireland health and social care service must not be satisfied with 'good enough.' With a clear recognition of the reasons for its current problems in quality and safety of care, and with everyone working together, it could be amongst the best in the world.

4 KEY THEMES ESTABLISHED BY THE REVIEW

The Review established six key themes. Each is set out in some detail below. Exploration of these themes provides the basis for the Review's conclusions (in section 5) and recommendations (section 6).

4.1 A SYSTEM UNDER THE MICROSCOPE

Northern Ireland's health and social care system is subject to a high, perhaps unrivalled, level of media coverage – much of it negative. Over recent years, it has also been the subject of a series of high profile inquiries. All have highlighted numerous failings in the leadership and governance of care. Many have made extensive recommendations and the extent to which these have been implemented has itself been controversial. The pressures of increasing demand for care have meant that access has been more difficult. There has been a focus on over-crowding and delays in emergency departments, the front door of the hospital service. All of this has meant that the last five years has been a period of unprecedented scrutiny of the way that health and social care in Northern Ireland is planned, provided and funded.

4.1.1 A stream of inquiries highlighting service failures

The number of recent major investigations and inquiries into shortfalls in standards of care in health and social care services in Northern Ireland is striking in relation to the size of its population. This does not necessarily mean that such occurrences are commoner than elsewhere in the United Kingdom. It may simply be that the level of public and media scrutiny is higher and the pressure from this triggers a statutory response by government ministers and officials. The end-result is that the profile of the service is more often one of failure rather than success.

In March 2011, Dame Deirdre Hine, a former Chief Medical Officer for Wales, issued the report of her inquiry into deaths from *Clostridium difficile* in hospitals in the Northern Trust area. She had been brought in to investigate 60 deaths that had been attributed to the organism. She found that the true figure was 31 deaths. She found management, organisational, clinical governance and communication failings. She made 12 recommendations. It took 23 months to complete.

In February 2011, the Belfast Trust recalled 117 dental patients following a review of the clinical performance of a senior consultant. An independent inquiry commissioned by the Minister was published in July 2013 and made 45 recommendations. An action plan developed by the Department of Health, Social Services and Public Safety identified 42 key actions including on staffing, training, supervision and clinical governance. In November 2013, the Regulation and Quality Improvement Authority conducted an assessment of implementation of those actions.

In December 2011, an independent report by the Regulation and Quality Improvement Authority examined delays in the reporting of plain X-rays in all Trusts after concerns were expressed about delays in two hospitals. The review found that serious delays had occurred and were caused by three main factors: a shortfall in consultant radiology staffing, a growth in numbers of x-rays to be reported after the introduction of digital imaging and the introduction of a new policy to report on all hospital chest x-rays because of worries about patient safety. The review found that there was little awareness at regional level that a serious backlog in reporting was developing with potential risks to patients due to delayed diagnosis. The review made 14 recommendations.

In May 2012, Doctor Pat Troop, former chief executive officer of the Health Protection Agency in England, issued her final report of the independent investigation into an outbreak of infections in neonatal units due to the organism *Pseudomonas aeruginosa*. Five babies had died in the outbreak and 32 recommendations were made covering technical matters, management, governance, communication, training, and outbreak management.

In April 2012, the Minister asked for special measures to be put in place to oversee the Belfast Trust because of major concerns about serious adverse incidents in the emergency department, recommendations from the Pseudomonas review, reviews of paediatric congenital cardiac surgery and recommendations of the dental inquiry.

In December 2012, the Minister appointed a Turnround and Support Team to go into the Northern Health and Social Care Trust because of concerns about the weakness of governance and quality assurance systems, the paucity of clinical leadership, and uncertainties about the reliability of mortality data. This particular Trust has had five chief executive officers in the last seven years.

In June 2014, the Regulation and Quality Improvement Authority reported on its review of unscheduled care services in the Belfast Trust. The concerns that led to the review included: the declaration of a major incident, 12-hour waiting time breaches, dysfunctional patient flows and gross overcrowding of patient care areas. This triggered a fuller review that looked at matters region-wide. This produced 16 recommendations.

The dominant inquiry in recent times remains the *Independent Inquiry into Hyponatraemia–Related Deaths.* It is examining the deaths of children after being transfused in hospital with a fluid that was subsequently found to carry a significant risk. Concerns had been raised by the parents and others that this risk should have been identified much earlier, that action should have been taken to stop it being used, that there was a cover-up and that systems for monitoring safety were inadequate. It is being chaired by John O'Hara QC and was commissioned in 2003/4 but, because of other legal processes, was not able to hear full evidence until more recently. The report is expected in 2015.

The criticisms in inquiries like these have been largely justified and must be followed by action to improve the situations. Whether establishing formal, often lengthy, and costly inquiries is the right way to drive improvement is very debatable. Certainly doing so as the normative response to failure has important disadvantages. In particular, it often paralyses the organisation under scrutiny as its staff become pre-occupied with preparing evidence and supplying information. The learning is often put on hold - sometimes never to be returned to - until the inquiry is over. The burden of recommendations to be implemented and progress-checked can be overwhelming, so that the implementation becomes a bureaucratic exercise rather than a watershed moment for leadership, culture and the content of practice. It might be better to define a clear threshold for when a full-blown inquiry is initiated.

4.1.2 Intense political and media interest in service provision

Northern Ireland's health and social care system is subject to a high degree of political, as well as media, interest. This is a valid and expected feature of a publicly-funded system. Ironically, though, the way in which this interest becomes manifest often creates results that are counter to the true public interest. There have been many examples of local communities – and therefore their politicians – wanting to keep a local hospital open, contrary to the analysis of service planners. This has created

a situation in which Northern Ireland has more inpatient units than is really justified for the size of population, and the expense of maintaining them impedes provision of other services that would represent better value for money and more appropriately meet the needs of the population. Likewise, political pressure and media interest has prevented the salaries of top managers from being raised too substantially. However, senior executives in the Northern Ireland care system are now paid much less than their counterparts elsewhere in the United Kingdom. The public would be better served if their care system could compete to attract the very best managerial talent. The pressure to keep salaries down may be penny-wise and pound-foolish.

4.2 THE DESIGN OF THE SYSTEM HINDERS HIGH QUALITY, SAFE CARE

When a quality or safety problem arises somewhere within the Northern Ireland care system, the tendency is to point to the individuals or services involved, and to find fault there. As with so many other features identified in this report, this tendency is far from unique to Northern Ireland. But it represents, in the view of the Review Team, too narrow a focus. In reality, the greatest threats to the quality of care that patients receive, and to their safety, come from the way in which the system as a whole is designed and operates.

In short, the services that exist are not the services that the population truly requires. Political and media pressure acts to resist change, despite the fact that change is much needed. It is not clear who is in charge of the system, and the commissioning system is underpowered. All of this compounds the pressures, creating high intensity environments that are stressful for staff and unsafe for patients – particularly out of hours. These effects are explored further below.

The Northern Ireland care system has some elements in common with the other United Kingdom countries, and some that differ. Observers, asked to describe the Northern Ireland system, often point first to the integration of health and social care as its distinguishing feature. It is clear though from the findings of this Review that whilst the integrated design of the system has great advantages, it falls well short of perfection in promoting the highest standards of care and in preventing the dysfunctions in the co-ordination of care that are prevalent elsewhere.

4.2.1 Service configuration creates safety concerns

A striking feature of the provision of care in Northern Ireland is the wide distribution of hospital-type facilities outside the major city, Belfast, some serving relatively small populations by United Kingdom standards. This geographical pattern leads to specialist expertise being too thinly spread, and to the patchy availability of experienced and fully competent staff. It means that it is not possible everywhere to deliver the same quality of service for an acutely ill person at 4 a.m. on a Sunday as at 4 o'clock on a Wednesday afternoon. There is therefore a two-tier service operating in Northern Ireland - in-hours and out-of-hours - that is more pronounced in some places than in others. This is one of the biggest influences on the quality and safety of care. Delivery of services is too often higher risk than it should be in a 21st Century healthcare system because of the pattern of services.

Past analysts and observers have pointed to the current level and siting of provision not being in keeping with maintaining high standards of care. Some populations are just too small to warrant full-blown general hospital facilities yet they are kept in place because of public and political pressure. Amongst those who work within the system, there is deep frustration that the public are not properly informed about the higher risks of smaller hospitals and that the misapprehension that alternative forms of provision are in some way inferior to a hospital. These issues are illuminated by two wry comments made to the Review: "the word 'hospital' should be removed from the Oxford English Dictionary" and " Northern Ireland needs more roads not more hospitals."

Despite its small size, there is less co-operative working across Northern Ireland than might be expected. Silos reign supreme. The Health and Social Care Board runs regional commissioning teams, covering areas such as learning

disability, mental health, prison health and a very broad category of 'hospital and related services'. However, particular scope exists to do more in improving standards in areas of clinical care where there is a strong evidence base for what is effective. In the cases where clinicians have worked together across organisational boundaries, remarkable transformations have occurred. This happened in cardiology where a regionally planned and coordinated service means that more patients with heart attacks get treated early, get less damage to their hearts, and more people live rather than die. The Ambulance Trust is the only one of the six Trusts organised on a regional basis. The Review Team was very struck by how much pressure this important service was under. This is consistent with the headline stories in other parts of the United Kingdom about ambulance services being unable to meet their service standards because of huge surges in demand. All parts of the service are taking the strain – from those in the control centre to those on the road. Yet when the detail of their situations is explored in depth, it is clear again that the problems stem from dysfunctional patient flows and pathways where different parts of the system are not working together.

4.2.2 Adverse consequences for primary and social care

The pressures on hospitals have consequences for primary and community services. There is a constant need for hospitals to discharge patients as soon as they possibly can to free-up beds for new admissions. Generally, this happens when an older person is judged medically fit for discharge. However, this does not necessarily mean that their physical and social functioning has reached a level where they can cope with a return to the community. The Review was told by general practitioners and social care staff that they often have to step in to provide unscheduled support in such circumstances and, because of inadequate communication at the time of discharge, they can be left in the dark about ongoing treatment plans and even be unclear about something as basic as a patient's medication regime. Some general practitioners spoke of spending long, frustrating hours trying to get to speak to a hospital doctor about their patient, without success.

Over the last decade, there has been a major increase in the dependency levels of people being cared for in the community. For example, the use of PEG feeding (directly into the stomach through a tube in the skin) is now commonplace in community settings, whereas it used to be a hospital treatment. As a result, community nursing staff have much more complex caseloads. There is also greater complexity in the other forms of disability, as well as in the treatments that people are receiving and other technologies that are supporting them.

The Review Team was very struck by the experience of one on-call pharmacist whom they talked to. He was responsible for preparing the discharge medication for patients leaving hospital on a particular Bank Holiday weekend. He reported filling a doctor's prescription for 20 different medications for each of four patients. This strongly illustrates several points. Firstly, it is not right that such an excessive amount of medication should be routinely prescribed. It should be rigorously reviewed and adjusted. Secondly, it again shows the complexity and multiple conditions affecting many patients, who move regularly between hospital and community. Thirdly, it highlights the opportunity for a much stronger role for under-appreciated disciplines like pharmacy on the boundary between hospital and population.

The integration of health and social care means that the Review Team's discussions within Trusts necessarily took account of the important role of social care staff, and particularly social workers. They are a vital part of the workforce and although under equal pressure to their

healthcare counterparts, the Review was encouraged to hear about the strong emphasis on professional development in Northern Ireland and the particular expertise in specialist areas such as adult safeguarding.

The knock-on effects of pressures in the hospital system for community services are not restricted to post-discharge matters. Many hospital departments are so pre-occupied with urgent work and the high volume of patients that they do not have time to provide proper responses when patients or their doctors make contact to ask about progress with an outpatient appointment or test results.

4.2.3 High-pressure environments fuel risk to patients and sap morale

The demand from patients who need emergency care, as well as those who require planned investigations and treatments, is extremely high. The pressures on emergency departments and hospital wards are very great. Over-crowded emergency departments and overflowing hospital wards are high-risk environments in which patients are more likely to suffer harm. This is because delays in assessment and treatment occur but also because staff have to make too many important and difficult decisions in a short space of time - what psychologists call cognitive overload. That they will make mistakes and misjudgments is inevitable, and some of them will be in life-and-death areas. Experience in other safety-critical industries, and research, shows that high-pressure, complex, and fast-moving environments are dangerous. If inadequate staff levels are added to the mix, risks escalate further.

The Review met with many groups of health and social care staff, speaking on condition of anonymity. They are overwhelmingly conscientious people who feel deeply for their patients and want to excel in the care that they deliver. Yet, the workloads in some situations are unacceptably high; so too are stress levels. The stress comes not only from the large numbers of cases per se, but much more from the feeling of staff that they are not giving patients the quality of care they were trained to deliver. There is guilt too in knowing that they are forced to compromise their standards to levels that they would not accept for their own families. The phrase "doing just enough" was repeatedly used in the Review's meetings with front-line staff. There are extra pressures for some groups of staff. Doctors in training can find themselves in situations that are beyond their competence and experience. Sometimes they can call on back-up from senior staff, sometimes they have to do their best until the morning or Monday comes. Some nurses can find themselves dealing with an unacceptably large number of patients on a hospital ward at night. They too feel that they are having to lower their professional standards. This assessment is not based on isolated anecdotes but much more widespread and consistent accounts.

4.2.4 Transformation efforts are moving slowly

Transforming Your Care began as a substantial review of health and social care provision in Northern Ireland, commissioned in 2011. The review was led by the then-Chief Executive of the Health and Social Care Board, supported by an independent panel. It was a strong, forward-thinking piece of work.

The whole of the United Kingdom, like most developed countries, has a fundamental problem: the health and social care system that it has is not the health and social care system that it needs. The pattern of ill-health in the population has changed substantially since the systems were founded, and the systems have not changed to keep up. *The Transforming Your Care review* set out a convincing case for change. It described inequalities in health, rising demands, and a workforce under pressure. It particularly established that Northern Ireland has too many acute hospitals

- that elsewhere in the United Kingdom, a population of 1.8 million people would likely be served by four acute hospitals – not the 10 that Northern Ireland had.

Transforming Your Care set out a broad new model of care, which aimed to be tailored to today's needs and person-centered. In practical terms, its most substantial proposal was to move £83 million away from hospitals and give it to primary, community and social care services.

Those interviewed by this Review Team unanimously supported the need for this initiative. The widespread feeling, though, is that *Transforming Your Care* is simply not being implemented.

As a result of weak communication and little action, there is substantial skepticism about *Transforming Your Care*. The Review Team heard it variously referred to as "Transferring Your Care", "Postponing Your Care", and even "Taking Your Chances". One of its central concepts, 'shift left', is viewed particularly warily. Carers see it as a euphemism for dumping work onto them; general practitioners likewise. Those working in the community see their workload increasing, and worry that there is no clarity at all about what the overall care model is supposed to be.

The frustrations of the general practitioner community in Northern Ireland that *Transforming Your Care* has not worked, is not properly planned nor funded, has led them to take matters into their own hands and form federations. General practices themselves are financially contributing to these, in a move to establish community-centered care pathways.

The needs that *Transforming Your Care* sets out to address are becoming ever more pressing. Its implementation needs a major boost in scale and speed, and communication needs particular attention.

4.2.5 An under-powered system of commissioning

At 1.8 million, the population of Northern Ireland is relatively small to justify what is a quite intricately designed health and social care management structure. In addition to the Department of Health, Social Services and Public Safety, there are six Trusts, a Health and Social Care Board with five Local Commissioning Groups, a Public Health Agency, and several other statutory bodies.

A central feature is the split between care providers and commissioners, which increases the complexity of the system and its overhead costs. This began life as the so-called purchaser-provider split, introduced by Margaret Thatcher's government in the late-1980s. In various iterations, it has remained a feature of the NHS ever since. The introduction of a purchaser-provider split was originally intended to create a competitive 'internal market' to drive up quality and so increase value for money. However, the scope for genuine competition has always been very limited. The term 'commissioning' subsequently superseded 'purchasing'. Commissioning involves a wider set of functions – assessing need and planning services accordingly, and the use of financial incentives to intentionally drive the system's development relating to the type of services provided, their quality and their efficiency.

Within the United Kingdom, the English NHS has the most developed commissioning system. NHS England, the national commissioning board, is now separate from the central government Department of Health. It is a pure commissioning organisation, completely free from overseeing the performance of Trusts. Its only relationship with the provider side of the market is through the commissioning process. It devolves the vast majority of funds to local Clinical Commissioning Groups (of general practitioners) that make decisions about the allocation of money against a national

framework of policies and goals. Services are priced under a tariff system. This tariff has become increasingly complex, to facilitate locally agreed variation and to incorporate pay-for-performance elements.

There are several contextual differences between England and Northern Ireland, of which the most obvious is population size. In England, the overhead costs associated with establishing and administering a complex tariff system are essentially divided between 53 million people. With a population one-thirtieth the size, the cost per head of running a similar system in Northern Ireland would be difficult to justify.

The problem for Northern Ireland is that it has gone just partially down the commissioning path. It does not have the benefits of a sophisticated commissioning system, yet has the downside of increased complexity and overhead costs. The worst of both worlds.

Northern Ireland has no service tariffs. The Health and Social Care Board allocates money by a process akin to block contracting. This approach was abolished years ago in England because it was considered old-fashioned, crude and not conducive to achieving value for money. Fully developed tariff systems reimburse providers on a case-by-case basis, with the amount paid dependent on the diagnosis or the procedure undertaken, the complexity of the patient and, in some cases, measures of the quality of care. In Northern Ireland, the funding system is far more basic. Staff the Review Team spoke to believed that it makes no distinction, for example, between a cystoscopy (a simple diagnostic procedure, usually a day case) and a cystectomy (a complex operation), a clear absurdity if true.

Northern Ireland's five Local Commissioning Groups are not like England's Clinical Commissioning Groups. The Local Commissioning Groups have a primary focus on identifying opportunities for local service improvement. They have very few resources and, in effect, are advisers and project managers rather than commissioners. England's Clinical Commissioning Groups, by stark contrast, have a high degree of control over resource allocation.

It is imperative, somewhere in the system, for needs to be assessed, services planned and funds allocated. Whichever part of the system is responsible for this must be sufficiently resourced to do it well – arguably, the Health and Social Care Board is currently not.

The Northern Ireland system would benefit from stronger thought- leadership from within. There is no established health and social care think-tank, and some key disciplines such as health economics are not strongly represented.

Northern Ireland could choose to go down any number of different routes. It could strengthen the current Health and Social Care Board, particularly to create a tariff that includes a strong quality component. Alternatively, it could devolve budgetary responsibility to the five Trusts, making them something akin to Accountable Care Organisations in other countries, responsible for meeting the health and social care needs of their local population. The Trusts would then buy in primary care services, and contract between themselves for tertiary care services.

Recommending a commissioning model is beyond the scope of this Review. It is clear, though, that the Northern Ireland approach to commissioning is not currently working well, and that this is surely affecting the quality of services that are being provided. For that reason, the Review Team must recommend that this issue be addressed.

4.2.6 Who runs the health and social care system in Northern Ireland?

It was instructive for the Review Team to have asked this question of many people. The question elicited a variety of answers, the common feature of which was that no one named a single individual or organisation. Indeed, most reflected their uncertainty with an initial general comment. Typical was a remark like: "The Minister has a high profile."
When pressed to directly answer the question: who runs the service? Their answers included: "The Minister", " The Permanent Secretary in the Department of Health", " The Chief Executive of the Health and Social Care Board", and " The Director of Commissioning of the Health and Social Care Board."

These responses reflect the complexity of the governance arrangements at the top of the health and social care system in Northern Ireland. They show that ambiguity has been created in the minds of people – both clinicians and managers – throughout the system.

The question of who is in charge is both simple and subtle. Whilst overall accountability versus calling the shots versus making things happen are aspects of governance that would have a single leadership locus in many places, this is not the case in Northern Ireland. There is no single person or place in the organisational structure where these things come together in a way that everyone working in the service, the public and the media clearly understand.

The present arrangements have evolved over time but the Review of Public Administration in 2007 led to many of them. Prior to this the Department of Health, Social Services and Public Safety was larger and oversaw four Commissioning Boards and 18 Trusts. There were highly-centralised control mechanisms and the service was subjected to many and frequent circulars and directives. Since then there has been a smaller Department of Health, Social Services and Public Safety that is more focused on providing policy support to the Minister. A single Health and Social Care Board has been created from the previous four. The number of Trusts has been reduced from 18 to six, five organised to provide health and social care services by geographical area and the sixth an ambulance Trust for the whole region. Another important change has been the advent of a fully-devolved administration and the end of direct rule where power was in the hands of civil servants rather than elected local politicians. The lack of clarity about who is in charge is a major problem for Northern's Ireland care system. The difficulty is not that there is no figurehead, but that strategic leadership does not have the visibility of other systems. Without a clear leader, progress is piecemeal and change is hesitant and not driven through at scale – the Review Team was told "there are more pilots than in the RAF".

4.2.7 Clarifying the role of healthcare regulation

Aside from being commissioned by the Department of Health, Social Services and Public Safety to conduct occasional service-specific inspections, the Regulation and Quality Improvement Authority has until now conducted a program of thematic reviews driving more at quality improvement than at regulation.

From 2015, the Minister has decided that the regulator should undertake a rolling programme of unannounced inspections of the quality of services in all acute hospitals in Northern Ireland. The Regulation and Quality Improvement Authority is being directed in this task to examine selected quality indicators in relation to triage, assessment, care, monitoring and discharge. As a result of this change, the regulator will reduce its normal annual programme of thematic reviews.

These changes give the Regulation and Quality Improvement Authority a much stronger locus in the healthcare side of provision. However, this body has no real tradition of doing this kind of work, unlike its counterparts elsewhere in the United Kingdom. For example, in England, the various health regulators have evolved over a 15-year period with frameworks, methodologies, metrics and inspection regimes. For this reason, the Review is recommending that healthcare regulation in Northern Ireland is re-examined in the round, rather than approaching it piecemeal on an initiative basis.

4.3 INSUFFICIENT FOCUS ON THE KEY INGREDIENTS OF QUALITY AND SAFETY IMPROVEMENT

The recognition that quality and safety should be a priority in the planning and delivery of health and social care arrived late to this sector in developed nations. Until the early 1970s, services operated on the tacit understanding that doctors' and nurses' education, training, professional values and standards of practice ensured that most care was good care. It was not until measurement of quality became more commonplace that it was realised that faith in this ethos had been badly misplaced. A series of scandals blew apart public confidence in the NHS. There were many victims, and it became clear that trust alone was not sufficient. Often, such events depicted cultures in some health and social care organisations in the United Kingdom and other countries that had tolerated poor practice and even sought to actively conceal it.

Organised programmes to assure quality and improve it initially came into healthcare through approaches developed in the industrial sector, notably total quality management and continuous quality improvement. Until 1998, there had never been a framework to progress quality and patient safety in the United Kingdom's NHS. From that time, a comprehensive approach was introduced with: *standards* set by the National Institute for Clinical Excellence and in National Service Frameworks; a programme of *clinical governance* to deliver assurance and improvements at local level backed up by a statutory duty of quality; and, inspection of standards and *clinical governance* arrangements carried out by the Commission for Health Improvement. These roles have changed over time. Some still cover all, or most, of the United Kingdom, whilst others have been taken up differently in the four countries.

Much recent commentary on the NHS in the United Kingdom has focused on whether its leadership is really serious about quality and safety. There is a widespread view within the service that financial performance and productivity are what really matter to managers, despite what might be in the mission statements of their organisations. This came home to roost in the scandalous events at the Mid-Staffordshire NHS Trust in England where the Francis Inquiry heard that concerns about quality were down-played against financial viability in the pressure to gain Foundation Trust status.

A key consideration in quality and safety of healthcare is whether it is embedded in the mainstream at all levels. Up until the late-1990s, it was largely the domain of academics and enthusiasts. Since then, those who are fully committed to its underlying principles and goals have increased in number. However, it is still debatable what proportion of board members, management teams, and clinical leaders are 'card-carrying' quality and safety enthusiasts.

Prominent in international experience are four essential ingredients to improving the quality and safety of care. These are: clinical leadership, cultural change, data linked to goals, and standardisation. In Northern Ireland seeds of each can be found, but none is blossoming. This is substantially holding Northern Ireland's care system back from achieving its full potential.

4.3.1 Clinical leadership

A crucial test of the strength of the quality and safety system is the extent of clinical engagement. This is partly a question of hearts and minds but also a case of knowledge, skills and the philosophy of clinical practice.

The quality and safety of care will only get better if those who deliver the care are not only *involved* in improving it, but are *leading* the improvement effort. In the very best healthcare

systems in the world, clinicians are in the driving seat, supported by skilled managers. Traditionally, doctors, nurses and other health professionals have seen their duty to the patient in front of them. Rightly, this remains the important primary requirement for establishing a culture of good clinical practice. However, this is not enough to enable consistently high standards of care, nor to make care better year-on-year. This requires a paradigm shift in clinical practice, a different mission of practice, so that all healthcare professionals see the essence of their work not just in the care of individual patients but in ensuring that the service for all their patients reaches a consistently high standard and that opportunities for improvement are identified and taken. Accomplishing this is not easy. Clinicians will point out that their workloads are too heavy to make time to reflect on these wider considerations or that they do not have access to reliable data to allow them to compare their service to best practice or that they have not had training in quality and safety improvement.

Clinicians need to step forward to lead. This involves expanding their sense of responsibility beyond the individual patient in front of them to the system as a whole. When clinicians do step forward, they need to be supported. They need to be given responsibility and resources. They need to be given training, because leading improvement is technically and emotionally difficult.

In Northern Ireland, the Review Team met a small number of talented clinicians who have decided to step forward, and who are succeeding in leading positive change. The Review Team met many more clinicians who have tried to engage with 'management' in the past, have been knocked back, and have given up trying. There are many great ideas lying latent in the heads and hearts of clinicians, untapped by the system. The Review Team saw some effort, particularly in the South Eastern Trust, to provide clinicians with the skills that they need to lead improvement projects. Across the system as a whole though, the scale and scope of these is nowhere near what is needed.

4.3.2 Cultural change

Culture determines how individuals and teams behave day to day. It determines how clinicians view and interact with patients; whether they consider harm to be "one of those things", "the cost of doing business", or a feature of healthcare that, with effort, can be banished; whether they react to seeing problems in the system by complaining, or by taking on responsibility for fixing them.

All healthcare systems in the world realise the importance of culture. The difference between the best and the rest is what they do about this. The very best do not hope that culture will change; they put major effort into actively changing it. Their approach is not light-touch or scattergun; they see changing culture as a central management aim.

The Cleveland Clinic in the United States of America, for example, set out to improve patient experience, most of which is determined by how staff behave towards patients. The Clinic's management wanted all staff to better work as a team, and to see their role as being important for patient care – from doctors and nurses, to cleaners, receptionists and electricians. They designated them all 'caregivers'. All 40,000 caregivers attended a series of half-day training sessions, designed to build their practical communication skills and their awareness of self, others and team. They made patient experience scores widely available – ranked by doctor, by hospital, and by department. These efforts have continued for several years. In 2013, the Chief Executive's annual address to all caregivers included a powerful video about empathy. It has since been viewed 1.8 million times on YouTube. In short, the Cleveland Clinic made a major concerted effort to make patient experience important to all who work there.

It has paid off. With staff now more engaged than ever, the Cleveland Clinic has been able to move on to making safety and other elements of quality a crucial part of the culture too.

In Northern Ireland, as in many places, no effort has been made to influence culture on anything like this scale. Many people in the system are able to describe the culture, and many cite it as important. Scattergun efforts are made – a speech here, an awards ceremony there – but shifting culture is hard, and scattergun will not do it. Culture is viewed with a degree of helplessness – but the evidence from elsewhere is that it can be changed, and that doing so is powerful.

4.3.3 Data linked to goals

The importance of data and goals are news to nobody. Yet in Northern Ireland, as in too many other healthcare systems, data systems are weak and proper goals are sorely lacking.

Improving healthcare requires clear and ambitious goals. It requires a statement that preventable harm will be reduced to zero, or that the occurrence of healthcare associated infections will be cut in half within a year. Management guru Jim Collins would call these BHAGs – Big Hairy Audacious Goals. They are goals that are at once exciting and scary. They get people interested and motivated. They are the kind of goals that Northern Ireland should be setting for its care system.

If the goal is the destination, strong data are the sat nav. They show the current position in a form that provides useful information for action. Too often, data show where the system was over the last three months, or what performance has been across large units. They need instead to show the situation in real-time, or as near to it as possible. And they need to show performance at the very local level.

As with culture and leadership, data capability is an area that the best care systems in the world have invested in heavily. They have online dashboards that enable all aspects of the system to be measured, understood, and therefore managed. In comparison, Northern Ireland (and many other places) has a care system that is being managed as if through a blindfold. Investment in information technology is crucial and, if done intelligently, will pay dividends.

4.3.4 Standardisation

Doctors generally dislike standardisation (nurses warm to it more), but it is a crucial part of improving the quality and safety of healthcare.

One healthcare standardisation tool is the World Health Organization's Safe Surgery Checklist. Modelled after the checklists that pilots use throughout every flight, it lists a series of simple actions that should be taken before the patient receives anaesthetic, before the operation starts, and before the patient is moved from the operating theatre. Each item on the list is something blatantly obvious – checking the patient's identity, confirming the type of operation that is planned, and so forth. Without the checklist, each of these things is done most of the time – but not all of the time. The checklist ensures that they are done all of the time – to avoid the occasional instance, as happens, in which nobody properly checks the operation type, and the patient has the wrong operation.

Care bundles are a concept that in recent years have brought higher quality to the areas of care where they have been used well. They help clinicians to reliably give every element of best practice treatment for common conditions such as pneumonia. The evidence is clear: they save lives. Without them, patients get best, safest practice only some of the time and those who do not are the unlucky ones who can suffer greatly as a consequence.

Checklists and care bundles are not widespread in healthcare primarily, because they are counter-cultural. Doctors' training, in particular, emphasises the importance of retaining knowledge, of autonomy, and of variation between patients. All of these go against the idea of standardisation.
The concept of standardisation does not just relate to novel methods like checklists or care bundles. It is also concerned with all patients with a particular disease receiving a consistent process of care based on best practice internationally. The idea that people with conditions like bowel or oesophageal cancer should be receiving different treatment based on clinical preference or where they live is a disgrace. Healthcare should not be a lottery.

The best healthcare systems in the world have a high degree of standardisation. Not for everything – but for the areas of care where the evidence shows that it makes a difference. They have a substantial number of care pathways, checklists, and care bundles. This does not leave the clinicians without a job – far from it. Their judgement is vital in deciding which pathway, checklist or care bundle to use, and in spotting the cases in which a standard approach is not appropriate. They still spend the majority of their time working without reference to any of these things, but use them whenever they are needed.

Northern Ireland has some good examples of work in this area, including the rollout of a National Early Warning System for acutely ill patients, a care bundle for sepsis, an insulin passport, and regional chest drain insertion training. However, the opportunity for standardisation is much greater and needs to be applied at a more fundamental level, which influences the model of practice beyond this series of individual initiatives. There is not yet a critical mass of clinicians clamouring for more standardisation. There are multiple examples of different Trusts approaching the same clinical scenario in different ways, and wanting to retain their autonomy to do so. If Northern Ireland wants to be anything like as good on safety, clinical effectiveness and patient experience as the Cleveland Clinic and other centres of excellence, it needs to be more open to big change.

4.3.5 The recipe for success

There is little doubt that quality and safety are not fully embedded in the planning, design and delivery of services in Northern Ireland. More sleep is lost over budgets than about whether patients are treated with dignity and respect, whether outcomes of care are genuinely world class and whether patients are properly protected from harm when they are being cared for.

Four vital, and often superficially treated, ingredients for quality and safety improvement are: clinical leadership, cultural change, data linked to goals, and standardisation. They are highly inter-linked.

The Northern Ireland care system is not seeing the wood for the trees on these ingredients. The *Quality 2020* strategy cites them (and does set some big goals), but they are not held as central and are therefore somewhat lost. They need to be given far more prominence, because they form the bedrock on which all quality and safety improvement is built.

With focused effort, Northern Ireland could: build a cadre of skilled clinical leaders; develop a culture in which quality improvement is second nature; set big goals; establish the information technology systems required to measure quality locally and in real-time; and standardise processes substantially. If the care system makes these activities central to its quality and safety efforts, improvement will follow and will flourish. Without building this bedrock, no other efforts to improve quality and safety will gain any significant purchase.

4.4 EXTRACTING FULL VALUE FROM INCIDENTS AND COMPLAINTS

Most patient safety programmes have at their core a process to capture and analyse errors and accidents that arise during the provision of care. This is based on the long-established premise that only by learning from things that go wrong can similar events be prevented in the future. To some extent, this draws on the experience of other industries that have successfully reduced accidents and risk year-on-year. This thinking has led to the establishment of incident reporting systems in health services across the world, some operating only at the level of healthcare organisations, some encompassing whole countries and some restricting reports to those within one field of medicine (e.g. surgery).

It is not always appreciated that reporting of incidents (which can be voluntary or mandatory) is only one way of assessing harm in the care of patients. Numerous other approaches have been used, including: prospective observation of care processes; trigger tools involving retrospective case note review; expert case note review; Hospital Standardised Mortality Ratios (and similar metrics); and mining electronic hospital databases.

Alongside Northern Ireland's incident reporting systems runs a complaints system. Globally, surveys have consistently shown that what patients want from a complaints system are: an explanation, an apology, and a reassurance that improvements to the service will be made based on their experience. Other jurisdictions have found that the features of a good complaints system are: satisfactory local resolution of the majority of complaints; speedy response times; excellent communication with patients; good record keeping; apologies made in-person by the senior staff involved not on their behalf; accurate monitoring of the numbers and categories of complaint; effective learning at the local and systemic level.

All these systems have a common primary purpose: to improve the quality of care, and to reduce avoidable harm.

4.4.1 Incident reporting elsewhere

Globally, incident reporting systems vary greatly in: the nature of the data captured, the extent of public release of information, whether reporting is voluntary or mandatory, and the depth of investigation undertaken.

Most reporting systems start by defining in general terms what should be reported. Terminology varies; *adverse event, incident, error, untoward incident* are all in common use internationally. The epithet serious can be applied to any of the terms. The largest national system in the world was established in the NHS in England and Wales as a result of the report *An Organisation with a Memory*. From 2004 until recently, it was run by an independent body, the National Patient Safety Agency, and is called the National Reporting and Learning System. NHS staff are encouraged to make an incident report of any situation in which they believe that a patient's safety was compromised.

In this system, a *"patient safety incident"* is defined as *"any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving NHS care."* Reports are first made to a local NHS organisation and then sent in batch returns by the local risk manager to the national level. Staff make a small number of reports electronically directly to the National Reporting and Learning System. The information required covers: demographic and administrative data; the circumstances of occurrence; a categorisation of causation; an assessment of the degree of harm as "no", "low", "moderate", "severe", or "death"; and action taken or planned to investigate or prevent a recurrence. These data are captured in a structured reporting form, but there is also a section of free text where the reporter is asked to describe

what happened and why they think it happened. Data are anonymised to remove the names of patients and staff members.

In just over a decade, covering the NHS in England and Wales, nearly 10 million patient safety incidents have accumulated in this database. Since 2012, it has been mandatory to report all cases of severe harm or death. It remains voluntary to report all other levels of harm.

During the period of its existence, the National Patient Safety Agency in England and Wales issued 77 alerts and many other notices about specific risks, most of which had been identified by analysis of patient safety incident reports. New arrangements for issuing alerts are in place following the abolition of the National Patient Safety Agency.

This system of incident reporting in England and Wales holds a huge amount of data but only a small proportion of it is effectively used. It is currently being reviewed and is unlikely to continue in exactly the same way.

Worldwide, the problems associated with incident reporting are remarkably consistent, whatever system design is adopted. Firstly, under-reporting is the norm, although its degree varies. This seems to depend on the prevailing culture and whether incidents are seen as an opportunity to learn or as a basis for enforcing individual accountability and apportioning blame. It also depends on staff perceptions about the difference their report will make and how easy it is for them to convey the information that they are required to. Reporting rates are much lower in primary care services than in hospitals. Secondly, given the volume of reports made, there is often insufficient time, resource and expertise to carry out the depth of analysis required to fully understand why the incident happened. Thirdly, the balance of activity within reporting systems goes on collecting, storing, and analysing data at the expense of using it for successful learning. Indeed, there are relatively few examples worldwide of major and sustained reductions in error and harm resulting because of lessons learnt from reporting.

4.4.2 Incident reporting in Northern Ireland

Incident reporting began in the Northern Ireland health and social care system in 2004. Two categories of incident were established: *an adverse incident and a serious adverse incident.* The former were reported and investigated locally within each Trust. The latter were documented and investigated locally but also had to be reported to the Department of Health, Social Services and Public Safety. Staff make 80,000 to 90,000 adverse incident reports each year. Over 400 Serious Adverse Incident reports were made in 2013. In the five-year period from 2009, the number of Serious Adverse Incidents related to Emergency Departments rose from 8 to 36.

An adverse incident is defined as:

"Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation."

In 2010, major new guidance was issued passing responsibility for managing and further developing the serious adverse incident system to the Health and Social Care Board, where it remains to this day. Further guidance was issued in 2013 with new reporting rules.

To be regarded as a Serious Adverse Incident for reporting purposes, the incident must fall into one of the following categories: the serious injury or unexpected/unexplained death of a service user, staff member or visitor; the death of a child in health or social care; an unexpected serious risk to a service user and/or staff member and/or member of the public; an unexpected or significant threat to service delivery or business continuity; serious

self-harm or assault by a service user, staff member, or member of the public within a healthcare facility; serious self-harm or serious assault by any person in the community who has a mental illness or disorder and is in receipt of mental health and/or learning disability services, or has been within the last twelve months; and, any serious incident of public interest.

Any staff member may report an adverse incident. The reporter is not asked to make a judgment about whether the incident meets the serious adverse incident criteria. A responsible manager makes it based on their reading of the incident and application of the guidelines. Any Serious Adverse Incident must be reported to the Health and Social Care Board within 72 hours. A subset of Serious Adverse Incidents must be simultaneously reported to the Health and Social Care Board and the Regulation and Quality Improvement Authority.

Trusts in Northern Ireland differ slightly in the procedure adopted for encouraging, receiving and investigating incident reports. Generally, all staff are encouraged to make reports as a way of making care safer. They complete an incident report and submit it to the Trust's risk management department so that it can be entered into the risk management database. Increasingly, more reports are being made on-line which cuts out the laborious form-filling which is an undoubted barrier to staff making a report and often leads to paper mountains in the risk management department. Trusts vary in the proportion of incidents that they investigate, the depth of that investigation and the extent to which action is agreed and implemented. Clinical governance committees (or their equivalents), sub-committees of the Trust board or the Board itself usually look at a selection of individual incident reports, at aggregated incident data or at both.

The number of Serious Adverse Incidents varies between Trusts (Figure 1). To some extent this reflects their differing number of patients. However, there is no way of knowing at present whether a higher level of incidents means that the organisation is less safe than others or that it is more safe and that its staff are more conscientious in making reports so that learning can improve patient safety. Whilst data are available on Serious Adverse Incident types, the categories and classifications used do not make it easy to aggregate data in a way that enables systemic weaknesses to be identified. Opportunities are therefore being lost for surveillance of patient safety across Northern Ireland.

The vast majority of Serious Adverse Incidents are reported by the five acute Trusts. Much smaller numbers are reported by the ambulance service and by primary care (Figure 2). The number of incidents reported has increased quite substantially from 2013 to 2014 (Figure 3). In part this is because of improved awareness of the reporting system. In part it is because the reporting criteria were changed – most notably, requiring that all child deaths be reported.

Figure 1. Serious Adverse Incident reports: by Trust

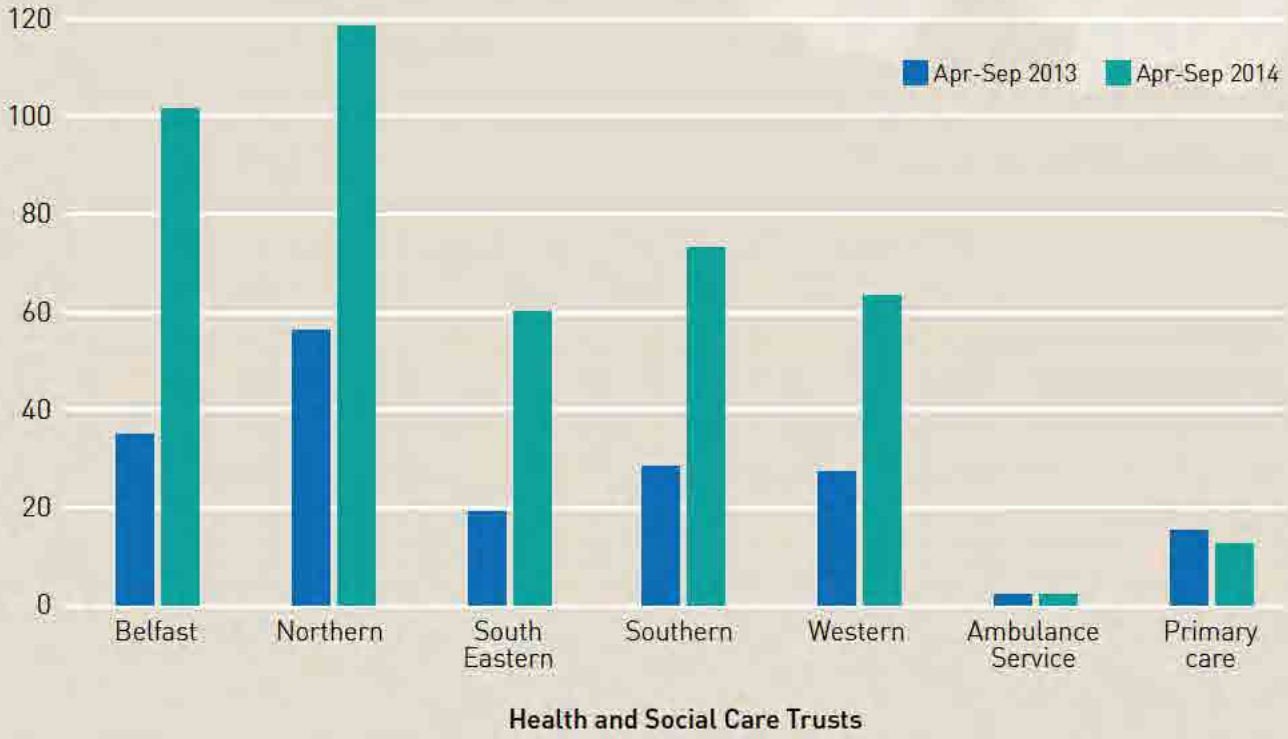
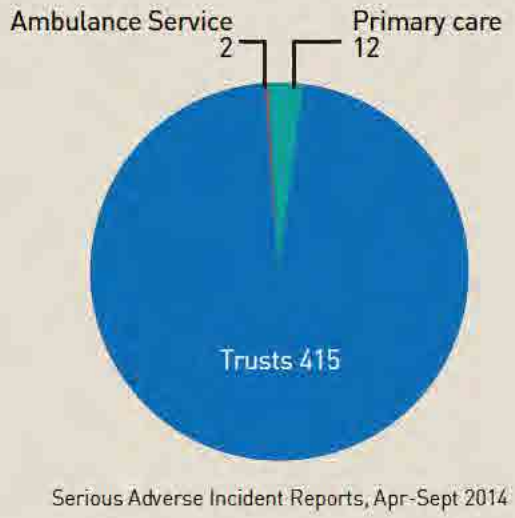
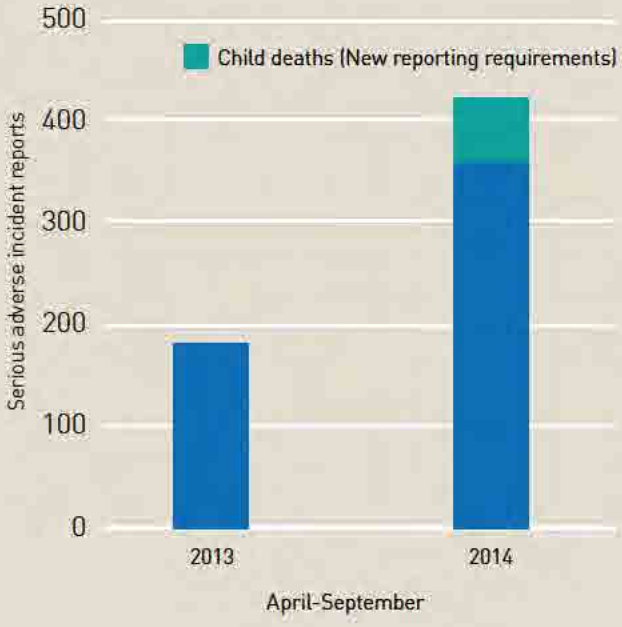


Figure 2. The great majority of Serious Adverse Incident reports are made by the Health & Social Care Trusts



Serious Adverse Incident Reports, Apr-Sept 2014

Figure 3. Serious Adverse Incident reporting increased between 2013 and 2014. Some of the increase was because reporting criteria changed, particularly introducing a requirement to report all child deaths.



All Serious Adverse Incidents are investigated. The type (and therefore intensity) of the investigation should depend on the severity of the incident, its complexity, and the potential to learn from it. Three levels of investigation are stipulated:

- *Level 1* involves a Significant Event Audit – a method of assessing what has happened and why, agreeing follow-up actions, and identifying learning.

- *Level 2* involves a Root Cause Analysis – a more detailed exercise to determine causation and learning, undertaken by a formal investigation team chaired by somebody not involved in the incident.

- *Level 3* involves a full-blown independent investigation.

Most Serious Adverse Incidents start at Level 1 investigation, and may proceed to Level 2 or 3 if the Level 1 investigation suggests that this is necessary or would be useful. A minority start at Level 2 or 3 immediately, bypassing Level 1.

A Designated Review Officer, assigned by the Health and Social Care Board and Public Health Agency, provides independent assurance that an appropriate level of investigation has been chosen, and that it is conducted appropriately.

The process of dealing with Serious Adverse Incidents at the operational level of the service is very involved and highly regulated with little room for flexibility. There are a number of decision-making points at which important judgments must be made by staff on matters such as what level the incident falls into and whether to refer an incident to the coroner.

4.4.3 Frustrations with the incident reporting system

The staff who use the incident reporting system have concerns and frustrations. Firstly, at the policy level, the requirements to report Serious Adverse Incidents places a considerable burden on them to complete forms and meet deadlines, with very little flexibility to deviate from the proscribed procedure. There is an acceptance by staff that it is important to document and investigate Serious Adverse Incidents but the pressure to complete all the steps of the process often means that there is no time to reflect on what can be learned so as to reduce risk for future patients. One of the Serious Adverse Incidents that the Review Team discussed with Trust staff had involved interviews with 34 different people. It was by no means the most complex incident that the Review Team heard about.

There is an almost universal view that the requirement to report and investigate all child deaths in hospital as Serious Adverse Incidents has been a retrograde and damaging policy decision. The consequence of it has been that, if a child dies from a cause such as terminal cancer or a congenital abnormality, a grieving family must be advised that there is to be an investigation. Inevitably, this strongly implies that the service has been at fault. Such an approach is not kind to such families, puts staff in a very difficult position, and diverts attention from the investigation of genuinely avoidable incidents involving the care of children. In a separate aspect of incident policy, many staff working within the mental health field have concerns about the inflexibility of the Serious Adverse Incident scheme as it applies to suicide of their patients. Whilst the time-scales for investigation impose a necessary discipline on the process generally, the range of factors, individuals and agencies that need to be part of the determination of the root causes of the suicide of a mental health patient are very great indeed. The pressure to adhere to statutory deadlines can mean that the work in such cases can sometimes be incomplete and so has limited value in preventing recurrences.

Secondly, at the cultural level, some medical, nursing and social care staff are concerned that, in reporting an adverse incident, they will expose themselves to blame and possible disciplinary action. Junior doctors told the Review Team that making too many reports draws suspicion that they are trouble-makers and that an active interest in patient safety could damage their career prospects. They prefer to make their views on patient safety known through the medical trainee annual survey (Figure 4), where they can remain anonymous.

Figure 4. Percentage of medical trainees reporting concerns about patient safety and the clinical environment

Trust:	Belfast	Northern	South Eastern	Southern	Western
Patient safety	6.5%	6.8%	3.0%	4.7%	3.2%
Clinical environment	2.8%	3.6%	0.8%	1.4%	0.4%
Total	9.3%	10.4%	3.8%	6.0%	3.7%

Source: General Medical Council National Training Survey 2013. Numbers are rounded.

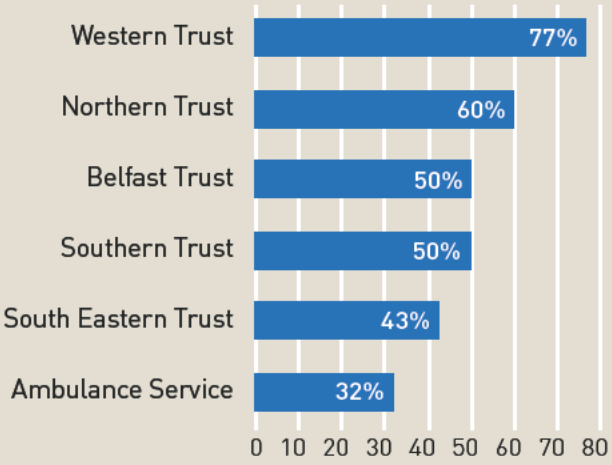
These cultural barriers to reporting and learning are not unique to Northern Ireland. Creating a culture where the normative behavior is learning, not judgment, is very much the responsibility of political leaders, policy-makers, managers and senior clinicians. This does not mean that no-one is ever accountable when something goes wrong but it does mean that a proper regard should be given to the overwhelming evidence that a climate of fear and retribution will cause deaths not prevent them.

Thirdly, at the operational level, staff frustrations with the incident reporting processes range from the very practical, such as not being able to find the form necessary to make the report, to the deeper de-motivating features of the system such as never receiving any feedback or information on the outcome of the report that they had made. Other weaknesses of the process perceived by staff include: having little training in how to investigate properly, reporting an incident then being asked to investigate it yourself, and a tendency for investigations to descend into silos even though there might have been a multi-specialty element to the patient's care.

4.4.4 The complaints system in Northern Ireland

Patients, their carers, and their families can make a complaint about the services received in person, by telephone or in writing. If the complaint concerns the health or social care services delivered by one of the six Trusts in Northern Ireland, a senior officer within the organisation will work with the staff involved in the person's care to investigate and produce a response. A letter from the chief executive officer of the Trust must go to the complainant within 20 working days. However, performance is suboptimal and very variable in this respect (figure 5).

Figure 5. All Trusts are failing to meet the standard 20-day substantive response time for complaints (% meeting standard shown; 2013-14)



The best outcome is for the complaint to be resolved locally to the complainant's complete satisfaction. This is not always possible and if the complainant is not satisfied with the response, the complaint can be re-opened and further investigation can be undertaken or external advice sought. If this still does not resolve the complaint, the complainant can make a submission to the Ombudsman. He will look at whether the process of responding to the complaint was undertaken appropriately. He can also investigate the substance of the complaint but under present legislation, he cannot make these reports public. This bizarre situation means that the public is unaware of where standards have fallen short and what the Ombudsman thinks should be done.

An increasing number of people who have complaints contact The Patient and Client Council asking for help. The Council does not have powers to investigate complaints, only to provide support. Nearly 2000 complainants contacted the Council last year. Many such contacts were from people who had tried to navigate the complaints system alone and had had difficulties. The Patient and Client Council's involvement often helps in facilitating resolution of the complaint, sometimes by arranging meetings of the two sides.

Complaints about primary care are handled somewhat differently. They are raised with the Health and Social Care Board directly. The number of complaints from primary care is lower than might be expected. This may reflect the reluctance of patients to complain about a service that they are totally reliant on.

4.4.5 Involvement of the coroner

Northern Ireland, like elsewhere, is still grappling with a difficult question: what is the appropriate role for the Coroner in the investigation of deaths that may have been caused, at least in part, by patient safety problems? This is not an easy question. It is difficult to create guidance that precisely defines which deaths should be investigated by the coroner and which should not. And Coroner's inquests have major pros and cons.

When somebody dies and their care may have been perceived as poor, some families call for a Coroner's inquest. The positive elements of this are that the Coroner is independent of the health and social care system, has clear legal powers, and is skilled in the investigation of deaths.

On the other hand, conducting an inquest into every Serious Adverse Incident that results in a death would be a resource-intensive undertaking. It also may not result in the most effective learning. Few could honestly say that the courtroom environment does not intimidate them. It is not the easiest place to build a constructive relationship between the clinicians involved in the care of the deceased and the deceased's family. It is not the most conducive environment to open, reflective learning.

In cases of negligence or gross breaches of standards of care, it is very clear that referral to the Coroner is the most appropriate course.

At the other end of the spectrum, in a few cases there is a Serious Adverse Incident at some point during a patient's care and this patient subsequently dies, but the death is entirely unrelated to the incident and so an inquest is really not warranted. In between these two extremes lies a substantial grey area, in which the relative merits of a Coroner's inquest and an internal Serious Adverse Incident investigation are debatable. This is not only the case in Northern Ireland, but across the United Kingdom as a whole (except that Scotland does not have a Coroner).

This is a complex issue. Currently only a subset of the deaths that could be the subject of a Coroner's inquest actually become so. Some are not reported to the coroner's office (largely appropriately, it seems) and some are discussed with the coroner's office but not listed for inquest. In other words, the judgments of clinicians and coroners' officers alike have a substantial bearing on which cases proceed to inquest. The subset of cases that end up in front of a coroner's inquest are also determined as much by family's wishes as by the content of the cases.

To some this may sound shocking but, given the complexity of the issues involved, the status quo is not entirely unreasonable and is in line with practice internationally. But the status quo is certainly not ideal. There is substantial room for improvement, so that the coroner can more optimally contribute to the system's learning.

4.4.6 Redress

The creation of financial, and other new, forms of redress would have to be linked to the handling of complaints, incidents and medical negligence claims in a whole systems manner. This is a highly complex area that was extensively examined in England in the report *Making Amends*. In the end, the central idea of introducing some payments for victims of harm and recipients of poor quality care, as well as potential litigants, was not taken forward. There were sound principles behind the proposals, but there was a leap-in-the-dark element too. Priority was given instead to action to improve the quality and safety of care and to improve responses to complaints. However, one of the other proposals of *Making Amends*, the introduction of a Duty of Candour, is finally being implemented in England. The Review Team considers that priority in Northern Ireland should be given to the areas covered by its recommendations, to making important changes to generate safer higher quality care, rather than embarking on new policies for redress, including financial compensation.

4.4.7 The nature of learning

The whole question of how *learning* takes place in healthcare through the scrutiny and analysis of incident reports or through their investigation has been little debated. Indeed, the term learning itself is very loosely applied in this context. Strictly applied, it would mean acquiring new knowledge from incidents about how harm happens. Yet, the way in which the word learning is repeatedly used in the context of patient safety is more than increasing understanding. It implies that behaviour will change or actions will be taken to prevent future harm. Unfortunately, although there are some exceptions, there is little evidence that major gains in the reduction of harm have been achieved in Northern Ireland or in many other jurisdictions through the so-called learning component of patient safety programmes.

In Northern Ireland, the main formally-identified processes for reducing risk or improving patient safety, aside from action plans derived at Trust level, are:

- the production of learning letters
- the bi-annual Serious Adverse Incident Learning Report
- the circulation of newsletters such as *Learning Matters*
- thematic reviews
- training and learning events

- implementing the recommendations of reviews and inquiries
- disseminating alerts and guidance imported from other parts of the United Kingdom or further afield.

On many, perhaps most, occasions when something goes wrong, the potential for learning from this is very rich indeed. This potential too often goes unrealised. This is a problem not just in Northern Ireland, but in care systems worldwide.

Three features determine the extent to which investigation of an adverse event results in risk being reduced:

- How deep the investigation gets, in understanding the true systemic issues that helped something go wrong
- How systemic the investigation's focus is, in considering where else a similar problem could have occurred beyond the local context in which it did occur
- How strong the corrective actions are in actually, and sustainably, reducing the risk of a repeat

The first of these, depth of investigation, is done reasonably well. A decade ago, harm was often put down to 'human error'. There is now far greater recognition that this is a superficial interpretation – that there are almost always problems within the system which not only allowed that harm to occur but made it more likely. The technique of root cause analysis is widely used in Northern Ireland, and helps to uncover some of the causal elements. Often, though, it does not find the deeper reasons. This is partly because of the time pressures to finish the investigation, partly because not all staff have had the necessary training to do this deeper analysis, and partly because of a lack of human factors expertise in the process. Also, many hospital incidents involve primary care in the chain of possible causation, yet primary care staff play a minor, or no, role in many investigations.

In relation to the systemic view, when a problem occurs, there is too great a tendency to investigate that specific problem, without looking for the broader systemic issues that it highlights. Problems are often addressed in the department where they occur, without asking whether they could have occurred in other departments, for example. Similarly, if a medication incident occurs, there is a tendency to fix the problem for that medication, without looking at whether there is a problem for similar medication or routes of administration.

This narrow, reactive approach fails to make full use of incident reports. In short, it reflects an erroneous assumption that the system as a whole is working fine, and that the problems that allowed the event to occur are specific, local ones. This is not the case. There are systemic problems through the health and social care system. Incidents of harm are distributed largely by chance – by location and by type. Fixing each specific problem is like playing "Whack-A-Mole" – it does not get to the nub of the issues.

The ultimate aim of investigation is to reduce the risk of harm, not simply to understand what went wrong. Corrective action is too often inadequate. There is no automatic link between understanding what went wrong and being able to reduce the risk of it happening again. Indeed, making the leap between investigation and risk reduction is really very challenging.

In Northern Ireland, the action lists that are generated by Serious Adverse Incident investigation commonly feature plans of the following kinds:

- Making staff aware that the incident took place
- Explaining to staff what went wrong
- Circulating a written description of the incident and actions taken to other parts of the health and social care system to share the learning

Such information sharing actions should form part of the plan but they do not amount to systemic measures that will reliably and significantly reduce the risk to patients.

Research and experience outside health care has shown that safety comes down to appreciating that big improvements are not made by telling people to take care but by understanding the conditions that provoke error.

Action plans often also feature some change to current paperwork or introduction of new documentation. This, too, is very reasonable but often has a weak impact on outcomes. It also has the important downside that mounting paperwork reduces the time for patient care and introduces complications of its own.

So what do strong corrective actions look like? Technological solutions have an important role to play. Electronic prescribing systems, patient monitoring systems, and shared care records can address multiple patient safety issues simultaneously (although their implementation and use is not without risk). Policies, rules, and checklists can also be useful, but are easy to implement badly and more difficult to implement well.

As discussed earlier in this Report, one area of high potential is the use of standardisation of procedure. It is underutilised in healthcare worldwide but where it is applied it has brought results. Standardisation of procedure is a mainstay of safety assurance and improvement in other sectors.

In large part, though, healthcare systems worldwide are not yet good at implementing solutions that will truly reduce risk. It is not the case that Northern Ireland is lagging behind – but that Northern Ireland is struggling with this problem alongside other countries.

Identifying the systemic issues and identifying strong corrective actions: each of these is tough; an art and a science in itself; an area in need of intense and rigorous study. Until these issues are tackled head on, in Northern Ireland and elsewhere, the system's learning when things go wrong will fall short.

When something goes wrong, patients and families ask for reassurance that it will not happen again. As it stands, nobody can honestly provide this reassurance. In fact, it is difficult even to say that the risk has been significantly reduced – let alone to zero. This needs to change.

4.4.8 Strengths and weaknesses of Northern Ireland's systems for incident reporting and learning

No system of reporting and analysing patient safety incidents is perfect. In an ideal world, all events and occurrences in a health service that caused harm or had the potential to cause harm would be quickly recognised by alert, knowledgeable front-line staff who would carefully document and communicate their concern. They would be enthusiastic about their involvement in this activity because they would have seen many examples of how such reports improved the safety of care. The resulting investigation would be impartial and multi-disciplinary, involving expertise from relevant clinical specialties but, crucially, also from other non-health disciplines that successfully contribute to accident reduction in other fields of safety. Investigation would be carried out in an atmosphere of trust where blame and retribution were absent, and disciplinary action or criminal sanctions would only be taken in appropriate and rare circumstances. Action resulting from investigation would lead to re-design of processes of care, products, procedures and changes to the working practices and styles of individuals and teams. Such actions would usually lead to measurable and sustained reduction of risk for future patients. Some types of harm would be eliminated entirely.

Very few, if any, health services in the world could come anywhere near to this ideal level of performance in capturing and learning from incidents of avoidable harm. This is so for all sorts of reasons ranging from an insufficiency of leaders skilled and passionate enough to engage their whole workforces on a quest to make care safer, through an inability to investigate properly the volume of reports generated, to the weak evidence-base on how to reduce harm.

The system of adverse incident reporting in Northern Ireland operates to highly-specified processes to which providers of health and social care must adhere. The main emphasis is on the Serious Adverse Incidents. The requirements laid down for reporting, documenting and investigating such incidents together with the rules for communicating about them and formulating action plans to prevent recurrence have created an approach that has strengths and weaknesses (Figure 6). In general, the mandatory nature of reporting means that there is likely to be less under-reporting than in many other jurisdictions. However, staff in Trusts must exercise judgment on whether to classify occurrences of harm as Serious Adverse Incidents. Whether they always make the right decision has not been formally evaluated. The Review did not find any evidence of suppression or cover-up of cases of serious harm.

Figure 6. Serious Adverse Incident reporting system in Northern Ireland: Strengths and weaknesses

Dimension	Strengths	Weaknesses
Accountability	Absolute requirement to report and investigate	Creates some fear and defensiveness
Coverage	Relatively high for serious outcomes	Less attention given to incidents with lower harm levels
Timescales	Clear deadlines for investigation and communication	Pressure to meet deadlines leaves little time for reflection
Investigation	Reasonable depth with frequent root cause analysis	Quality variable and little use of human factors expertise
Staff engagement	All appear to understand the importance of reporting	Do not often see the reports translating into safer care
Patient and family involvement	Requirement to communicate reinforced by checklist	Often creates tension and little ongoing engagement
Learning	Specified action plan required in every case	Not clear whether action is effective in reducing future risk

4

Tight time-scales are laid down for the various stages of handling a Serious Adverse Incident. These generally add a necessary discipline to a process that in other places can become protracted or drift off-track. There is a need, though, for some flexibility where an investigation requires more time. This is particularly so in the mental health field where the avoidable factors in a death can be very complex and are only discernible after interviewing very many people.

It is important to recognise that, whilst almost all of the experience and research literature is about patient safety, Northern Ireland has an integrated health and social care system. Social care in the United Kingdom has its own traditions in recognising, investigating and learning from episodes of serious harm involving those who use its services; the fields of child protection and mental health exemplify this. It is not entirely straightforward to integrate incidents in social care into the overall patient safety approach but the essential principles and concepts are little different.

The Northern Ireland health service falls short of the ideal just as do most other parts of the United Kingdom and many other places in the world. In all of these places, including Northern Ireland, patients are dying and suffering injuries and disabilities from poorly designed and executed care on a scale that would be totally unacceptable in any other high-risk industry.

The Northern Ireland approach to incident reporting and learning does not make its services any less safe than most of the rest of the United Kingdom or many other parts of the world. However, this should not be a reason for comfort, nor a cause for satisfaction.

The current requirement for all child deaths to be reported and managed as serious adverse incidents seems to be doing far more harm than good. It is distressing for families, burdensome for staff, and is not producing useful learning.

The ethos of improving safety by learning from incident investigations needs to shift:

- Away from actions that only make a difference in the particular unit where the incident occurred, towards actions that also make a difference across the whole of Northern Ireland
- Away from actions that only target that particular incident, towards actions that also reduce the risk of many related incidents occurring
- Away from weak actions such as informing staff, training staff and updating policies, towards stronger actions of improving systems and processes
- Away from long lists of actions, towards smaller numbers of high-impact actions

Less attention has been given in Northern Ireland to adverse incidents that do not meet the definition of a Serious Adverse Incident. They are reported, analysed and acted upon at Trust level. Only exceptionally are they considered centrally. The numbers are much greater so the logistics of analysing more would be considerable. However, there is much to be learned from situations when something went wrong in a patient's care but they did not die or suffer serious harm.

4.5 THE BENEFITS AND CHALLENGES OF BEING OPEN

The health and social care system aspires to a 'no blame' culture, or a 'just' culture, in which staff can be open without fear of inappropriate reprisal. In reality, this is not the culture that currently exists. This is not primarily the fault of those delivering health and social care.

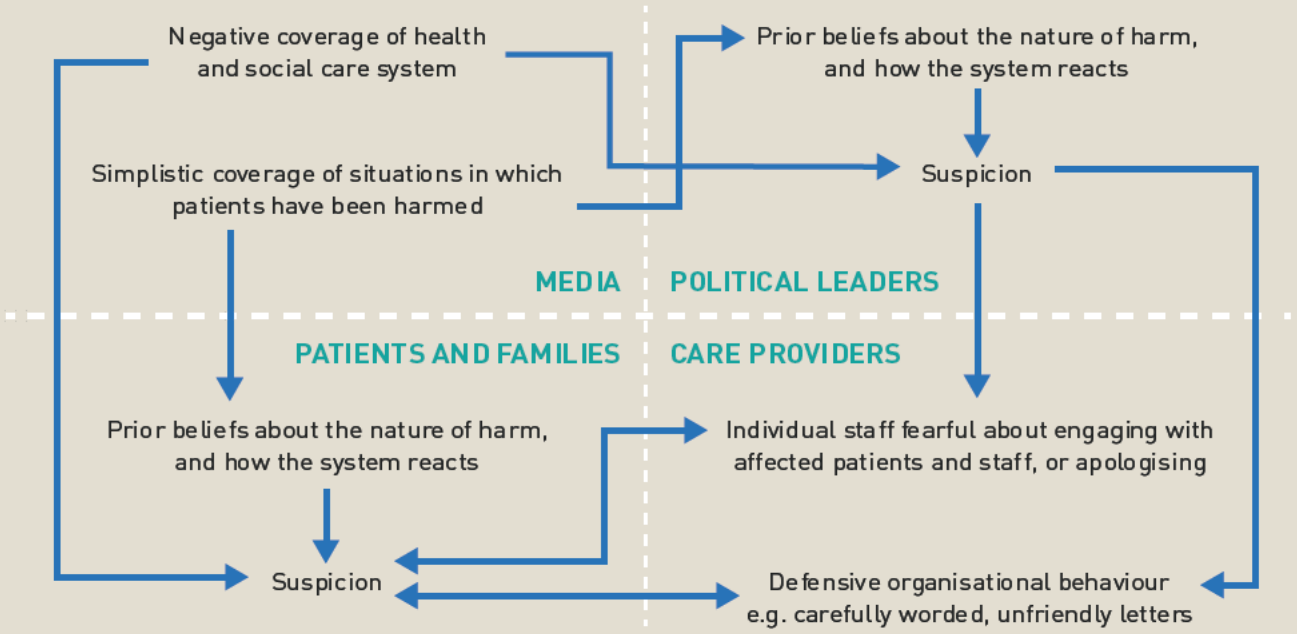
Openness is not something that can simply be demanded. It needs the right conditions in order to flourish. The enemy of openness is fear.

When something goes wrong, many patients' and families' first reaction is to want to know who is to blame. The situation often escalates, with the media coverage and political pressure that the detail of the story generates. In an ideal world, leaders of the system should be able to step in to paint a proper picture of the background to these complex events, and to build public understanding that few are a simple case of incompetence and carelessness. Instead, to remove the heat from the situation, approaches are announced that may not be the most effective way to achieve learning. On top of this, day-by-day the media portrays health and social care in a mainly negative light. There has been one inquiry after another. These are conditions conducive to blame and fear, not to transparency and openness.

Despite these adverse conditions, the Review Team found front-line staff willing to talk about problems, and to be open with families and patients when things go wrong. There is a willingness to be open – but there is blame, and there is fear.

Northern Ireland needs to increase the degree of openness and transparency in talking about harm, and decrease the degree of blame and fear. The responsibility cannot lie solely within the health and social care system. They are complex cycles.

Figure 7. The vicious cycle of suspicion and fear



Openness and transparency, blame and fear: these are multi-dimensional issues that cannot be improved directly by legislation, rules or procedures alone. As this Report has made clear, Northern Ireland is far from unique.

4.5.1 Governance arrangements to promote openness

Promoting openness and avoiding fear is about culture. Responsibility for this sits with many people, within and beyond the health and social care system. Governance may sound like a blunt tool and, used alone, it would be. But alongside other approaches, appropriate governance arrangements can promote openness and dispel fear.

The Serious Adverse Incident process currently requires Trusts to inform affected patients (or families) that their care is the subject of investigation. In general, they are invited to provide input and are provided with a copy of the investigation report. A checklist has been introduced to prompt investigators to take these steps. This is commendable, and represents a basic, but important, degree of openness with patients and families.

The nature of the involvement with patients and families in the aftermath of a Serious Adverse Incident cannot be shaped by a checklist alone. The Review Team heard from each of the Trusts how they handled this aspect of the policy. It is clear that this is a difficult area to get right. Early contact with the family in the event of a death is important but could come at a time when funeral arrangements are being made and perceived as intrusive or insensitive. The bureaucracy of the procedure can create an official feeling that opens up distance in the relationship with the family. It is important that staff in the Trust have the skill, experience and credibility to communicate with a family. It is helpful to have staff who deal with this situation regularly and have good inter-personal and counselling skills. They should be there with the clinical staff who may encounter the situation less frequently. Experience from elsewhere suggests that regular contact with the patient and family is important, not just a couple of one-off meetings with long silences in between. In the best services, the patient and family are fully involved in the process of learning and action-planning. Where this happens, it is empowering for everyone. This is only happening to a limited extent in Northern Ireland currently.

The Serious Adverse Incident process is also overseen by a Designated Review Officer within the Public Health Agency. This is also a welcome feature of the system although there is potential for these officers, or their function, to play a more substantial role.

Every Trust has appropriate arrangements for Serious Adverse Incidents to be discussed within the departments affected. The fact that these conversations are taking place usefully promotes a culture in which talking about harm becomes easier, and openness becomes the norm.

Every Trust also has arrangements for organisation-level oversight of this process. In most, this responsibility sits with a sub-committee of the Trust board. This too is good practice.

When something goes wrong, there is a tendency for the Department of Health, Social Services and Public Safety to deal directly with the Trust's Executive Team, bypassing the board. This happens partly from expediency – because the executive directors are present full-time, and are therefore available to take an urgent phone call from an official concerned about briefing the minister. But it serves to diminish the role of the board, and misses opportunities to build the board's familiarity with these issues and capability in dealing with them.

There is great concern and depth of feeling amongst staff in the system who have attempted to uncover poor standards of

care and been denigrated. Their role as whistleblowers has placed them in an even more isolated position. This unsatisfactory situation needs to be resolved.

4.5.2 Perceptions of openness

The Serious Adverse Incident guidelines include some requirements intended to help openness and transparency. A recent look-back exercise, quality controlled by the Regulation and Quality Improvement Authority, suggests that patients and families are being appropriately informed when a Serious Adverse Incident occurs. This creates a substantially higher degree of openness than is the case in many countries worldwide. In the main, the Trust staff who are leading the investigation are willing to spend time meeting with patients and families.

However, several features of the investigation process too often give patients and families an adverse impression:

- The investigation process is frequently delayed beyond the stipulated timeline, and patients and families experience delays in getting responses to calls and emails. Such delays make people start to wonder, "what is going on?"
- When the investigation process starts, the degree of openness and transparency that the patient and/or family feel they are seeing is highly dependent on the communication skills of the Trust staff that they meet with. Some staff are highly skilled in these potentially difficult meetings; others are not.
- Standard practice is for patients and families to meet with the manager and/or clinician leading the investigation, and not to be asked whom else they would like to meet with. Many, for example, would find it helpful to meet with the staff directly involved in the incident, to put their questions directly, but this is not routinely offered. Such meetings have the potential to be intensely difficult; to be very useful if they go well, but harmful if they go badly.

4.5.3 Duty of candour

In 2003, the head of the Review Team (as Chief Medical Officer for England) issued a consultation paper, *Making Amends*, which set out proposals for reforming the approach to clinical negligence in the NHS. One key recommendation was that a duty of candour should be introduced.

As long ago as 1987 Sir John Donaldson (no relation), who was then Master of the Rolls, said "I personally think that in professional negligence cases, and in particular in medical negligence cases, there is a duty of candour resting on the professional man". There was, at the time of the *Making Amends* report, no binding decision of the courts on whether such a duty exists.

In November 2014, the General Medical Council and the Nursing & Midwifery Council issued a joint consultation document proposing the introduction of a professional duty of candour. Such a duty will give statutory force to the General Medical Council's Code of Good Medical Practice for doctors.

In the concomitant healthcare organisational measures introduced in England, a new "Duty of Candour" scheme will mean that hospitals are required to disclose information about incidents that caused harm to patients, and to provide an apology.

In Northern Ireland, it is already a requirement to disclose to patients if their care has been the subject of a Serious Adverse Incident report. There is no similar requirement for adverse incidents that do not cause the more severe degrees of harm. In promoting a culture of openness, there would be considerable advantages in Northern Ireland taking a lead and introducing an organisational duty of candour to match the duty that doctors and nurses are likely to come under from their professional regulators.

4.6 THE VOICES OF PATIENTS, CLIENTS AND FAMILIES ARE TOO MUTED

The best services in the world today give major priority to involving patients and families across the whole range of their activities, from board-level policy making, to design of care processes, to quality improvement efforts, to evaluation of services, to working on reducing risk to patients as part of patient safety programmes.

At the heart of the traditional approach to assessing whether a service is responsive to its patients and the public are surveys of patient experience and attitudes. This is still a very important part of modern health and social care. In many major centres whose services are highly rated, such surveys are regularly carried out and used to judge performance at the organisational, service and individual practitioner level, as well as, in some cases, being linked to financial incentives. Indeed, in the United States system, observers say that it was not until surveys of patient experience were linked to dollars that it was taken seriously. This is not a prominent feature of the Northern Ireland system, although there is some very good practice, for example the 10,000 Voices initiative, which has so far drawn on the experience of over 6,000 patients and led to new pathways of care in pain management, caring for children in Emergency Departments, and generally focusing on the areas of dignity and respect.

Looked at from first principles, the kind of questions a user, or potential user, of a service could legitimately require an answer to would include:

How quickly will I first be seen, how quickly will I get a diagnosis and how quickly will I receive definitive treatment?

If my condition is potentially life-threatening, will the local service give me the best odds of survival or could I do better elsewhere?

Will each member of staff I encounter be competent and up-to-date in treating my condition and how will I know that they are?

Does the service have a low level of complications for treatment like mine compared to other services?

How likely am I to be harmed by the care that I receive and what measures does the service take to prevent it?

If I am unhappy with a care-provider's response to a complaint about my care, will the substance of it be looked at by people who are genuinely independent?

Which particular service elsewhere in the United Kingdom, and other parts of the world, achieves the best outcome for someone like me with my condition? How close will my outcome be to that gold standard?

Very few of these questions could be answered reliably in Northern Ireland and other parts of the United Kingdom.

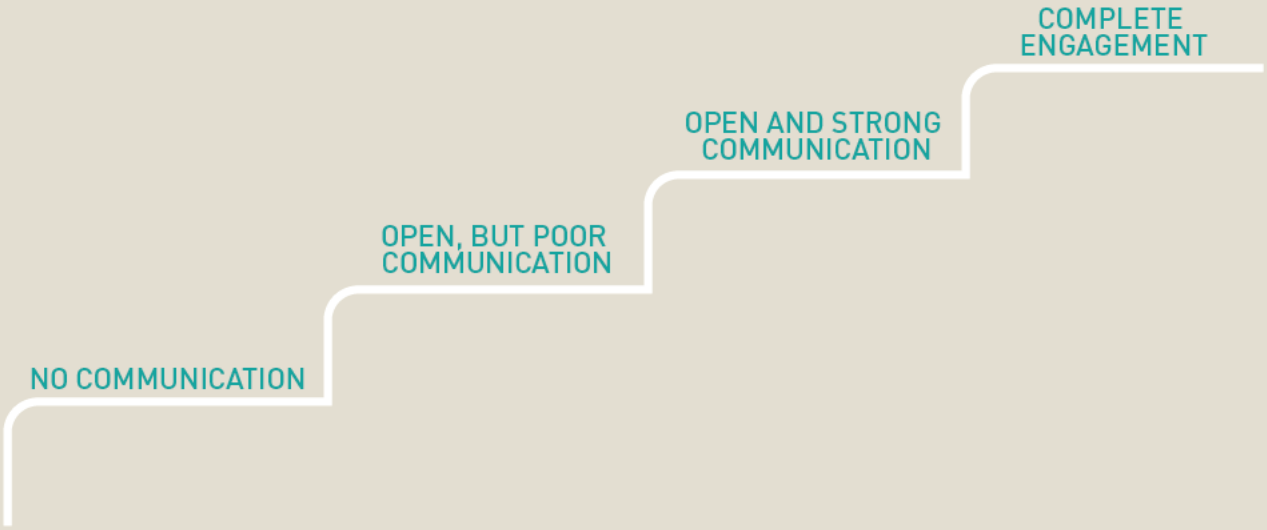
There are many potential themes for patient and family engagement in health and social care, for example:

- in shaping and designing services
- in measuring the quality of care
- in setting standards for consultation
- in shared decision-making
- in self-care of chronic diseases
- in preventing harm
- in giving feedback on practitioner performance

Few services do all of these, some only scratch the surface of genuine involvement, others do a few well. Overall, the Northern Ireland care system is engaged in some of these areas but certainly not in an organised and coherent way.

The terms of reference of the Review put particlar emphasis on harm. Globally, there is a spectrum in how well health and social care systems interact with patients, clients and families when things go wrong (figure 8). The ideal approach is to engage patients and families completely in the process of learning. They often find this hugely beneficial, because it allows them to play an active part in reducing the risk for future patients. It is also immensely powerful for staff, to hear patients' stories first-hand and to work with them to improve things.

Figure 8. Levels of engagement with patients and families when something goes wrong



Northern Ireland should aim for level three as an absolute minimum, but strive for level four.

The system is too often falling down to level two because:

- Staff who communicate with patients and families during the Serious Adverse Incident investigation process have variable communication skills – some are excellent, but some are less good. Little formal effort has been made to train staff to manage these difficult interactions well.
- Patients and families are often not offered the opportunity to meet with those who they would like to – the staff directly involved in the incident. Instead, they tend to meet with managers, and with clinicians who were not involved.
- There are frequently delays in the process of investigating a Serious Adverse Incident.
- Patients and families are too often sent letters filled with technical jargon and legalese.

When something goes wrong, the harm itself is intensely difficult for patients and families. Poor communication compounds this enormously.

5 CONCLUSIONS

5.1 RELATIVE SAFETY OF THE NORTHERN IRELAND CARE SYSTEM

5.1.1 There is some perception amongst politicians, the press and the public that Northern Ireland's health and social care system:

- Has fundamental safety problems that are not seen elsewhere
- Is less safe than other parts of the United Kingdom, or comparable countries
- Suffers from lack of transparency, a tendency to cover-up, and an adverse culture more broadly.

5.1.2 The Review found no evidence of deep-seated problems of this kind. Northern Ireland is likely to be no more or less safe than any other part of the United Kingdom, or indeed any comparable country globally.

5.1.3 This does not mean that safety can be disregarded, because it is clear from reading the incident reports and accounts of patients' experience that people are being harmed by unsafe care in Northern Ireland, as they are elsewhere. Northern Ireland, like every modern health and social care system, must do all it can to make its patients and clients safer.

5.2 PROBLEMS GENERATED BY THE DESIGN OF THE HEALTH AND SOCIAL CARE SYSTEM

5.2.1 There are longstanding, structural elements of the Northern Ireland care system that fundamentally damage its quality and safety. The present configuration of health facilities serving rural and semi-rural populations in Northern Ireland is not fit for purpose and those who resist change or campaign for the status quo are perpetuating an ossified model of care that acts against the interests of patients and denies many 21st Century standards of care. Many acutely-ill patients in Northern Ireland do not get the same standard of care on a Sunday at 4 am as they would receive on a Wednesday at 4 pm and, therefore, a two-tier service is operating. It may be that local politics means that there is no hope of more modern care for future patients and if so this is a very sad position.

5.2.2 The design of a system to provide comprehensive, high quality, safe, care to a relatively small population like Northern Ireland's needs much more careful thought. This applies to almost all aspects of design including: the role of commissioning, the structuring of provision, the relationship between primary, secondary and social care, the distribution of facilities geographically, the funding flows, the place of regulation, the monitoring of performance, and the use of incentives. Nowhere is the old adage: "I would not start from here" truer than in the Northern Ireland care system today.

5.2.3 There is widespread uncertainty about who is in overall charge of the system in Northern Ireland. In statutory terms, the Permanent Secretary in the Department of Health, Social Services and Public Safety is chief executive of the health and social care system but how this role is delivered from a policy-making position is not widely understood or visible enough.

5.2.4 In the specific domain of quality and safety itself, whilst it is reflected in the goals and activities of boards and senior management teams in Northern Ireland, it is not yet fully embedded with the commitment and purpose to make a real difference. The Review was most impressed with the work of the South Eastern Trust in this regard. The Review Team could not assess each Trust in depth, but its judgment on the South Eastern Trust is backed up, for example, by the national survey of trainee doctors.

5.3 FOCUS ON QUALITY AND SAFETY IMPROVEMENT

5.3.1 *Quality 2020* is a ten-year strategy with a bold vision – that the health and social care system should "be recognised internationally, but especially by the people of Northern Ireland, as a leader for excellence in health and social care". Three years on, there is good evidence of the strategy being implemented. An influential steering group oversees the work.

5.3.2 The Review Team judged that *Quality 2020* represents a strong set of objectives, and that there is clear evidence of extensive work and of some successes in implementation. However, this does not amount to quality and safety improvement being given the primacy of focus that it needs, and Northern Ireland is not seeing the wood for the trees about the need to establish crucial aspects of quality and safety improvement which are not well represented at present: clinical leadership, cultural change, data linked to goals, and standardisation.

5.4 THE EXTENT TO WHICH SERIOUS ADVERSE INCIDENT REPORTING IMPROVES SAFETY

5.4.1 The system of Serious Adverse Incident reporting in Northern Ireland has been an important way to ensure that the most severe forms of harm that are inadvertently caused by care processes are recognised and investigated.

5.4.2 The Serious Adverse Incident process fulfils five main purposes:

- a public accountability function
- a response to the patients and families involved
- a communications alert route
- a barometer of risk within health and social care
- a foundation for learning and improvement

5.4.3 The kinds of incidents reported into this system appear little different to other parts of the United Kingdom and are similar to many other parts of Europe, North America and Australasia. Many harmful events are potentially avoidable and the human cost to patients and families in Northern Ireland is of grave concern, as it is in other jurisdictions.

5.4.4 Good practice elsewhere in the world suggests that patients who suffer harm and their families should be fully informed about what has happened, how it happened and what will be done to prevent another similar occurrence. More than this, they should be fully engaged in working with the organisation to make change. Patient and family engagement is a good and established feature of Serious Adverse Incident reporting in Northern Ireland but it often falls short of this fully engaged scenario. The extent to which it is valued and trusted by patients and families appears to vary, depending on the staff communicating with them.

5.4.5 The design for the specification, and recording, of information on each Serious Adverse Incident is sub-optimal particularly in gathering appropriate information on causation; this hinders aggregation of data to monitor trends and assess the impact of interventions.

5.4.6 The process for investigating Serious Adverse Incidents is clearly set out and involves root cause analysis-type methods. In many cases, it lacks sufficient depth in key areas such as human factors analysis. The degree of oversight by supervisory officials (the Designated Review Officers) is variable in extent and timeliness. Local health and social care staff generally approach the task of investigation conscientiously but many lack the training and experience to reach a standard of international best practice in unequivocally identifying the cause and specifying the actionable learning. They get little expert help and guidance in undertaking this activity.

5.4.7 The most important test of the capability of a patient safety incident reporting system is its effectiveness in reducing future harm of the kind that is being reported to it. Unfortunately, there are few places around the world where there is a powerful flow of learning that moves from identifying instances of avoidable harm, through understanding why they did or could happen, to successful elimination of the risk for future patients. Northern Ireland is no exception to this regrettable state of affairs.

5.4.8 There are two main levels of learning from Serious Adverse Incidents in Northern Ireland. The first is local. The lack of a consistently high standard of investigation and action-planning are barriers to effective risk-reduction within health and social care organisations. Another barrier is the limited degree to which front-line staff are involved in discussing and seeking solutions to things that have gone wrong. Experience elsewhere suggests that this practical and intellectual engagement,

if well-led, often sparks great interest and commitment to patient safety amongst front-line staff. This is not really happening in Northern Ireland at present, for a number of reasons. Firstly, staff do not have the time and space to do it and the leadership of Trusts is not consistently creating and facilitating such opportunities. The Regulation and Quality Improvement Authority has established training in Root Cause Analysis for front-line staff, and this will help. Secondly, the specified rules of the Serious Adverse Incident system mean that Trusts are under a great deal of pressure to meet the time-scales laid down and are often dealing with many such cases simultaneously. As a result, the activity is too often slipping into an incident management role or worse a necessary chore that 'feeds the beast'.

5.4.9 The second level of learning is across the Northern Ireland health and social care system as a whole. The main role is played by the Health and Social Care Board working with the Public Health Agency (and the Regulation and Quality Improvement Authority where appropriate). These bodies have established a multi-disciplinary Quality Safety and Experience Group that undertakes much of the work in assessing patterns, trends and concerns arising from the analysis of locally-generated Serious Adverse Incidents and deciding what action needs to be taken on a Northern Ireland-wide basis. It does so by issuing learning letters, reports, guidance, newsletters and other specified action that the service needs to take. This is a valuable function from which considerable action aimed at improvement has flowed. Experience of improving patient safety elsewhere has shown that specifying action on a particular safety problem is not the same thing as implementing the change required. The latter is often much more difficult and depends on factors such as the systems, culture, attitudes, local priorities and leadership in the organisation receiving the action note. In the Northern Ireland care system more skill needs to be added to the implementation process. This is closely linked to the difficulties that arise when local services feel overloaded with central guidance and requirements for action. They only have enough management and clinical leadership capacity to implement a small number of changes at a time.

5.4.10 General practitioners, and others in primary care, report their Serious Adverse Incidents directly to the Health and Social Care Board, not through any of the Trusts. Levels of reporting of patient safety incidents in primary care services around the world are very low and much less is known about the kinds of harm that arise in this setting compared to hospitals. It is not surprising that the same is so in Northern Ireland. Another aspect of the primary care dimension is that many of the incidents that the Review discussed with the Trusts in Northern Ireland had a primary care element in the key areas of the care processes that had failed, yet general practitioners seemed to be less frequently involved in the investigation and planning of remedial action.

5.4.11 There are two particular aspects of the criteria for Serious Adverse Incident reporting in Northern Ireland that are not working in the best interests of a successful system. Firstly, the requirement that every death of a child in receipt of health and social care should automatically become a Serious Adverse Incident is causing major problems. A proportion of such deaths every month are due to natural causes. Some of the conditions concerned - for example, terminal cancer and serious congenital abnormalities - are particularly harrowing for the parents. After the death of a child, in such circumstances, for a family to be told that their child's death has been categorised as a Serious Adverse Incident carries the clear implication that the quality or safety of care was poor and at fault or even that the death could have been avoided. This can be enormously distressing for families and

is grueling for staff. It is cruel, unnecessary and liable to undermine public confidence in children's services.

5.4.12 Secondly, using the same time-scales for investigating Serious Adverse Incidents in mental health as in in other fields of care is also causing major problems. The complexity of many mental health cases, the long past history of many such patients and clients, and the number of people and organisations who may be able to contribute relevant information to the investigation mean that a longer period is necessarily required to get to the truth than is currently permitted.

5.4.13 Overall, the system of Serious Adverse Incident reporting in Northern Ireland, in comparison to best practice, scores highly on securing accountability, reasonably highly on the level of reporting, does moderately well on meaningful engagement with patients and families, and is weak in producing effective, sustained reduction in risk. Also, the climate of accountability and intense political and media scrutiny does not sit easily with what best practice has repeatedly shown is the key to making care safer: a climate of learning not judgment.

5.4.14 The Review concluded that front-line clinical staff are insufficiently supported to fulfill the role of assessing and improving the quality and safety of the care that they and their teams provide. The lack of time, the paucity of reliable, well-presented data, the absence of in-service training in quality improvement methods, and the patchiness of clinical leadership are all major barriers to achieving this vital shift to mass clinical engagement.

5.5 OPENNESS WITH PATIENTS AND FAMILIES

5.5.1 The Serious Adverse Incident investigation system contains, in the view of the Review Team, sufficient checks and balances to ensure that affected patients and families are informed that something went wrong, except in exceptional circumstances.

5.5.2 Such mechanisms are part of good governance, but alone are insufficient. It will be culture – not accountability – that increases the reporting of harm, and staff's comfort in talking openly about harm.

5.5.3 Those conducting investigations are committed to rigorous investigation, and to being open with patients and families about what is found. But whilst some communicate well in person and in writing, others are less strong. This can come across to families as a lack of openness.

5.5.4 High-profile inquiries and negative media coverage have led some to believe that there is widespread cover-up of harm in the health and social care system. This is simply inconsistent with what the Review Team observed, which was a system trying, as many others in the world are, to get to grips with the difficult problem of patient safety.

5.5.5 Fear and suspicion powerfully inhibit openness. The health and social care system needs to rise to the challenge of tackling these threats head on. Perception is important – even simple delays and communication weaknesses can fuel suspicion. And if staff hear more from the media than direct from their leaders, this does not dispel fear.

6 RECOMMENDATIONS

Recommendation 1: Coming together for world-class care

A proportion of poor quality, unsafe care occurs because local hospital facilities in some parts of Northern Ireland cannot provide the level and standard of care required to meet patients' needs 24 hours a day, 7 days a week. Proposals to close local hospitals tend to be met with public outrage, but this would be turned on its head if it were properly explained that people were trading a degree of geographical inconvenience against life and death. Finding a solution should be above political self-interest.

We recommend that all political parties and the public accept in advance the recommendations of an impartial international panel of experts who should be commissioned to deliver to the Northern Ireland population the configuration of health and social care services commensurate with ensuring world-class standards of care.

Recommendation 2: Strengthened commissioning

The provision of health and social care in Northern Ireland is planned and funded through a process of commissioning that is currently tightly centrally-controlled and based on a crude method of resource allocation. This seems to have evolved without proper thought as to what would be most effective and efficient for a population as small as Northern Ireland's. Although commissioning may seem like a behind-the-scenes management black box that the public do not need to know about, quality of the commissioning process is a major determinant of the quality of care that people ultimately receive.

We recommend that the commissioning system in Northern Ireland should be re-designed to make it simpler and more capable of reshaping services for the future. A choice must be made to adopt a more sophisticated tariff system, or to change the funding flow model altogether.

Recommendation 3: Transforming Your Care – action not words

The demands on hospital services in Northern Ireland are excessive and not sustainable. This is a phenomenon that is occurring in other parts of the United Kingdom. Although triggered by multiple factors, much of it has to do with the increasing levels of frailty and multiple chronic diseases amongst older people together with too many people using the hospital emergency department as their first port of call for minor illness. High-pressure hospital environments are dangerous to patients and highly stressful for staff. The policy document Transforming Your Care contains many of the right ideas for developing high quality alternatives to hospital care but few believe it will ever be implemented or that the necessary funding will flow to it. Damaging cynicism is becoming widespread.

We recommend that a new costed, timetabled implementation plan for *Transforming Your Care* should be produced quickly. We further recommend that two projects with the potential to reduce the demand on hospital beds should be launched immediately: the first, to create a greatly expanded role for pharmacists; the second, to expand the role of paramedics in pre-hospital care. Good work has already taken place in these areas and more is planned, but both offer substantial untapped potential, particularly if front-line creativity can be harnessed. We hope that the initiatives would have high-level leadership to ensure that all elements of the system play their part.

Recommendation 4: Self-management of chronic disease

Many people in Northern Ireland are spending years of their lives with one or more chronic diseases. How these are managed determines how long they will live, whether they will continue to work, what disabling complications they will develop, and the quality of their life. Too many such people are passive recipients of care. They are defined by their illness and not as people. Priority tends to go to some diseases, like cancer and diabetes, and not to others where provision remains inadequate and fragmented. Quality of care, outcome and patient experience vary greatly. Initiatives elsewhere show that if people are given the skills to manage their own condition they are empowered, feel in control and make much more effective use of services.

We recommend that a programme should be established to give people with long-term illnesses the skills to manage their own conditions. The programme should be properly organised with a small full-time coordinating staff. It should develop metrics to ensure that quality, outcomes and experience are properly monitored. It should be piloted in one disease area to begin with. It should be overseen by the Long Term Conditions Alliance.

Recommendation 5: Better regulation

The regulation of care is a very important part of assuring standards, quality and safety in many other jurisdictions. For example, the Care Quality Commission has a very prominent role in the inspection and registration of healthcare providers in England. In the USA, the Joint Commission's role in accreditation means that no hospital wants to fall below the standards set or it will lose reputation and patients. The Review Team was puzzled that the regulator in Northern Ireland, the Regulation and Quality Improvement Authority, was not mentioned spontaneously in most of the discussions with other groups and organisations. The Authority has a greater role in social care than in health care. It does not register, or really regulate, the Trusts that provide the majority of healthcare and a lot of social care. This light-touch role seems very out of keeping with the positioning of health regulators elsewhere that play a much wider role and help support public accountability. The Minister for Health, Social Services and Patient Safety has already asked that the regulator start unannounced inspections of acute hospitals from 2015, but these plans are relatively limited in extent.

We recommend that the regulatory function is more fully developed on the healthcare side of services in Northern Ireland. Routine inspections, some unannounced, should take place focusing on the areas of patient safety, clinical effectiveness, patient experience, clinical governance arrangements, and leadership. We suggest that extending the role of the Regulation and Quality Improvement Authority is tested against the option of outsourcing this function (for example, to Healthcare Improvement Scotland, the Scottish regulator). The latter option would take account of the relatively small size of Northern Ireland and bring in good opportunities for benchmarking. We further recommend that the Regulation and Quality Improvement Authority should review the current policy on whistleblowing and provide advice to the Minister.

6

Recommendation 6:
Making incident reports really count

The system of incident reporting within health and social care in Northern Ireland is an important element of the framework for assuring and improving the safety of care of patients and clients. The way in which it works is falling well below its potential for the many reasons explained in this report. Most importantly, the scale of successful reduction of risk flowing from analysis and investigation of incidents is too small.

We recommend that the system of Serious Adverse Incident and Adverse Incident reporting should be retained with the following modifications:

- **deaths of children from natural causes should not be classified as Serious Adverse Incidents;**
- **there should be consultation with those working in the mental health field to make sensible changes to the rules and time-scales for investigating incidents involving the care of mental health patients;**
- **a clear policy and some re-shaping of the system of Adverse Incident reporting should be introduced so that the lessons emanating from cases of less serious harm can be used for systemic strengthening (the Review Team strongly warns against uncritical adoption of the National Reporting and Learning System for England and Wales that has serious weaknesses);**
- **a duty of candour should be introduced in Northern Ireland consistent with similar action in other parts of the United Kingdom;**
- **a limited list of Never Events should be created**
- **a portal for patients to make incident reports should be created and publicised**
- **other proposed modifications and developments should be considered in the context of Recommendation 7.**

Recommendation 7:
A beacon of excellence in patient safety

There is currently a complex interweaving of responsibilities for patient safety amongst the central bodies responsible for the health and social care system in Northern Ireland. The Department of Health, Social Services and Public Safety, the Health and Social Care Board, and the Regulation and Quality Improvement Authority all play a part in: receiving Serious Adverse Incident Reports, analysing them, over-riding local judgments on designation of incidents, requiring and overseeing investigation, auditing action, summarising learning, monitoring progress, issuing alerts, summoning-in outside experts, establishing inquiries, checking-up on implementation of inquiry reports, declaring priorities for action, and various other functions. The respective roles of the Health and Social Care Board and the Public Health Agency are clearly specified in legal regulations but seem very odd to the outsider. The Health and Social Care Board has no full-time officers of its own who lead on quality and safety and no in-house medical or nursing director. These functions are grafted on from the Public Health Agency. The individuals concerned have done some excellent work on quality and patient safety and carry out their roles very conscientiously. However, symbolically, and on grounds of organisational coherence, it appears strange that the main body responsible for planning and securing care does not hold these functions in the heart of its business. The Department of Health, Social Services and Public Safety's role on paper is limited to policy-making but, in practice, steps in regularly on various aspects of quality and safety. The Review Team thought long and hard before making a recommendation in this area. In the end, we believe action is imperative for two reasons: firstly, the present central arrangements are byzantine and confusing; secondly, the overwhelming need is for development of the present system to make it much more successful in bringing about improvement. Currently, almost all the activities

(including those listed above) are orientated to performance management not development. There is a big space for a creative, positive and enhancing role.

We recommend the establishment of a Northern Ireland Institute for Patient Safety, whose functions would include:

- **carrying out analyses of reported incidents, in aggregate, to identify systemic weaknesses and scope for improvement;**
- **improving the reporting process to address under-reporting and introducing modern technology to make it easier for staff to report, and to facilitate analysis;**
- **instigating periodic audits of Serious Adverse Incidents to ensure that all appropriate cases are being referred to the Coroner;**
- **facilitating the investigation of Serious Adverse Incidents to enhance understanding of their causation;**
- **bringing wider scientific disciplines such as human factors, design and technology into the formulation of solutions to problems identified through analysis of incidents;**
- **developing valid metrics to monitor progress and compare performance in patient safety;**
- **analysing adverse incidents on a sampling basis to enhance learning from less severe events;**
- **giving front-line staff skills in recognising sources of unsafe care and the improvement tools to reduce risks;**
- **fully engaging with patients and families to involve them as champions in the Northern Ireland patient safety program, including curating a library of patient stories for use in educational and staff induction programmes;**
- **creating a cadre of leaders in patient safety across the whole health and social care system;**
- **initiating a major programme to build safety resilience into the health and social care system.**

Recommendation 8: System-wide data and goals

The Northern Ireland Health and Social Care system has no consistent method for the regular assessment of its performance on quality and safety at regional-level, Trust-level, clinical service-level, and individual doctor-level. This is in contrast to the best systems in the world. The Review Team is familiar with the Cleveland Clinic. That service operates by managing and rewarding performance based on clinically-relevant metrics covering areas of safety, quality and patient experience. This is strongly linked to standard pathways of care where outcome is variable or where there are high risks in a process.

We recommend the establishment of a small number of systems metrics that can be aggregated and disaggregated from the regional level down to individual service level for the Northern Ireland health and social care system. The measures should be those used in validated programmes in North America (where there is a much longer tradition of doing this) so that regular benchmarking can take place. We further recommend that a clinical leadership academy is established in Northern Ireland and that all clinical staff pass through it.

Recommendation 9:
Moving to the forefront of new technology

The potential for information and digital technology to revolutionise healthcare is enormous. Its impact on some of the long-standing quality and safety problems of health systems around the world is already becoming evident in leading edge organisations. These developments include: the electronic medical record, electronic prescribing systems for medication, automated monitoring of acutely-ill patients, robotic surgery, smartphone applications to manage workload in hospitals at night, near-patient diagnostics in primary care, simulation training, incident reporting and analysis on mobile devices, extraction of real-time information to assess and monitor service performance, advanced telemedicine, and even smart kitchens and talking walls in dwellings adapted for people with dementia. There is no organised approach to seeking out and making maximum use of technology in the Northern Ireland care system. It could make a big difference in resolving some of the problems described in this report. There is evidence of individual Trusts making their own way forward on some technological fronts, but this uncoordinated development is inappropriate - the size of Northern Ireland is such that there should be one clear, unified approach.

We recommend that a small Technology Hub is established to identify the best technological innovations that are enhancing the quality and safety of care around the world and to make proposals for adoption in Northern Ireland. It is important that this idea is developed carefully. The Technology Hub should not deal primarily with hardware and software companies that are selling products. The emphasis should be on identifying technologies that are in established use, delivering proven benefits, and are highly valued by management and clinical staff in the organisations concerned. They should be replicable at Northern Ireland-scale. The overall aim of this recommendation is to put the Northern Ireland health and social care system in a position where it has the best technology and innovation from all corners of the world and is recognised as the most advanced in Europe.

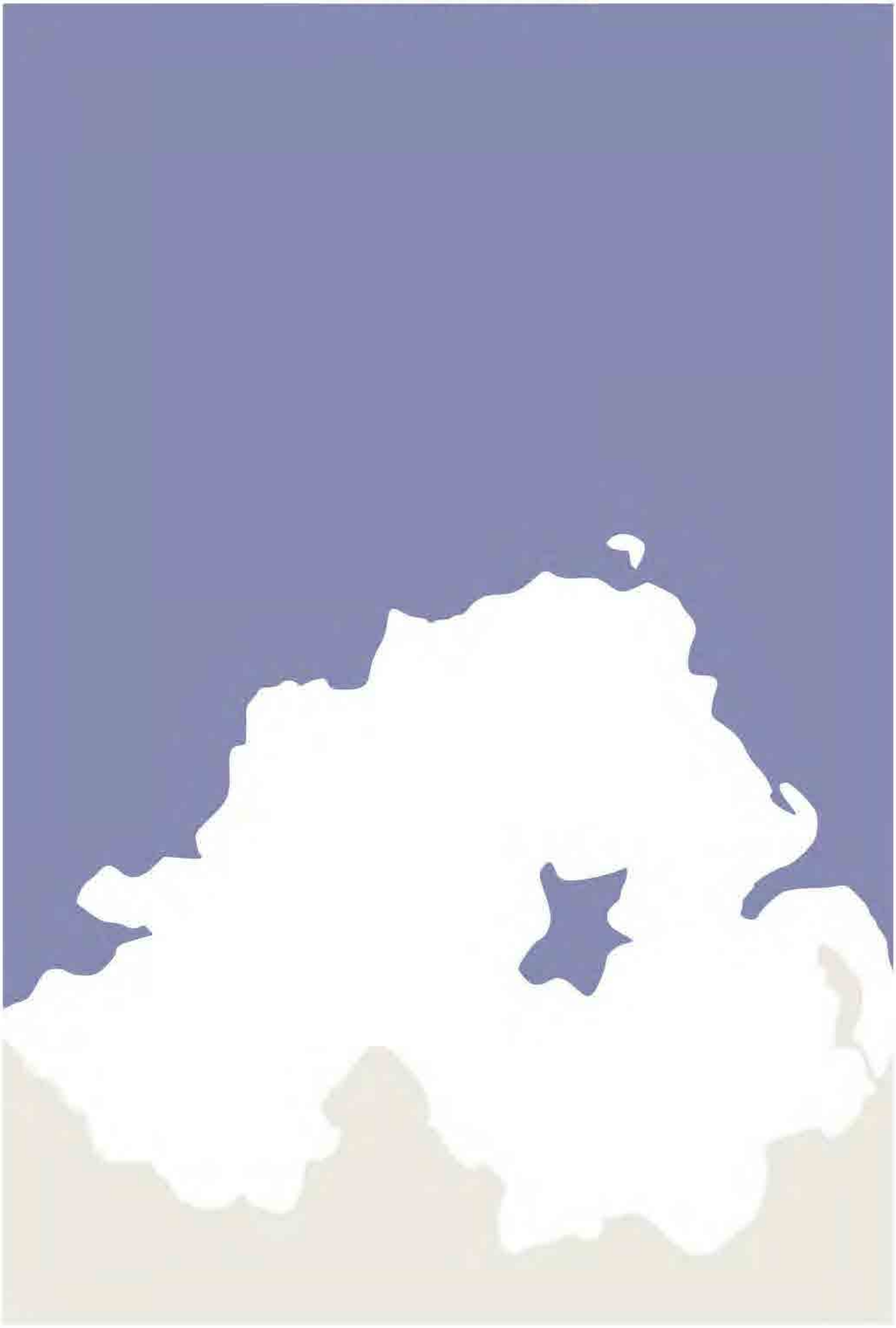
Recommendation 10: A much stronger patient voice

In the last decade, policy-makers in health and social care systems around the world have given increasing emphasis to the role of patients and family members in the wider aspects of planning and delivering services. External reviews – such as the Berwick Report in England - have expressed concern that patients and families are not empowered in the system. Various approaches have been taken worldwide to address concerns like these. Sometimes this has been through system features such as choice and personally-held budgets, sometimes through greater engagement in fields like incident investigation, sometimes through user experience surveys and focus groups, and sometimes through direct involvement in the governance structures of institutions. In the USA, patient experience data now forms part of the way that hospitals are paid and in some it determines part of the remuneration of individuals. This change catalysed the centrality of patients to the healthcare system in swathes of North America. Observers say that the big difference was when dollars were linked to the voice of patients. Northern Ireland has done some good work in the field of patient engagement, in particular the requirement to involve patients and families in Serious Adverse Incident investigation, the 10,000 voices initiative, in the field of mental health and in many aspects of social care. Looked at in the round, though patients and families have a much weaker voice in shaping the delivery and improvement of care than is the case in the best healthcare systems of the world.

We recommend a number of measures to strengthen the patient voice:

- **more independence should be introduced into the complaints process; whilst all efforts should be made to resolve a complaint locally, patients or their families should be able to refer their complaint to an independent service. This would look again at the substance of the complaint, and use its good offices to bring the parties together to seek resolution. The Ombudsman would be the third stage and it is hoped that changes to legislation would allow his reports to be made public;**
- **the board of the Patients and Client Council should be reconstituted to include a higher proportion of current or former patients or clients of the Northern Ireland health and social care system;**
- **the Patients and Client Council should have a revised constitution making it more independent;**
- **the organisations representing patients and clients with chronic diseases in Northern Ireland should be given a more powerful and formal role within the commissioning process, the precise mechanism to be determined by the Department of Health, Social Services and Public Safety;**
- **one of the validated patient experience surveys used by the Centers for Medicare and Medicaid Services in the USA (with minor modification to the Northern Ireland context) to rate hospitals and allocate resources should be carried out annually in Northern Ireland; the resulting data should be used to improve services, and assess progress. Finally and importantly, the survey results should be used in the funding formula for resource allocation to organisations and as part of the remuneration of staff (the mechanisms to be devised and piloted by the Department of Health, Social Services, and Public Safety).**

In implementing the above recommendations, the leaders of the Northern Ireland health and social care system should be clear in their ambition, which is in our view realistic, of making Northern Ireland a world leader in the quality and safety of its care. Northern Ireland is the right place for such a transformation, and now is the right time.



MEMORANDUM OF UNDERSTANDING

BETWEEN

THE DEPARTMENT OF HEALTH,

THE PUBLIC HEALTH AGENCY

AND

THE SAFEGUARDING BOARD FOR NORTHERN IRELAND

XX May 2019

CONTENTS

INTRODUCTION

1. The Safeguarding Board for Northern Ireland is a partnership of 27 members whose common purpose is to help safeguard and promote the welfare of children and young people in Northern Ireland and protect them as far as possible from all forms of neglect and abuse. The partnership is chaired by a person independent of the member agencies, and receives corporate support from the Regional Agency for Public Health and Social Well-being (PHA) to facilitate the operation of the partnership.

2. This Memorandum of Understanding (MoU) is a tri-lateral agreement between the Department of Health (the Department), the Regional Agency for Public Health and Social Well-being (hereafter referred to as the Public Health Agency (PHA)) and the Safeguarding Board for Northern Ireland (SBNI). This MoU replaces the MoU dated September 2012 between the Department, the PHA and the SBNI. It takes account of the findings and recommendations of the SBNI Review Report (the 'Jay Report'), accepted by the Minister of Health and published in August 2016. It also takes account of a subsequent review of the SBNI staffing and hosting arrangements completed in December 2016.

PURPOSE OF THIS MOU

3. This MoU specifies the roles, responsibilities and obligations of the Department and the PHA in relation to the SBNI. It also sets out how the SBNI will relate to the PHA and the Department in accountability terms. A full description of the statutory objective, functions and duties of the SBNI is set out in separate guidance[1] to the SBNI. They are summarised below.

4. As the corporate host, the PHA will either provide or secure the necessary corporate governance structures, accommodation, financial management, IT, HR and legal services, necessary to meet the staffing, accommodation and running

[1] SBNI Guidance is currently under review.

of the SBNI. The PHA will also employ the staff supporting the SBNI (The SBNI Central Support Team). This will enable the SBNI to effectively function within the resources made available to it by the Department and SBNI members.

5. The majority of the 'corporate host' services will be provided to the SBNI on the same basis as they are available to all PHA staff. However, where the SBNI requires services above and beyond those provided by the PHA's Service Level Agreement with the Business Services Organisation, the additional costs will be covered by the SBNI. In particular the SBNI will cover the costs for its Equality Unit support (because the SBNI is required to register with the Equality Commission), and its accommodation (including equipment, telephone rental and calls and other office running costs). The Chair of the SBNI and the SBNI Central Support Team will comply with PHA policies and procedures relating to corporate hosting services and functions.

6. This MoU does not affect existing statutory functions nor amend any other policies or agreements relating to the activities of the PHA or the SBNI. It is not a legally binding document; it is not a contract between partners, nor is it intended to cover every aspect of the relationship between the three parties. Each signatory agrees to work together within the framework outlined in this MoU.

The SBNI

7. The SBNI was established under the Safeguarding Board Act (NI) 2011 (SBNI Act) [2] as an unincorporated statutory partnership. It is sponsored by the Department. The SBNI is a multi-disciplinary interagency partnership, chaired independently from its members, and its statutory objective is to coordinate and ensure the effectiveness of what is done by each person or body represented on the SBNI (its members) for the purposes of safeguarding and promoting the welfare of children and young people in Northern Ireland. The statutory functions of the SBNI are:

[2] The SBNI Act is available at: http://www.legislation.gov.uk/nia/2011/7/contents

i. to develop policies and procedures for safeguarding and promoting the welfare of children in Northern Ireland;
ii. to promote an awareness of the need to safeguard and promote the welfare of children;
iii. to keep under review the effectiveness of what is done by members to safeguard and promote the welfare of children;
iv. to undertake case management reviews without discretion in such circumstances as may be prescribed;
v. to review such information as may be prescribed in relation to deaths of children in NI;
vi. to advise the Regional Health and Social Care Board and Local Commissioning Groups in relation to safeguarding and promoting the welfare of children:
    i. as soon as reasonably practicable after receipt of a request for advice; and
    ii. on such other occasions as the SBNI thinks appropriate.
vii. to promote communication between the SBNI and children and young people; and
viii. to make arrangements for consultation and discussion in relation to safeguarding and promoting the welfare of children.

The PHA

8. The PHA was established under section 12(1) of the Health and Social Care (Reform) Act (Northern Ireland) 2009 and is an Arm's Length Body (ALB) of the Department of Health. It delivers a range of health functions including:

i. health and social wellbeing improvement;
ii. health protection;
iii. public health support to commissioning and policy development; and
iv. HSC research and development.

In addition, PHA is a member of the SBNI under section 1(3) of the SBNI Act.

9. In accordance with Regulations[3] made under the SBNI Act, the PHA is required to:

   i. Employ and appoint staff to support the operation of the SBNI;

   ii. Provide office and other accommodation to staff appointed to support the SBNI; and

   iii. Make arrangements for the upkeep of that accommodation.

PHA Corporate Host Functions

10. The PHA will act as corporate host to the SBNI. The staff it employs to support the SBNI (The SBNI Central Support Team) will have access to the full range of corporate services available to any employee of the PHA. Some of these services will be provided by the Health and Social Care Board or the Business Services Organisation under Service Level Agreement with the PHA. The SBNI Central Support Team is required to adhere to corporate policies and procedures of the PHA and their performance will be managed in accordance with the performance management arrangements of the PHA.

11. The PHA will provide the SBNI with the following:

- PHA staff who will act as the SBNI Central Support Team;
- accommodation and office facilities; and
- access to a range of corporate services: HR, training, finance, IT, legal, equality proofing and advice and support in connection with complaints handling and information management.

12. The PHA will assume line management responsibility for the most senior members of SBNI staff. It is a matter for the CEO of the PHA to decide where within the PHA line management responsibility will sit, and to nominate a PHA

[3] The Safeguarding Board for Northern Ireland (Membership, Procedure, Functions and Committee) Regulations (Northern Ireland) 2012 are available at: http://www.legislation.gov.uk/nisr/2012/324/contents/made

official with sufficient seniority to act as line manager to the most senior SBNI members of staff.

13. The nominated PHA official and the SBNI Chair must establish formal arrangements to:
    - agree the performance objectives of the most senior staff;
    - be kept informed of achievements against agreed objectives; and
    - with the support of corporate HR, address any performance issues arising relating to any member of SBNI staff.

14. The nominated PHA official will also act as the link between the SBNI Central Support Team and PHA Corporate Services. This will require the individual to keep corporate hosting arrangements under review and to work with the SBNI Chair to address any issues arising relating to corporate hosting. Any issues that cannot be resolved between the Chair and the nominated PHA official should be brought to the attention of the Chief Executive of the PHA. If necessary, the Chief Executive of the PHA will bring any unresolved issues to the attention of the Director of Family and Children's Policy in the Department.

15. The PHA is a member agency of the SBNI and, in that role, must fulfil the duties ascribed to all member agencies, including the specific duty to cooperate under section 10 of the SBNI Act. The PHA must also play its role in the exercise of the SBNI's statutory functions and the delivery of its statutory objective. However, the PHA is not accountable for the overall performance of the SBNI in terms of its statutory objective, functions and duties.

16. While the financial allocation to support the operation of the SBNI is made to the PHA by the Department of Health, decisions relating to the use of the allocation in support of strategic and annual business plan objectives are a matter for the SBNI under the guidance and leadership of the Chair of the SBNI. However, the PHA will ensure that all expenditure mandated by the SBNI fully complies with financial legislation, policy and procedures. In addition, if the PHA is of the view that additional resources are required to effectively provide corporate support to

the SBNI, this should be brought to the attention of the Department through the PHA sponsor branch.

The Department

17. On behalf of the Northern Ireland Executive, the Department sponsors and will provide funding to support the operation of the SBNI on an annual basis. Funding allocations will be made through the PHA. Expectations in connection with the funding allocation to the SBNI through the PHA are set out below (see Financial Management). On behalf of the Executive, the Department will continue to set the policy and legislative frameworks within which the SBNI operates and provide guidance as necessary. It will hold the SBNI to account for the exercise of its statutory objective, functions and duties through the Chair of the SBNI. It will hold the PHA to account for its corporate hosting role through the PHA Chief Executive. See Assurance and Accountability Arrangements below.

ASSURANCE AND ACCOUNTABILITY ARRANGEMENTS

PHA Corporate Host Responsibilities

18. The relationship between the PHA and the Department, and the framework within which the PHA operates as an ALB of the Department is specified in the Management Statement and Financial Memorandum (MSFM)[4] in place between these bodies. The MSFM makes reference to the PHA's corporate hosting responsibilities to the SBNI, acknowledging that the PHA is accountable to the Department for the discharge of its corporate host obligations to the SBNI. However, the PHA is not accountable for how the SBNI discharges its statutory objective, functions and duties.

19. As an unincorporated statutory partnership, the SBNI will not have a separate MSFM. A copy of this MoU will be appended to the MSFM of the PHA and these

[4] MSFM for PHA was reviewed and signed off in October 2018 (HE1/18/227679)

arrangements should be reflected in any future update to the Department's Framework Document[5].

20. The Chair of the SBNI and the PHA nominated official may be asked by the Department to attend a relevant section of the PHA/Department Accounting Officer-led assurance and accountability meetings if there are particular SBNI corporate host issues which require discussion. The CEO of the PHA will be advised in advance of the attendance of the Chair of the SBNI.

21. If requested, the SBNI Chair and/or the PHA nominated official will attend meetings of the PHA Governance and Audit Committee in relation to matters of relevance to the Committee arising from corporate hosting responsibilities/functions.

SBNI Statutory Objective, Functions and Duties

22. The SBNI, through the Chair, will account directly to the Department for the exercise of its statutory objective, functions and duties. In accordance with guidance issued by the Department, the SBNI will develop a Strategic Plan and Annual Business Plans and in accordance with section 6 of the Safeguarding Board Act (Northern Ireland) 2011 will produce an annual report. See Performance against Objectives below.

23. Every 4 years, the SBNI, through the Chair, will submit to the Department a draft strategic plan covering the planned priorities, strategic aims and objectives for the next 4 years. It will set out how the SBNI will deliver on its statutory objective, functions and statutory duties. The plan will be subject to Departmental approval and will be supported by annual Business Plans.

24. In January each year, the SBNI, through the Chair, will provide the Department with a draft Business Plan for the year ahead (April to March). It will include key

[5] https://www.health-ni.gov.uk/publications/dhssps-framework-document-september-2011

actions, supported by measures of success/expected outcomes, to be undertaken in the year ahead and will include financial information.

25. By August each year, the SBNI, through the Chair, will provide the Department with a draft annual report for the previous year.

26. The PHA, as corporate host for the SBNI, has no responsibility for the development of the SBNI Strategic and Business Plans, their review or approval. However as a core member of the SBNI, the PHA will contribute fully to the development of the SBNI's Strategic and Business Plans.

27. The Chair of the SBNI will formally meet with the Department's Director of Family and Children's Policy twice each year. The PHA nominated official may be asked to attend if there are particular SBNI corporate host issues which require discussion. In February, the agenda will include the discussion and agreement of the SBNI's Business Plan for the year ahead. In August, the agenda will include discussion and acceptance of the annual report. The attendance by others at the meeting will be agreed by the Chair of the SBNI and the Department's Director. These meetings will be minuted by the Department.

Performance Against Objectives

28. As indicated in paragraph 23, the SBNI is required to submit to the Department a draft 4-year Strategic Plan. The plan will reflect the SBNI priorities, strategic aims and objectives. It will set out how the SBNI will deliver on its statutory objective, functions and statutory duties. The plan will be subject to Departmental approval and will be supported by an annual Business Plan.

Declaration of Assurance to the PHA

29. The Chair of the SBNI must provide a declaration of assurance to the PHA, confirming (or otherwise) that:
    - The SBNI Central Support Team has adhered to all relevant PHA policies and procedures;

- The resources allocated to the SBNI by the Department have been deployed in full to further the objectives/priorities of the SBNI identified in its Strategic Plan and supporting Business Plans;
- Any unused resources have been flagged to the PHA within a reasonable timescale.

30. The declaration of assurance will inform the PHA mid-year and year-end Assurance Statement and Governance Statement to the Department. In circumstances where the Chair cannot provide an assurance to the PHA in connection with any of the above, an explanation must be provided in the declaration.

FINANCIAL MANAGEMENT

31. As an unincorporated statutory partnership, the SBNI is unable to hold its own funds. It receives funds from the Department via the PHA and may receive funding from other sources. Any financial allocation from sources other than the Department must be declared to the PHA and must be held by the PHA.

32. The PHA will receive an annual financial allocation from the Department to enable the SBNI to meet its statutory objective, functions and duties. This funding will provide for both running costs including the staff, accommodation and services provided by the PHA and the programme activity agreed by the SBNI and included in its annual Business Plan.

33. Prior to the approval of the SBNI Business Plans, the Department will consult with the Chief Executive of the PHA to confirm that in his/her role as Accounting Officer there are no financial issues that may impact on either the content or delivery of the SBNI plans. Where plans are subject to change after approval, the Department will further consult the Chief Executive of the PHA if this is deemed necessary.

34. The PHA will not use funds allocated for the SBNI for any other purpose. Any request for additional resources in respect of the SBNI must be referred to the Department. The PHA Accounting Officer will be advised of all requests and approvals of additional resources and expenditure, as he/she will be held accountable for this expenditure.

35. Details of the SBNI's financial allocations and expenditure will be included within the PHA Annual Accounts. The PHA must be satisfied that the level of detail fully accounts for all SBNI financial allocations.

36. The Chair of the SBNI and the SBNI Central Support Team will comply with PHA Standing Financial Instructions (SFI) and all other financial policies and procedures of the PHA.

37. Responsibility for the proper management of financial allocations to the SBNI, from all sources, falls to the Chief Executive of the PHA as Accounting Officer.

PROCUREMENT

38. The SBNI will comply with HSC procurement regulations and processes as set out in the PHA Standing Orders and SFI and other relevant policies and procedures. Goods and Services will be procured by the SBNI Central Support Team in line with the normal HSC policies and procedures, as specified in PHA Standing Orders and SFI, or through BSO PALS where this is required.

39. SBNI will work with PHA in respect of any social care procurements it is undertaking and these will be included on the PHA Social Care Procurement Plan. They will be taken forward by the SBNI Central Support Team with access to the full range of guidance and advice from BSO PALS Social Care Procurement Unit (over threshold) and PHA staff (under threshold).

GOVERNANCE

Risk Registers

40. The SBNI must maintain its own internal Risk Register. It must inform the Department of risks identified in relation to the exercise of its statutory objective, functions and duties or the delivery of its Strategic Plan and/or Business Plan. It must inform the PHA of risks identified that relate to corporate hosting arrangements. The PHA must determine if any such risks should be included in its Risk Register and/or identified to the Department.

Business Continuity Plan

41. The Chair of the SBNI will nominate a member of the SBNI Central Support Team to liaise with the PHA in connection with Business Continuity Planning arrangements to ensure the continued functioning of the SBNI in the event of disruption to normal business.

Internal Audit

42. The SBNI will be included within the PHA annual Internal Audit work plan in respect of those areas relating to the PHA corporate host functions. The SBNI will provide Management Responses to relevant draft audit findings or recommendations and will designate a senior member of the SBNI Central Support Team to undertake this function. Responses must be provided to Internal Audit within required timescales to enable it to finalise the report for submission to the PHA Governance and Audit Committee, in compliance with the standard Internal Audit reporting procedures of the HSC. Where it considers it necessary, the Department will establish separate audit arrangements for those areas for which the SBNI provides assurance directly to the Department.

Information Management

43. The remit of the PHA Personal Data Guardian (PDG) and Senior Information Risk Owner (SIRO) encompasses the SBNI in respect of records generated by or held by the SBNI Central Support Team in pursuance of SBNI business. The SBNI will designate a senior member of the SBNI Central Support Team as Information Asset Owner (IAO) who will be responsible for ensuring that information is managed appropriately and for providing assurances to the SBNI via the Chair and the PHA. The IAO will participate in the PHA's Information Governance Steering Group.

44. The SBNI Central Support Team will comply with all the PHA Information Governance policies and procedures. PHA will provide advice and guidance.

45. Freedom of Information (FOI) requests relating to the work of the SBNI will be dealt with in accordance with PHA FOI policies and procedures. On receipt of a relevant FOI request by the PHA Information Governance Team, it will be forwarded to the SBNI IAO, who will identify the relevant SBNI information handler. The response will be issued through the PHA, based on the SBNI information provided, PHA Information Governance advice and approval of the SBNI IAO.

Complaints Handling

46. Complaints relating to the work of the SBNI, will be dealt with through the normal PHA complaints procedure. SBNI staff will provide the necessary information and input to respond to the complaint. The PHA, and where appropriate, the Department, will provide advice and guidance.

47. The Chair of the SBNI will inform the Permanent Secretary of the Department of any complaints about the SBNI accepted by the NI Public Services Ombudsman for investigation and about the SBNI's proposed response to any subsequent recommendations from the Ombudsman.

48. The Chair of the SBNI will inform the PHA nominated official of any matters arising from complaints relating to any member of the SBNI Central Support Team.

Alerts

49. The Chair of the SBNI must alert:
    - the Department in a timely manner of any matter which he/she considers would adversely impact the delivery of the SBNI's statutory objective, functions, duties or reputation or the reputation of the Department;
    - the PHA in a timely manner of any matter which would adversely impact the functions or reputation of the PHA.

50. The PHA must alert:
    - the Chair of the SBNI and the Department in a timely manner of any matter which it considers would adversely impact the reputation of the SBNI.
    - the Department in a timely manner of any matter arising from its SBNI corporate host responsibilities/functions, which would adversely impact the delivery of PHA functions or reputation or the reputation of the Department.

LEGAL SERVICES

51. The Departmental Solicitor's Office will provide legal services for matters relating to the SBNI's statutory objective, functions and duties. The PHA will secure legal services from the BSO Directorate of Legal Services for those matters relevant to the PHA's corporate hosting responsibilities/functions.

ACCOMMODATION AND EQUIPMENT

52. The PHA will provide agreed office accommodation, and standard office equipment for specific use by the SBNI Central Support Team and Chair of the

SBNI. The costs of accommodation, (including equipment, telephone rental and calls, and other office running costs) will be covered by the SBNI management and administration budget. The SBNI may secure alternative accommodation, for example, as currently at the HSC Leadership premises, covering the total cost from the SBNI management and administration budget. In these instances the SBNI will comply with the normal approval mechanisms as set out by DoH Assets and Estate Management Branch.

HUMAN RESOURCES

53. With the exception of the Chair of the SBNI and Lay Members, who are publicly appointed by the Department, SBNI Central Support Team staff are employees of the PHA assigned specifically to support the SBNI. The creation of new posts within the SBNI Central Support Team will require the prior approval of the Department. The SBNI Central Support Team staff should not be utilised elsewhere in the PHA without formal agreement with the Department.

Management of SBNI Central Support Team Staff

54. The relationship between the PHA and the SBNI will be one of partnership and collaboration, ensuring appropriate working relationships and support for SBNI Central Support Team staff.

55. The SBNI Central Support Team staff, as employees of the PHA, will be subject to the same policies and procedures as other PHA staff, including leave and attendance, complaints, grievances, discipline and whistle blowing.

56. A line management structure must exist within the SBNI Central Support Team. The PHA nominated official must assure him/herself that the structure is sufficiently robust and bring any concerns about the structure to the attention of the Chair of the SBNI. Any unresolved concerns must be brought to the attention of the Department. The arrangements for approving staff leave requests as they relate to the most senior members of SBNI Central Support Team must be agreed by the Chair of the SBNI and the PHA nominated official. All other leave

requests will be handled in accordance with 'internal' SBNI line management arrangements.

57. The Chair of the SBNI will advise the PHA nominated official of any issues emerging in relation to SBNI Central Support Team staff and their adherence to PHA policies and procedures. Individual incidents/breaches of these policies and procedures will be managed in keeping with normal HSC good practice, PHA guidance and escalation arrangements.

Performance Appraisal

58. Annual appraisal of SBNI Central Support Team staff will be conducted against SBNI business and individual staff objectives and in line with the HSC Performance Appraisal processes operated by the PHA. Appraisal of the most senior staff of the SBNI Central Support Team will be conducted jointly by the Chair of the SBNI and the PHA nominated official. Line Managers of other Central Support Team staff will be responsible for performance appraisal/management with input from the SBNI Chair where relevant/necessary.

59. Appraisal of the performance of the SBNI Chair and Lay Members will be conducted in line with established Public Appointment arrangements.

Staff Training and Development

60. The PHA is responsible for induction training and for securing the provision of training and development of members of the SBNI Central Support Team in line with performance management agreements.

Recruitment of Staff

61. Through the BSO HR service, the PHA will secure the timely recruitment of staff to SBNI Central Support Team posts approved by the Department.

PRESENTATIONAL ISSUES

Communication and Liaison Arrangements

62. The PHA and the SBNI (through the Chair) will keep each other promptly and regularly informed about any work being undertaken or issues arising which may impact on the other, or in which the other has an interest. Both parties must keep the Department informed about any matter which is likely to be of interest to the Department or the Minister.

Media Handling and Support

63. It is anticipated that day to day media handling and planned communications outputs will be managed and delivered directly by the SBNI. Where additional support over and above day-to-day communication activities is required the SBNI, through the Chair, will consult the PHA to determine whether the PHA Communications Team can provide support and to agree the cost of that support where appropriate.

64. If the SBNI plans to conduct a media/social marketing campaign, this should be discussed and agreed with the Department, and PHA where appropriate, including how the cost of conducting the campaign will be met.

Web site

65. The SBNI Central Support Team is responsible for the ongoing maintenance of the SBNI website. The cost of maintaining and developing the SBNI website will be met from the SBNI's financial allocation.

OTHER MATTERS

Indemnity

66. The SBNI Chair and publicly appointed Lay Members will be indemnified by the Department while engaged in SBNI business, provided they have acted honestly and in good faith, and have not acted recklessly. This means that the Department will indemnify the Chair of the SBNI and publicly appointed lay members in relation to any legal costs and damages which may be awarded against them in connection with the conduct of SBNI business.

Conflicts of Interest

67. If any conflicts of interest should arise for the Chief Executive of the PHA in connection with his/her SBNI corporate hosting responsibilities/functions, the matter should be referred to the Department for resolution. Any conflicts of interest or perceived conflicts of interest, which arise for the Chair of the SBNI, must be notified to the Department immediately.

AGREEMENT AND REVIEW OF THE MEMORANDUM OF UNDERSTANDING

68. This MOU will be reviewed after one year of operation and then every three years. It will also be amended, if necessary, following any relevant changes to the policies, procedures and structures of the parties concerned. Any issues arising at any stage from the operation of the MoU, must be brought to the Department's attention by the SBNI or the PHA, as soon as practicable.

69. Agreement to this Memorandum of Understanding is given by signature of the following:

On behalf of the PHA

Ms Valerie Watts
(Interim) Chief Executive

On behalf of the SBNI

Ms Bernie McNally
SBNI Chair

On behalf of the Department of Health

Mr Richard Pengelly
Permanent Secretary

MAHI - STM - 120 - 105

MANAGEMENT STATEMENT (Tab A) and FINANCIAL MEMORANDUM (Tab B)

Between DoH and PHA

August 2018

MANAGEMENT STATEMENT

1. INTRODUCTION

1.1 This document

1.1.1 This *Management Statement* and *Financial Memorandum* (MS/FM) has been drawn up by the Department of Health (DoH) in consultation with the Public Health Agency (PHA), Linenhall Street, Belfast. The document is based on a model prepared by the Department of Finance (DoF).

1.1.2 The terms and conditions set out in the combined M*anagement Statement* and *Financial Memorandum* may be supplemented by guidelines or directions issued by the sponsor Department/Minister in respect of the exercise of any individual functions, powers and duties of the PHA.

1.1.3 A copy of the MS/FM for the PHA should be given to all newly appointed Board Members, senior PHA executive staff and Departmental sponsor staff on appointment. Additionally the MS/FM should be tabled for the information of Board Members at least annually at a full meeting of the Board. Amendments made to the MS/FM should also be brought to the attention of the full Board on a timely basis.

1.1.4 Subject to the legislation noted below, this *Management Statement* sets out the broad framework within which the PHA will operate, in particular:

- the PHA's overall aims, objectives and targets in support of the sponsor Department's wider strategic aims, the NICS Outcomes Delivery plan and the outcomes and targets contained in the current draft Programme for Government (PfG).
- the rules and guidelines relevant to the exercise of the PHA's functions, duties and powers;
- the conditions under which any public funds are paid to the PHA; and
- how the PHA is to be held to account for its performance.

1.1.5 The associated *Financial Memorandum* sets out in greater detail certain aspects of the financial provisions which the PHA shall observe. However, the *Management Statement* and *Financial Memorandum* do not convey any legal powers or responsibilities.

1.1.6 The document shall be periodically reviewed by the sponsor Department in accordance with the timetable referred to in Section 7 below.

1.1.7 The PHA, the sponsor Department, or the Minister, may propose amendments to this document at any time. Any such proposals by the PHA shall be considered in the light of evolving Departmental policy aims, operational factors and the track record of the PHA itself. The guiding principle shall be that the extent of flexibility and freedom given to the PHA shall reflect both the quality of its internal controls to achieve performance and its operational needs. The sponsor Department shall determine what changes, if any, are to be incorporated in the document. Legislative provisions shall take precedence over any part of the document. Significant variations to the document shall be cleared with DoF Supply after consultation with the PHA, as appropriate. (The definition of "significant" will be determined by the sponsor Department in consultation with DoF).

1.1.8 The *MS/FM* is approved, signed and dated by the sponsor Department and the PHA's Chief Executive.

1.1.9 Any question regarding the interpretation of the document shall be resolved by the sponsor Department after consultation with the PHA and, as necessary, with DoF Supply.

1.1.10 Copies of this document and any subsequent substantive amendments shall be placed in the Library of the Assembly. (Copies shall also be made available to members of the public on the PHA's website).

1.2 The founding legislation, functions, duties and powers of the PHA

1.2.1 The PHA is established under section 12 (1) of the Health and Social Care (Reform) Act (Northern Ireland) 2009 (hereafter referred to as the Act). The PHA does not carry out its functions on behalf of the Crown.

1.2.2 The PHA is established for the purposes specified in section 13 of the Act. The PHA's general powers etc. are listed in Schedule 2 to the Act.

1.3 Classification

1.3.1 For policy/administrative purposes the PHA is classified as a Health and Social Care body (akin to an executive non-Departmental public body) and for national accounts purposes is classified to the central government sector).

1.3.3 References to the PHA include, where they exist, all its subsidiaries and joint ventures that are classified to the public sector for national accounts purposes. If such a subsidiary or joint venture is created, there shall be a document setting out the arrangements between it and the PHA.

2. AIMS, OBJECTIVES AND TARGETS

2.1 The approved overall aim for the PHA is to improve the health and social well-being of the population and the quality of care provided, and to protect the population from communicable disease or emergencies or other threats to public health. As well as the provision or securing of services related to those functions, the PHA will commission or undertake programmes of research, health awareness and promotion etc. This aim will be delivered through three core functions of the PHA:

- securing the provision of and developing and providing programmes and initiatives designed to secure the improvement of the health and social well-being of and reduce health inequalities between people in Northern Ireland,

- protecting the community (or any part of the community) against communicable disease and other dangers to health and social well-being including dangers arising on environmental or public health grounds or arising out of emergencies; and

- providing professional input to the commissioning of health and social care services which meet established quality standards and which support innovation.

2.2 The PHA also has a general responsibility for promoting improved partnership working with local government and other public sector organisations to bring about real improvements in public health and social well-being on the ground and anticipating the new opportunities offered by community planning.

2.3 Objectives and key targets - The Department determines the PHA's performance framework in light of the Department's wider strategic aims, the NICS Outcomes Delivery Plan, and current draft PfG objectives and targets.

2.4 The key targets, standards and actions to be delivered by the PHA are set out in its Annual Business Plan supported by the 3 year strategic plan. These are defined by the Department within Commissioning Directions and approved by the Minister. The Department also determines, by direction, the format and broad content of the Commissioning Plan, which is to be drawn up by the HSCB in accordance with section 8 of the Act, i.e. in consultation with the PHA, having due regards for any advice or information provided by the Agency, and published only with its approval. The Commissioning Plan explains how the PHA will meet each of the targets, standards and actions for which it is deemed by the Department to have sole or lead responsibility. The document will also set out the PHA's contribution to the commissioning process through its professional medical expertise.

3. RESPONSIBILITIES AND ACCOUNTABILITY

3.1 **The Minister**

3.1.1 The Minister is accountable to the Assembly for the activities and performance of the PHA. Their responsibilities include:

- approving the PHA's strategic objectives and the policy and performance framework within which the PHA will operate (as set out in this *Management Statement* and *Financial Memorandum* and associated documents);
- keeping the Assembly informed about the PHA's performance; as part of the HSC system;
- carrying out responsibilities specified in the founding legislation including appointments to the board (including its Chairman) and laying of the annual report and accounts before the Assembly; and
- approving the remuneration scheme for Non-Executive board members and setting the annual pay settlement each year under these arrangements.

3.2 **The Accounting Officer of the sponsor Department**

3.2.1 The Permanent Secretary, as the sponsor Department's principal Accounting Officer (the 'Departmental Accounting Officer'), is responsible for the overall organisation, management and staffing of the sponsor Department and for ensuring that there is a high standard of financial management in the Department as a whole. The Departmental Accounting Officer is accountable to the Assembly for the issue of any grant-in-aid to the PHA. The Departmental Accounting Officer designates the Chief Executive of the PHA as the PHA's Accounting Officer, and may withdraw the Accounting Officer designation if he/she believes that the incumbent is no longer suitable for the role.

3.2.2 In particular, the Departmental Accounting Officer of the sponsor Department shall ensure that:

- the PHA's strategic aim(s) and objectives support the sponsor Department's wider strategic aims, the NICS Outcomes Delivery Plan and current draft PfG objectives and targets;
- the financial and other management controls applied by the sponsor Department to the PHA are appropriate and sufficient to safeguard public funds and for ensuring that the PHA's compliance with those controls is effectively monitored ("public funds" include not only any funds granted to the PHA by the Assembly but also any other funds falling within the stewardship of the PHA);

- the internal controls applied by the PHA conform to the requirements of regularity, propriety and good financial management; and
- any grant-in-aid to the PHA is within the ambit and the amount of the Request for Resources and that Assembly authority has been sought and given.

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

3.2.4 The Departmental Accounting Officer (DAO) is also responsible for ensuring that arrangements are in place to:

- continuously monitor the PHA's activities to measure progress against approved targets, standards and actions, and to assess compliance with safety and quality, governance, risk management and other relevant requirements placed on the organisation;
- address significant problems in the PHA, making such interventions as he/she judges necessary to address such problems;
- periodically carry out an assessment of the risks both to the Department's and the PHA's objectives and activities;
- inform the PHA of relevant Government policy in a timely manner; and
- bring concerns about the activities of the PHA to the full PHA Board, requiring explanations and assurances that appropriate action has been taken.

3.3 The sponsoring team in the Department

3.3.1 Within the sponsoring Department, **Health Development Policy Branch (HDPB)** is the sponsoring team for the PHA. The Branch, in consultation as necessary with the relevant Departmental Accounting Officer, is the primary source of advice to the Minister on the discharge of his/her responsibilities in respect of the PHA, and the primary point of contact for the PHA in dealing with the sponsor Department. The sponsoring team shall carry out its duties under the management of a senior officer, who shall have primary responsibility within the team for overseeing the activities of the PHA.

3.3.2 The Executive Board Member (EBM) sponsor from the Department is the Chief Medical Officer, Dr Michael McBride. The EBM Sponsor has primary responsibility for overseeing sponsorship of the PHA. In particular the EBM supports the Permanent Secretary in ensuring sponsorship is applied systematically; provides an assurance that a proportionate approach to assurance and accountability is in place; manages the PHA's business planning process; and ensures that significant governance, risk management or internal control issues are escalates within the Department. The EBM Sponsor also undertakes end-year appraisals for PHA Chairs and participates in ground-clearing and accountability meetings as required.

3.3.3 The sponsoring team shall advise the Minister on:

- an appropriate framework of objectives and targets for the PHA in the light of the Department's wider strategic aims, the NICS Outcomes Delivery Plan and current draft PfG objectives and targets;
- an appropriate budget for the PHA in the light of the Department's overall public expenditure priorities; and
- how well the PHA is achieving its strategic objectives and whether it is delivering value for money.

3.4 The PHA's Board

3.4.1 The Board Members are appointed by the Minister, following an open competition in accordance with the Code of Practice issued by the Commissioner for Public Appointments for Northern Ireland. The established departmental practice is that initial appointments are usually for a four year period. Re-appointment for a second term of

appointment can be considered. In the absence of a Government Minister the Permanent Secretary of the Department of Health can appoint Board Members. The PHA Board is made up of a Non-Executive Chair, the Chief Executive, seven Non-Executive Directors, and three Executive Directors. Executive Directors are employees of the PHA.

3.4.2 The Board must ensure that effective arrangements are in place to provide assurance on risk management, governance and internal control. The Board must set up an Audit Committee, which complies with the requirements of The Code of Conduct and Code of Accountability originally issued in November 1994, updated and reissued in July 2012. Circular HSS(PDD) 08/94 also set out detailed guidance on the establishment of audit committees. And any subsequent relevant guidance, is chaired by an independent non-executive, and comprising solely independent members, to provide independent advice on the effectiveness of the internal control and risk management systems.

3.4.3 The Board has corporate responsibility for ensuring that the PHA fulfils the aims and objectives set by DoH and approved by the Minister, and for promoting the efficient, economic and effective use of staff and other resources by the PHA. To this end, and in pursuit of its wider corporate responsibilities, the Board shall:

- establish the overall strategic direction of the PHA within the policy and resources framework determined by the sponsor Minister and Department;
- constructively challenge the PHA's executive team in their planning, target setting and delivery of performance;
- ensure that the sponsor Department is kept informed of any changes which are likely to impact on the strategic direction of the PHA or on the attainability of its targets, and determine the steps needed to deal with such changes;
- ensure that any statutory or administrative requirements for the use of public funds are complied with; that the Board operates within the limits of its statutory authority and any delegated authority agreed with the sponsor Department, and in accordance with any other conditions relating to the use of public funds; and that, in reaching decisions, the Board takes into account all relevant guidance issued by DoF and the sponsor Department;
- ensure that the Board receives and reviews regular financial information concerning the management of the PHA; is informed in a timely manner about any concerns about the activities of the PHA; and provides positive assurance to the sponsor Department that appropriate action has been taken on such concerns;
- demonstrate high standards of corporate governance at all times, including using the independent audit committee, (see paragraph 4.7) to help the Board to address the key financial and other risks facing the PHA; and
- appoint with the Minister's approval, or with the sponsor Department's approval, a Chief Executive to the PHA and, in consultation with the sponsor Department, set performance objectives and remuneration terms linked to these objectives for the Chief Executive, which give due weight to the proper management and use of public monies.

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

- comply at all times with the Code of Practice (see paragraph 3.4.2) that is adopted by the PHA and with the rules and guidance relating to the use of public funds and to conflicts of interest. The Code of Conduct draws attention to the requirement for public service values to be at the heart of Health and Social Care (HSC) in Northern Ireland. High standards of corporate and personal conduct are essential. Moreover, as the HSC is publically funded, it is accountable to the Northern Ireland Assembly for the services provided and for the effective and economical use of

taxpayers' money. It also sets out measures to deal with possible conflicts of interest of board members;
- not misuse information gained in the course of their public service for personal gain or for political profit, nor seek to use the opportunity of public service to promote their private interests or those of connected persons or organisations; and to declare publicly and to the board any private interests that may be perceived to conflict with their public duties;
- comply with the Board's rules on the acceptance of gifts and hospitality, and of business appointments; and
- act in good faith and in the best interests of the PHA.

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

3.4.6 The sponsor Department shall have access to all Board meeting (and Governance and Audit Committee) papers and minutes.

3.5 The Chairman of the PHA

3.5.1 The Chairman is appointed as set out in paragraph 3.4.1.

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

3.5.3 The Chairman has a particular leadership responsibility on the following matters:
- formulating the Board's strategy;
- ensuring that the Board, in reaching decisions, takes proper account of guidance provided by the Minister or the sponsor Department;
- promoting the efficient, economic and effective use of staff and other resources;
- encouraging and delivering high standards of regularity and propriety;
- representing the views of the Board to the general public; and
- ensuring that the Board meets at regular intervals throughout the year and that the minutes of meetings accurately record the decisions taken and, where appropriate, the views of individual Board Members. Meetings must be open to the public, the public should be advised of meetings thought the press and the minutes must be placed on the PHA website after formal approval.

3.5.4 The Chairman shall also:
- ensure that all members of the Board, when taking up office, are fully briefed on the terms of their appointment and on their duties, rights and responsibilities, and receive appropriate induction training, including on the financial management and reporting requirements of public sector bodies and on any differences which may exist between private and public sector practice;
- advise the Department of the needs of the PHA when Board vacancies arise, with a view to ensuring a proper balance of professional and financial expertise; and
- assess the performance of individual Board Members. Board Members will be subject to ongoing performance appraisal, with a formal assessment being completed by the Chair of the Board at the end of each year. Members will be made aware that they are being appraised, the standards against which they will be appraised, and will have an opportunity to contribute to and view their report.

The Chair of the Board will also be appraised on an annual basis by the Departmental Accounting Officer.

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

3.5.5 The Chairman shall also ensure that a Code of Practice for Board Members is in place, based on the Codes of conduct for board members of public bodies (FD (DFP) 04/14 refers. The Code shall commit the Chairman and other Board Members to the Nolan "seven principles of public life", and shall include a requirement for a comprehensive and publicly available register of Board Members' interests.

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

3.6 The Chief Executive's role as Accounting Officer

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

3.6.2 The Chief Executive, as the PHA's Accounting Officer, is personally responsible for safeguarding the public funds for which he/she has charge; for ensuring propriety and regularity in the handling of those public funds; and for the day-to-day operations and management of the PHA. In addition, he/she should ensure that the PHA 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. In addition, the Chief Executive must, within three months of appointment, attend the training course 'An Introduction to Public Accountability for Accounting Officers'.

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

on planning and monitoring -

- establish, with approval of the sponsor Department, the PHA's corporate and business plans in support of the Department's wider strategic aims, the NICS Outcomes Delivery plan and current draft PfG objectives and targets;
- inform the sponsor Department of the PHA's progress in helping to achieve the Department's policy objectives and in demonstrating how resources are being used to achieve those objectives;
- ensure that timely forecasts and monitoring information on performance and finance are provided to the sponsor Department; that the sponsor Department is notified promptly if overspends or underspends are likely and that corrective action is taken.
- that any significant problems, whether financial or otherwise, and whether detected by internal audit or by other means, are notified to the sponsor Department in a timely fashion;

on PHA's corporate host responsibilities to the Safeguarding Board for Northern Ireland (the SBNI) -

- Ensure the PHA discharges and accounts for its corporate host obligations to the SBNI in accordance with the Memorandum of Understanding. The PHA acts as corporate host to the Safeguarding Board for Northern Ireland (the SBNI). It discharges functions primarily relating to the regulations made under section 1(5)(c)2 of the 2011 SBNI Act.

- The PHA is accountable to the Department for the discharge of its corporate host obligations to the SBNI but is not accountable for how the SBNI discharges its statutory objective, functions and duties.
- A copy of the Memorandum of Understanding between the Department, the PHA and the SBNI is attached at Appendix 2.

on advising the Board -

- advise the Board on the discharge of its responsibilities as set out in this document, in the founding legislation and in any other relevant instructions and guidance that may be issued from time to time by DoF or the sponsor Department;
- advise the Board on the PHA's performance compared with its aims and objectives;
- ensure that financial considerations are taken fully into account by the Board at all stages in reaching and executing its decisions, and that standard financial appraisal techniques are followed appropriately;
- take action in line with Section 3.8 of MPMNI if the Board, or its Chairman, is contemplating a course of action involving a transaction which the Chief Executive considers would infringe the requirements of propriety or regularity, or does not represent prudent or economical administration, efficiency or effectiveness;

on managing risk and resources -

- ensure that a system of risk management is maintained to inform decisions on financial and operational planning and to assist in achieving objectives and targets;
- ensure that an effective system of programme and project management and contract management is maintained;
- ensure compliance with the Northern Ireland Public Procurement Policy;
- ensure that all public funds made available to the PHA are used for the purpose intended by the Assembly, and that such monies, together with the PHA's assets, equipment and staff, are used economically, efficiently and effectively;
- ensure that adequate internal management and financial controls are maintained by the PHA, including effective measures against fraud and theft;
- maintain a comprehensive system of internal delegated authorities that are notified to all staff, together with a system for regularly reviewing compliance with these delegations;
- ensure that effective personnel management policies are maintained;

on accounting for the PHA's activities -

- sign the accounts and be responsible for ensuring that proper records are kept relating to the accounts and that the accounts are properly prepared and presented in accordance with any directions issued by the Minister, the sponsor Department, or DoF;
- sign a Statement of Accounting Officer's responsibilities, for inclusion in the annual report and accounts;
- sign a Governance Statement regarding the PHA's system of internal control, for inclusion in the annual report and accounts, that details significant internal control divergences;
- sign a mid-year assurance statement on the condition of the PHA's system of internal control;
- ensure that effective procedures for handling complaints about the PHA are established and made widely known within the PHA;
- act in accordance with the terms of this document and with the instructions and relevant guidance in *MPMNI* and other instructions and guidance issued from time to time by the sponsor Department and DoF - in particular, Chapter 3 of MPMNI and the Treasury document *Regularity and Propriety and Value for Money* (a copy

of which the Chief Executive shall receive on appointment). Section IX of the *Financial Memorandum* refers to other key guidance;

- give evidence, normally with the Accounting Officer of the sponsor Department, if summoned before the Public Accounts Committee on the use and stewardship of public funds by the PHA;
- ensure that an Equality Scheme is in place, reviewed and equality impact assessed as required by the Equality Commission and TEO;
- ensure that Lifetime Opportunities is taken into account; and
- ensure that the requirements of the Data Protection Act 2018 and the Freedom of Information Act 2000 are complied with.
- ensuring that a business continuity plan is developed and maintained;
- ensuring that effective procedures for handling adverse incidents are established and made widely known within the PHA;
- Copies of adverse inspection reports are shared with the Department
- Ensuring an acceptance and provision of Gifts and Hospitality Policy is in place that set out the principles and requirements under which gifts and hospitality can be received and in turn when such offers can be made**.**
- Ensuring that the requirements of relevant statutes, court rulings, and Departmental directions are fully complied with.

3.7 The Chief Executive's role as Consolidation Officer

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

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

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

- ensure that the PHA has in place and maintains sets of accounting records that will provide the necessary information for the consolidation process; and
- prepare the consolidation information (including the relevant accounting and disclosure requirements and all relevant consolidation adjustments) in accordance with the consolidation instructions and directions issued by DoF on the form, manner and timetable for the delivery of such information.

3.8 Delegation of duties

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

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

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

3.10 Consulting customers

3.10.1The PHA will work in partnership with its stakeholders and customers to deliver the services/programmes, for which it has responsibility, to agreed standards. It will consult

regularly to develop a clear understanding of citizens' needs and expectations of its services, and to seek feedback from both stakeholders and customers and will work to deliver a modern, accessible service. It will follow the guidance of the Health and Social Care (Reform) Act (Northern-Ireland) 2009 (points 19 and 20) as appropriate. http://www.legislation.gov.uk/nia/2009/1/pdfs/nia_20090001_en.pdf

PLANNING, BUDGETING AND CONTROL

4.1 The corporate plan

4.1.1 Consistent with the timetable for the NI Executive's Budget process reviews, the PHA shall submit to the sponsor Department a draft of the PHA's corporate plan [normally] covering the three years ahead. The PHA shall have agreed with the sponsor Department the issues to be addressed in the plan and the timetable for its preparation.

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

4.1.3 The plan shall reflect the PHA's statutory duties and, within those duties, the priorities set from time to time by the Minister. In particular, the plan shall demonstrate how the PHA contributes to the achievement of the Department's strategic aims, the NICS Outcomes Delivery Plan and current draft PfG objectives and targets.

4.1.4 The corporate plan shall set out:

- the PHA's key objectives and associated key performance targets for the forward years, and its strategy for achieving those objectives;
- a review of the PHA's performance in the preceding financial years and an estimate of performance in the current year;
- alternative scenarios to take account of factors which may significantly affect the execution of the plan, but which cannot be accurately forecast;
- a forecast of expenditure and income, taking account of guidance on resource assumptions and policies provided by the sponsor Department at the beginning of the planning round. These forecasts should represent the PHA's best estimate of all its available income not just any grant or grant-in-aid; and
- other matters as agreed between the sponsor Department and the PHA – for example - statement of purpose of organisation as per legislation, strategic aims, performance in preceding corporate plan period, governance and accountability arrangements, links with the NICS Outcomes Delivery Plan, draft PfG and wider ministerial/Departmental priorities.

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

4.2 The business plan

4.2.1 Each year of the corporate plan, amplified as necessary, shall inform the basis of the business plan for the relevant forthcoming year. The business plan shall include key targets and milestones for the year immediately ahead and shall be linked to budgeting information so that resources allocated to achieve specific objectives can readily be identified by the sponsor Department.

4.2.2 The business plan should include reference to SMART objectives that:

- support the delivery of the NICS Outcomes Delivery Plan and the current draft PfG Commitments;
- support the delivery of Departmental policy and strategy

- deliver on the functions etc. specified in the PHAs founding legislation setting out the purposes for which the PHA was created and the functions/services it is to deliver
- address known areas of underperformance, the findings of inquiries etc. and respond to particular events, serious adverse incidents and near misses.
- References to staff – training, development etc.

4.2.3 **DoF reserves the right to ask to see and agree the PHA's annual business plan.**

4.2.4 Corporate and business plans will be formally approved by the Permanent Secretary.

4.3 Publication of plans

4.3.1 The corporate and business plans shall be published and made available on the Internet.

4.4 Reporting performance to the sponsor Department

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

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

4.4.3 The PHA's performance in helping to deliver Departmental policies, including the achievement of key objectives, shall be reported to the Department on a regular basis. Performance will be formally reviewed twice yearly by the Permanent Secretary and other officials of the sponsor Department. The Minister shall meet the Board as appropriate to discuss the PHA's performance, its current and future activities, and any policy developments relevant to those activities.

4.4.4 The Department may, at its discretion, request evidence of progress against key objectives at any time. Senior Departmental officials will hold two Ground Clearing Sponsor Review Meeting(s) (SRM) with the PHA, and one non-Ground Clearing SRM per year. The purpose of these meetings is to discuss the PHA's overall performance, its current and future activities, any policy developments relevant to those activities safety and quality, financial performance and corporate control/risk management performance, and other issues as prescribed by the Department.

4.4.5 Issues identified at the Ground Clearing meeting which cannot be resolved at the meeting or through other avenues will be escalated for discussion to the Accounting Officer Accountability meeting with the Chair and Chief Executive of the PHA.

4.4.6 The PHA's performance against key targets shall be reported in the PHA's annual report and accounts (see Section 5.1 below).

4.5 **Budgeting procedures**

4.5.1 The PHA's budgeting procedures are set out in the *Financial Memorandum*.

4.6 Internal audit

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

4.6.2 The Department should outline the arrangements that they have determined as appropriate for the PHA taking account of DAO (DFP) 01/10 Internal Audit Arrangements between Departments and Arm's Length Bodies.) This will include specifying the Department's requirements in terms of

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

4.6.3 The PHA shall consult the sponsor Department to ensure that the latter is satisfied with the competence and qualifications of the Head of Internal Audit and that the requirements for approving the appointment are in accordance with PSIAS and relevant DoF guidance.

4.6.4 The sponsor Department will review the PHA's terms of reference for internal audit service provision. The PHA shall notify the sponsor Department of any subsequent changes to internal audit's terms of reference. The Sponsor branch will have an annual meeting with the PHA's internal audit to discuss the PHA's audit plan and strategy.

4.7 Audit Committee

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

4.7.2 The audit committee's meeting agendas, minutes and papers shall be forwarded as soon as possible to the sponsoring team.

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

4.7.4 The sponsor Department will review the PHA's audit committee terms of reference. The PHA shall notify the sponsor Department of any subsequent changes to the audit committee's terms of reference. The sponsor Department will attend at least one PHA audit committee meeting per year as an observer, and will not participate in any Audit Committee discussion.

4.8 Fraud

4.8.1 The PHA shall report immediately to the Counter Fraud and Probity Services (CFPS) within the BSO all frauds (proven or suspected), including attempted fraud. CFPS shall then report the frauds immediately to DoF and the C&AG. In addition the PHA shall forward to CFPS the annual fraud return, commissioned by DoF, on fraud and theft suffered by the PHA

4.8.2 All HSC bodies are required to have an Anti-Fraud Policy and Fraud Response Plan in place. This should be reviewed at least every 5 years and sent to CFPS for review. The PHA shall notify the sponsor Department of any subsequent changes to the policy or response plan.

4.9 Additional Departmental access to the PHA

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

5. EXTERNAL ACCOUNTABILITY

5.1 The annual report and accounts

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

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

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

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

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

5.2 External audit

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

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

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

5.3 VFM examinations

5.3.1 The C&AG may carry out examinations into the economy, efficiency and effectiveness with which the PHA has used its resources in discharging its functions. For the purpose of these examinations the C&AG has statutory access to documents as provided for under Articles 3 and 4 of the Audit and Accountability (Northern Ireland) Order 2003.

Where making payment of a grant, or drawing up a contract, the PHA should ensure that it includes a clause which makes the grant or contract conditional upon the recipient or contractor providing access to the C&AG in relation to documents relevant to the transaction. Where subcontractors are likely to be involved, it should also be made clear that the requirements extend to them.

6. STAFF MANAGEMENT

6.1 General

6.1.1 The decision to fill vacant or new senior positions in PHAs (at Director or Assistant Director level) is subject to approval by the Department, except where there are exceptional circumstances which have been agreed by the Department in advance.

6.1.2 Approvals for any change to the remuneration of Senior Executives must be obtained from the Department. This position will be kept under review by the Department.

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

- its rules for the recruitment and management of staff create an inclusive culture in which diversity is fully valued; where appointment and advancement is based on merit; and where there is no discrimination on grounds of gender, marital status, domestic circumstances, sexual orientation, race, colour, ethnic or national origin, religion, disability, community background or age;
- the level and structure of its staffing, including grading and numbers of staff, are appropriate to its functions and the requirements of efficiency, effectiveness and economy;
- the performance of its staff at all levels is satisfactorily appraised and the PHA's performance measurement systems are reviewed from time to time;
- its staff are encouraged to acquire the appropriate professional, management and other expertise necessary to achieve the PHA's objectives;
- proper consultation with staff takes place on key issues affecting them;
- adequate grievance and disciplinary procedures are in place;
- whistle blowing procedures consistent with the Public Interest (Northern Ireland) Order 2003 are in place; and

6.1.4 A code of conduct for staff is in place based on Annex 5A of Public Bodies: A Guide for Northern Ireland Departments (available at www.afmdni.gov.uk).

7. REVIEWING

7.1 The PHA shall be reviewed periodically, in accordance with the business needs of the sponsor Department and the PHA. Reference should be made to Chapter 9 of the Public Bodies: a Guide for Northern Ireland Departments.

7.2 The next review of the PHA will take place at a time determined by the Department.

SIGNED ON BEHALF OF THE DEPARTMENT OF HEALTH

RICHARD PENGELLY
PERMANENT SECRETARY

DATE: 11 September 2018

SIGNED ON BEHALF OF THE PUBLIC HEALTH AGENCY

VALERIE WATTS
CHIEF EXECUTIVE (INTERIM)

DATE: 10 October 2018

Documentary requirements **Appendix 1**

1.1 Documentation to be sent to the Sponsor Branch for information

Monthly (or as the occasion arises)

- Board meeting papers (including draft minutes) for each meeting as and when issued to Board members
- Audit Committee papers (including draft minutes) for each meeting as and when issued to Committee members
- Monthly financial monitoring returns to Finance Directorate in the Department
- Last MS noted – Assurance Committee papers (including draft minutes) for each meeting as and when issued to Committee members

Annually

- Register of Board members' interests.
- The annual report, with the draft submitted to the Department two weeks before the publications date (separate timetable for the annual accounts, Governance Statement etc. set by Finance Directorate).
- The Assurance Framework (annually)

Once and then when revised

- Code of Conduct for Board members
- Code of Practice for staff
- Audit Committee Terms of Reference
- Audit Strategy
- Assurance / Governance Committee Terms of Reference
- Complaints procedure
- Anti-Fraud Policy
- Fraud Response Plan
- Whistle-blowing procedures
- Grievance and Disciplinary procedures
- Equality scheme
- Publication scheme
- Consultation Scheme
- Business Continuity Plan

1.2 Documentation to be sent to the Sponsor Branch for consideration / comment / approval

Quarterly

- Report on quarterly assessment of progress being made in the delivery of the Commissioning Plan's aims and objectives.

Bi-annual

- Corporate Risk Register every six months

Annually

- Annual Governance Statement
- Mid-year Assurance Statement (by end-October)
- Annual Internal Audit work-plan
- Internal Audit Progress Report
- Annual Fraud return
- Corporate Plan (including the Business Plan) must be produced and approved by the Department.
- An annual Commissioning Plan established by the HSCB but approved by the PHA
- The Head of Internal Audit's end-of-year and mid-year opinion on risk management, control and governance

As specified

- Corporate Plan for approval

Once

- Adverse inspection reports by external bodies (e.g. RQIA, MHRA), as specified in directions
- Internal Audit reports with less than satisfactory assurance
- Reports to Those Charged with Governance

Appendix 2

Currently being reviewed – July 2018

MEMORANDUM OF UNDERSTANDING

BETWEEN

DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

PUBLIC HEALTH AGENCY

AND

SAFEGUARDING BOARD FOR NI

11 September 2012

CONTENTS

INTRODUCTION

1. This Memorandum of Understanding (MoU) is a tri-lateral agreement between the Department of Health, Social Services and Public Safety (the Department), Regional Agency for Public Health and Social Well-being (hereafter referred to as the Public Health Agency (PHA)) and the Safeguarding Board for Northern Ireland (SBNI). The SBNI was established under the Safeguarding Board (NI) Act 2011 as an unincorporated statutory body. It is sponsored by the Department.

2. The SBNI is a multi-disciplinary interagency body and its objective is to coordinate and ensure the effectiveness of what is done by its members to safeguard and promote the welfare of children in Northern Ireland. The SBNI will have a range of functions which it must undertake including:

i. developing policies and procedures for safeguarding and promoting the welfare of children in Northern Ireland;
ii. promoting an awareness of the need to safeguard and promote the welfare of children;
iii. keeping under review the effectiveness of what is done by members to safeguard and promote the welfare of children;
iv. undertaking case management reviews without discretion in such circumstances as may be prescribed;
v. reviewing such information as may be prescribed in relation to deaths of children in NI;
vi. advising the Regional Health and Social Care Board and Local Commissioning Groups in relation to safeguarding and promoting the welfare of children:
i) as soon as reasonably practicable after receipt of a request for advice; and
ii) on such other occasions as the Safeguarding Board thinks appropriate.
vii. promote communication between the Board and children and young persons; and
viii. making arrangements for consultation and discussion in relation to safeguarding and promoting the welfare of children

3. The PHA was established under section 12(1) of the Health and Social Care (Reform) Act (Northern Ireland) 2009 and is an Arms Length Body (ALB) of the Department of Health, Social Services and Public Safety (DHSSPS). It delivers a range of health functions including:

1. health and social wellbeing improvement;

- health protection;
- public health support to commissioning and policy development; and
- HSC research and development.

4. Chapter 7 of Managing Public Money Northern Ireland (MPMNI)**1** considers the working partnerships that public sector organisations may establish in order to deliver their objectives more effectively than they could acting alone.

5. It is also acknowledged in MPMNI that "*there are many different kinds of partnership. Each involves some tension between autonomy and accountability with scope for conflict if the terms of engagement are not resolved openly at the outset. Each partnership requires its own customised terms to work effectively. One size does not fit all'* This MoU describes the nature of the relationship between the Department, the PHA and the SBNI.
6. The PHA will act as corporate host to the SBNI discharging functions primarily relating to regulations made under section 1(5)(c)**2** of the 2011 SBNI Act. The relationship between

[1] Managing Public Money Northern Ireland sets out the main principles for dealing with resources used by public sector organisations in Northern Ireland (NI). http://www.ceforum.org/upload2/MPMNI_July08

the PHA and Department and the framework within which PHA operates as an ALB of the Department is specified in the Management Statement and Financial Memorandum (MSFM) in place between these bodies. The MSFM makes reference to the PHA's corporate host responsibilities to the SBNI, acknowledging that the PHA is accountable to the Department for the discharge of its corporate host obligations to SBNI but is not accountable for how the SBNI discharges its statutory objective, functions and duties.

7. This MoU does not affect existing statutory functions nor amend any other policies or agreements relating to the activities of the PHA or SBNI. It is not a legally binding document nor a contract between partners, nor is it intended to cover every aspect of the relationship between the three organisations. Each signatory agrees to work together within the framework outlined in this MoU.

8. It is acknowledged that the SBNI and its objective and functions of safeguarding and promoting the welfare of children in Northern Ireland are entirely separate from that of the PHA. However, in light of its small size, it has been agreed that the PHA, will support the SBNI by securing HR, financial and other support services for the Board. The PHA does not have its own in-house HR, IT, Equality and Finance functions and these are secured by it from BSO and HSCB through a Service Level Agreement. The arrangement of PHA acting as corporate host for SBNI will allow it to take advantage of the relationship PHA has with BSO and HSCB and therefore minimise the administrative apparatus necessary to support the SBNI.

PURPOSE

9. This MoU specifies the roles, responsibilities and obligations of the Department, PHA and the SBNI necessary to facilitate the arrangement whereby the PHA acts as host to the SBNI. As the corporate host, PHA will either provide or secure the necessary corporate governance structures, accommodation, financial management, IT, HR, Legal and Equality services, necessary to meet the staffing, accommodation and expenses needs of the SBNI. This will enable the SBNI to effectively function within the resources made available to it by the Department.

10. Within the SBNI financial allocation, provision will be made to cover the costs of the above services. PHA, as corporate host, will be consulted in advance of any proposed change to SBNI requirements and the SBNI will secure from the Department such approvals and additional resources as may be necessary to implement these requirements.

11. This MoU will be subject to review after one year and three years thereafter. In the early stages of the operation of the MOU, there may be initial issues requiring resolution. Any issues arising at any stage from the operation of the MoU, will be brought to the Department's attention by the SBNI or PHA, as soon as practicable.

ASSURANCE AND ACCOUNTABILITY ARRANGEMENTS

12. The PHA's responsibilities in respect of the SBNI governance functions are defined in the PHA's Management Statement and Financial Memorandum which clearly states that the PHA is accountable to the Department for the discharge of its corporate host obligations to SBNI but is **not** accountable for how the SBNI discharges its statutory objective, functions and duties. As an unincorporated statutory body, the SBNI will **not** have a separate MSFM. However, a copy of this MoU will be appended to the MSFM of the PHA

[2] Section 1(5) of the Safeguarding Board (NI) Act 2011 states "Regulations may make provision as to – (c) the staff, premises, and expenses of the Safeguarding Board (including provision as to which person or body provides the staff, premises or expenses)

and these arrangements should be reflected in any future update to the Department's Framework Document.

13. The Department must exercise oversight of the SBNI on an ongoing basis throughout the year. SBNI must provide regular performance reports and documentation demonstrating progress against Departmental priorities and assurance as to the ongoing effectiveness of their systems on internal control.

14. This will include twice yearly Department Accounting Officer sponsored assurance and accountability meetings between the Department and the SBNI Chair which will be timed and conducted in line with the arrangements for the equivalent meetings with DHSSPS sponsored Arms Length Bodies (ALBs).

15. PHA officers will not attend the SBNI twice yearly Department Accounting Officer sponsored assurance and accountability meetings. The SBNI Chair and Director of Operations may be asked by the Department to attend PHA twice yearly Department Accounting Officer sponsored assurance and accountability meetings if there are particular issues relating to corporate host functions which require discussion.

16. On an ongoing basis and at Department Accounting Officer sponsored accountability meetings, the Department will ask the PHA and the SBNI to account for risk management arrangements as they relate to the SBNI. The PHA will account for risks relating to its corporate host functions; the SBNI will account for any risks associated with its statutory objective, functions and duties directly to the Department.

17. If requested, the SBNI Chair and/or Director of Operations will attend meetings of the PHA Governance and Audit Committee in relation to corporate and resource governance matters. Matters relating to quality and performance against SBNI objectives will be handled through the Department's sponsorship arrangements with the SBNI and will be subject to the usual governance and assurance arrangements within the Department.

Assurance Framework

18. The SBNI is required to establish its own Internal Assurance Framework which should be broadly based on the arrangements set out in the DHSSPS Framework: A Practical Guide for Boards of DHSSPS Arms Length Bodies document (March 2009). The Framework will be reviewed every two years and should be shared in draft form with the PHA Governance and Audit Committee on an annual basis for their comment and approval for those elements relating to the corporate host functions.

Declaration of Assurance to Department

19. At the end of each year and mid-year the SBNI will provide Declarations of Assurance. A template for the Declaration of Assurance to the Department is attached at **Annex 1**. Twice yearly, a Declaration of Assurance will be provided to:
    - the PHA in relation to those matters which relate to the PHA's corporate host function, which will inform the PHA mid-year assurance statement and Statement of Internal Control **(**SIC); and
    - the Department in relation to performance against the SBNI's statutory objective, functions and duties and any risks associated with them.

Risk Register

20. The SBNI will put in place its own Risk Register. An updated risk register will be submitted by the SBNI to the Department, and for consideration, to the PHA Governance and Audit committee every six months, in respect of those areas relevant to the PHA as corporate host.

Business Continuity Plan

21. The SBNI will put in place its own Business Continuity arrangements, which will be developed and tested as part of PHA Business continuity planning.

Controls Assurance Standards

22. The relevance of specific Controls Assurance Standards (CAS) should be agreed between PHA, SBNI and the Department. The SBNI will comply with specified criteria within the relevant CAS.

Internal Audit

23. SBNI will be included within the PHA annual Internal Audit work plan. In keeping with established PHA procedures, SBNI audit reports will be brought to the PHA Governance and Audit Committee, for consideration of those areas where the SBNI provides assurance to the PHA. The SBNI shall provide a written declaration to the PHA that it has submitted final audit reports to the Department including management responses to any weaknesses found. The Department may wish to have separate audit arrangements for those areas for which the SBNI provides assurance directly to the Department.

Information Management

24. The SBNI will designate suitable members of its staff as Data Guardian, Senior Information Risk Owner (SIRO), and Information Asset Officer (IAO) who will be responsible for ensuring that information risk is managed appropriately and for providing assurances to the SBNI Chair.

25. The SBNI will be responsible for handling its own Freedom of Information requests.

Complaints Handling

26. The SBNI will put in place adequate arrangements for the handling of complaints against it relating to the discharge of its statutory objective, functions and duties. The PHA will not be liable in any way for the handling of such complaints against the SBNI. However, the PHA will work in partnership with the SBNI on complaints that are relevant to corporate hosting matters.

27. The Chair of the SBNI will inform the Permanent Secretary of the Department of any complaints about the SBNI accepted by the Ombudsman for investigation, and about the SBNI's proposed response to any subsequent recommendations from the Ombudsman.

28. The Chair of the SBNI will inform the Chief Executive of the PHA of any matters affecting employees of the PHA acting as officers of the SBNI.

Alerts

29. The SBNI must alert the Department in a timely manner of any action or risk which would adversely impact on the delivery of the SBNI's functions or reputation or that of the Department. The SBNI must alert the PHA in a timely manner of any action or risk which would adversely impact on the PHA. The PHA must alert the Chair of the SBNI and the Department in a timely manner of any material action or risk which would adversely impact on the SBNI. The PHA must alert the Department in a timely manner of any action or risk arising from these hosting arrangements which would adversely impact on the delivery of the PHA functions or reputation or that of the Department.

FINANCIAL MANAGEMENT

30. As an unincorporated statutory body, the SBNI is unable to hold its own funds. The PHA will receive an agreed financial allocation, including funding for Salaries and Wages, Goods and Services, SBNI accommodation costs and legal services, representing the full running costs of the SBNI.

31. Responsibility for the proper management of public funds allocated to SBNI falls to the CEO of the PHA, who will hold accounting officer responsibilities in respect of the SBNI's stewardship of public funds as set out in MPMNI. Normally accountability also extends to how an organisation performs against objectives. However, this will be a matter for the Chair of the SBNI who will account directly to the Department's Accounting Officer in relation to the delivery of the SBNI statutory objective, functions and duties. This will be set out in the revised Accounting officer letter to the CEO of the PHA.

32. On behalf of the SBNI and in line with his/her responsibilities, the Chief Executive of PHA, as Accounting Officer, will be expected to ensure effective financial arrangements are in place and effective financial services are secured from HSCB/BSO for the proper management of the SBNI budget.

33. Details of the SBNI's expenditure will be included within the PHA Annual Accounts.

34. The PHA will not use funds allocated for the SBNI for any other purpose. Any request for additional resources by SBNI or in respect of SBNI must be referred to the sponsor branch in the Department. The PHA Accounting Officer should be advised of all requests and approvals of additional resources and expenditure, as he/she will be held accountable for this expenditure.

35. It is the responsibility of the SBNI to ensure that it complies with PHA Standing Orders (where they relate to corporate host functions including finance), Standing Financial Instructions and all other financial policies and procedures of the PHA.

36. SBNI assurance on these matters, including the arrangements for ensuring the financial stability (including financial risks) of the SBNI, for ensuring value for money and that resources allocated by the Minister/Department are deployed fully in achievement of agreed outcomes will be provided by the SBNI to the PHA in its Declarations of Assurance.

PERFORMANCE AGAINST OBJECTIVES

37. The SBNI will be required to submit to the Department a draft 3-year strategic plan. The plan will reflect the SBNI priorities, strategic aims and objectives. It will set out how the SBNI will deliver on its statutory objective, functions and statutory duties. The plan will be subject to Departmental approval and will be supported by an annual Business Plan.

38. The Business Plan will include key actions, supported by performance targets and indicators, to be undertaken in the year ahead and will include budget information.

39. PHA, as corporate host for the SBNI, has no responsibility for the development of the SBNI Strategic and Business Plans, their review or approval. However as a core member of the SBNI, the PHA will contribute fully to the development of the SBNI's Strategic and Business Plans.

40. Prior to the approval of the SBNI Strategic and Business Plans the Department will consult the Chief Executive of the PHA in respect of any financial issues relevant to his/her role as PHA Accounting Officer.

LEGAL SERVICES

41. The Departmental Solicitors Office will provide legal services for matters relating to the SBNI's statutory objective, functions and duties. PHA will secure legal services from the Directorate of Legal Services for those matters for which PHA has responsibility in its SBNI corporate hosting role.

ASSETS AND ESTATE MANAGEMENT

42. The PHA will provide agreed office accommodation for SBNI staff. The proportionate costs of this accommodation will be met by SBNI. The PHA will provide standard office equipment. Costs of equipment, telephone line rental and telephone calls will be borne by SBNI. Access to PHA switchboard services will be provided free of charge.

43. The SBNI is accommodated within the premises of the PHA. The SBNI will comply with Departmental requirements placed on the PHA in relation to its usage of PHA leased premises. The SBNI will comply with specified criteria, set out in the Buildings, Land, Plant and Non Medical Equipment Controls Assurance Standard, as agreed with the PHA.

HUMAN RESOURCES

44. With the exception of the Chair and lay persons, who are publicly appointed by the Department, the employer of SBNI staff is the Public Health Agency. The Department has determined that all SBNI posts will be subject to the approval of the Department. The level and structure of SBNI staffing agreed with the Department should not be utilised elsewhere in PHA without formal agreement with the Department. Where the SBNI require additional support from PHA staff it will agree and make such financial provision as may be necessary for this.

45. The PHA will have responsibility for securing HSC payment arrangements for SBNI staff salaries and related costs. Staff costs and any associated processing costs will be borne by the SBNI.

Management of SBNI Staff

46. SBNI staff, as employees of the PHA, will be subject to the same policies and procedures as other PHA staff. The SBNI and its staff must comply with the HR policies and procedures set down by PHA including those relating to complaints, grievances, discipline and whistle blowing The Chair of the SBNI will advise the PHA Chief Executive or his/her nominated officer, of any issues emerging in relation to SBNI staff and their adherence to PHA policies and procedures. Individual incidents/breaches of these policies and procedures will be managed by the SBNI in the first instance, in keeping with normal HSC good practice, PHA guidance and escalation arrangements.

Staff Appraisal

47. Annual appraisal of SBNI staff will be conducted by the SBNI, against SBNI business and personal staff objectives and in line with the HSC Performance Appraisal processes operated by the PHA. The Chief Executive of the PHA will countersign the SBNI Chair's annual appraisal of the Director of Operations. Appraisal of the performance of the Chair and lay members will be conducted in line with established Public Appointment's arrangements.

Staff Training and Development

48. The SBNI is responsible for securing the provision of training and development of its staff in relation to SBNI functions and for making funds available for this purpose as approved by the Department. The SBNI will work with PHA to negotiate and resource shared training and development provision.

Recruitment of Staff

49. The PHA will secure the timely recruitment of agreed SBNI staff posts through the BSO HR service and the costs of recruitment will be borne by the SBNI.

PRESENTATIONAL ISSUES

Communication and Liaison Arrangements

50. Good communication is essential for effective working. PHA and SBNI agree to keep each other promptly and regularly informed about any work being undertaken or issues arising which may impact on the other, or in which the other organisation has an interest. Both parties must keep the Department informed about any matter which is likely to be of interest to the Department or the Minister.

51. Regular meetings will be held between the Chief Executive of the PHA and the Chair of the SBNI. Any disagreements which may arise between the PHA and the SBNI will normally be resolved amicably at the working level. If this is not possible, senior management at either organisation should seek to settle any issue. Failure to resolve disputes at this level should be referred to the Department.

Media Handling and Support

52. Day to day support for the SBNI in relation to media handling/communications will be provided by PHA. There may be occasions where conflicts of interest arise, when it is more appropriate for the SBNI to go directly to the Department for support.

Web site

53. The SBNI will commission the development of a website from the PHA. The development, ongoing maintenance and support costs will be borne by SBNI.

OTHER MATTERS

Indemnity

54. The SBNI Chair and the members of the Safeguarding Board (SBNI) will be indemnified by the Department while they are engaged in SBNI business, provided they have acted honestly and in good faith, and have not acted recklessly. This means that the Department will indemnify the Chair and the members of the SBNI in relation to any legal costs and damages which may be awarded against him or the other members of the SBNI, in connection with the conduct of SBNI business.

Conflicts of Interest

55. If any conflicts of interest should arise for the Chief Executive of the PHA in his role as Accounting Officer for the PHA and the SBNI, the matter should be referred to the Department for resolution.

AGREEMENT AND REVIEW OF THE MEMORANDUM OF UNDERSTANDING

56. This Memorandum will be reviewed after one year and three years thereafter. It will also be amended if necessary, following any relevant changes to the policies, procedures and structures of the parties concerned.

Agreement to this Memorandum of Understanding is given by signature of the following:

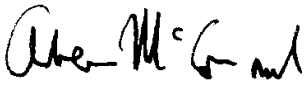
On behalf of PHA

…….. **Mr Eddie Rooney**
Chief Executive

On behalf of SBNI

…… **Mr Hugh Connor**
SBNI Chair

Endorsement on behalf of the Department of Health, Social Services and Public Safety



…… **Mr Andrew McCormick**
Permanent Secretary

This Memorandum of Understanding will be effective from 17 September 2012 and subject to review by 17 September 2013.

Annex 1

TEMPLATE - SBNI Declaration of Assurance to the Department

This statement concerns the condition of the system of internal control in the Safeguarding Board NI as at DD/ MMM /YYYY

The purpose of this assurance statement is to attest to the effectiveness of the system of internal control. In accordance with Departmental guidance, I do this under the following headings.

1. **Governance**

   A system of governance which encompasses effective corporate control arrangements is in operation e.g. corporate and business planning arrangements; risk management and internal controls; and monitoring and assurance thereon.

   A Declaration of assurance (see attached) has been provided to the PHA to inform their mid-year assurance statement or SIC.

2. **Significant Internal Control Problems** –

   [Insert details of significant internal control problems not otherwise covered e.g. description of the issue that has arisen and its (potential) impact on services, service-users, stakeholders etc, and a summary of the action taken or proposed to address the issue]

3. **Assurance Framework**

   I can confirm that an Assurance Framework, which operates to maintain, and help provide reasonable assurance of the effectiveness of controls, has been approved and is reviewed by the SBNI. Minutes of board meetings are available to further attest to this.

4. **Risk Register**

   I confirm that the Corporate Risk Register has been regularly reviewed by organisation and that risk management systems/processes are in place throughout the organisation. As part of the system of risk management, the Register is presented to the Department, and for consideration, to the PHA *Governance Audit* Committee, every six months – most recently on *[dd.mm.yy]*.

5. **Performance against Departmental Objectives**

   I confirm satisfactory progress towards the achievement of the objectives and targets set by the Department [*with the following exceptions:-*]

6. **External and Internal Audit reports (if relevant)**

   I confirm implementation of the accepted recommendations made by internal or external audit**,** with the following exception:

Signed
SBNI Chair

Tab B

FINANCIAL MEMORANDUM

BETWEEN

THE DEPARTMENT OF HEALTH

AND

THE PUBLIC HEALTH AGENCY

Agreement of Terms

This Financial Memorandum sets out the strategic control framework within which the Public Health Agency (PHA) is required to operate, including the conditions under which Government funds are provided as detailed in Managing Public Money Northern Ireland (MPMNI). It aims to achieve prudent and effective management of resources by the PHA, combined with a reasonable degree of day-to-day freedom for the PHA to manage its operations.

The Memorandum has been drawn up by the Department of Health (DoH), in consultation with the PHA, which agrees to conduct its finances within the conditions contained therein. The contents of the Memorandum have been approved by the Department of Finance (DoF). It will remain in force and binding on the PHA until such time as it is reviewed and/or revised by the Department of Health.

SIGNED ON BEHALF OF THE DEPARTMENT OF HEALTH

PERMANENT SECRETARY
DATE: 11 September 2018

SIGNED ON BEHALF OF THE PHA

CHIEF EXECUTIVE
DATE: 10 October 2018

1. INTRODUCTION

1.1. This Financial Memorandum sets out certain aspects of the financial framework within which the PHA is required to operate.

1.2. The terms and conditions set out in the combined Management Statement and Financial Memorandum (MSFM) may be supplemented by guidelines or directions issued by the Department/ Minister in respect of the exercise of any individual functions, powers or duties of the PHA.

1.3. The PHA should follow the standards, rules, guidance and advice in MPMNI and satisfy the conditions and requirements set out in the combined MSFM document, together with such other conditions as the Department/Minister may from time to time impose.

2. INCOME AND EXPENDITURE- GENERAL

2.1. **The Departmental Expenditure Limit (DEL)**

2.1.1. The PHA's current and capital expenditure form part of the Department's Resource DEL and Capital DEL respectively.

2.2. **Expenditure not proposed in the budget / Delegated Limits**

2.2.1. The PHA must not enter into any commitments or incur expenditure above pre-defined limits as set out in the delegated arrangements or which incur expenditure which is not provided for in the annual budget as approved by the Department. This reflects the general principles set out in MPMNI relating to the authority for expenditure, regularity, propriety and value for money which applies to all public expenditure.

2.2.2. The PHA shall not, without prior Departmental approval, enter into any undertaking to incur any expenditure outside its remit or which may be likely to bring either the PHA or the Department into disrepute.

2.3. **Novel, Contentious or Repercussive Proposals**

2.3.1. The PHA must obtain the approval of the Department of Health and the Department of Finance for any transactions which set precedents, are novel, potentially contentious or could cause repercussions elsewhere in the public sector. DoH and DoF approval must be obtained even where such transactions are within the PHA's delegated limits which appear to offer value for money. Examples include:

a. incurring expenditure for any purpose which is or might be considered novel or contentious, or which has or could have significant future cost implications, including staff benefits;
b. making any significant changes in the operation of funding of initiatives or particular schemes previously approved by the Department;
c. unusual financing transactions, especially those with lasting commitments; and
d. making any change of policy or practice which has wider financial implications (e.g. because it might prove repercussive among other public sector bodies) or which might significantly affect the future level of the resources required. The Department will advise on what constitutes 'significant' in this context.

2.3.2. The PHA must identify any factors that might set precedents or make expenditure novel, contentious or repercussive to the Department when submitting such proposals

for approval, whether capital, IT, Direct Award Contracts (DAC), consultancy, gifting etc. and irrespective of any existing delegations.

2.4. **Procurement**

2.4.1. The PHA's procurement policies shall reflect the public procurement policy adopted by the Northern Ireland Executive in May 2002 (refreshed May 2009); Procurement Guidance Notes and any other guidelines or guidance issued by DoH, Central Procurement Directorate (CPD) and the Procurement Board. The PHA shall also ensure that it complies with any relevant UK and EU or other international procurement rules.

2.4.2. In particular, the PHA shall reflect in its policies DoH and DoF Guidance on procurement which addresses the appropriate market testing and evidence retention that should take place for all levels of purchase, irrespective of value, as small expenditures may not require CoPE involvement, but nonetheless require a form of market testing.

2.4.3. Periodically and wherever practicable, the PHA's procurement policies shall be benchmarked against best practice elsewhere.

2.4.4. The PHA's procurement activity should be carried out by means of a Service Level Agreement (SLA) with a recognised and approved Centre of Procurement Expertise (CoPE). The relevant CoPEs are: the Business Services Organisation – Procurement and Logistics Service (BSO PaLS) for Goods and Services and Central Procurement Directorate – Health Projects (CPD HP) for Construction Works/Services. If another CoPE or equivalent is to be used for a specific project, this should be consented to in advance by either BSO PaLS or CPD HP depending on the subject matter.

2.4.5. The Accounting Officer may decide on the level of internal delegation required for approval of purchases subject to delegated limits set by DoH or DoF guidance, and subject to any additional SLA requirements regarding, or formal guidance on, lowest acceptable delegations given by the relevant CoPE.

2.4.6. Delegations for the approval of purchases should be formally recorded within the organisation's scheme of delegation.

2.5. **Competition**

2.5.1. Competition promotes economy, efficiency and effectiveness in public expenditure. Works, goods and services should be acquired through public competition unless there are convincing reasons to the contrary, and where appropriate should comply with EU and domestic advertising rules and policy. The form of competition chosen should be appropriate to the value and complexity of the goods or services to be acquired.

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

2.5.3. Where a contract is awarded to an economic operator (i.e. supplier, contractor) without competition, this is referred to as a Direct Award Contract (DAC). In light of their exceptional nature, all DACs should be dealt with in accordance with the advice requirements and delegations set out in DoH and DoF guidance and in accordance with the SLA or any formal general guidance on direct awards given by the relevant CoPE (in addition to complying with any other applicable delegations not arising as a result of DAC status e.g. capital or IT delegations).

2.5.4. The PHA shall send to the Department on a bi-annual basis (or on such other basis as shall be required by DoH) a report of contracts above the current de minimis limit for procurement expenditure in which competitive tendering was not employed.

2.6. **Best Value for money**

2.6.1. Procurement of work, supplies and services by the PHA shall be based on best value for money. This is defined as the most advantageous combination of costs, quality and sustainability to meet customer and PHA requirements. In this context, cost means consideration of the whole life cost; quality means meeting a specification which is fit for purpose and sufficient to meet the customer's requirements; and sustainability means economic, social and environmental benefits. It is not about minimising up front prices. Whether in conventional procurement, market testing, private finance or some other form of public private partnership, finding value for money involves an appropriate allocation of risk.

2.6.2. In accordance with MPMNI/Northern Ireland Guide to Expenditure Appraisal and Evaluation (NIGEAE), where appropriate, a full options appraisal should be carried out before procurement decisions are taken.

Expenditure and Payments

2.7. **Timeliness in paying bills**

2.7.1. The PHA shall collect receipts and pay all matured and properly authorised invoices in accordance with applicable terms, MPMNI and any guidance issued by the Department/ DoF.

2.8. **Payments in advance**

2.8.1. The PHA should control its commitments and expenditure to provide value for money. Payments made in advance of the delivery of a service are not value for money and should only be made in exceptional circumstances and require the approval of DoF. There are occasions where advance payments are acceptable and examples are listed in MPMNI.

2.9. **Deferred payments**

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

2.10. **Risk Management**

2.10.1. The PHA shall ensure that it has systems in place for identifying and managing risk and that the risks it faces are dealt with in an appropriate manner, in accordance with relevant aspects of best practice in corporate governance, and shall develop a risk management strategy, in accordance with the Treasury guidance *The Management of Risk: Principles and Concepts (the Orange Book) and MPMNI*.

2.10.2. The PHA shall take proportionate and appropriate steps to assess the financial and economic standing of any organisation or other body with which it intends to enter into a contract or which it intends to give grant or grant-in-aid.

2.11. **Fraud**

2.11.1. The PHA shall adopt and implement policies and practices to safeguard itself against fraud, and ensure it has adequate controls to detect and deter fraud in accordance with MPMNI and Departmental and DoF guidance which includes DoF's *Managing the Risk of Fraud*. In line with this the PHA should develop a fraud policy statement and fraud response plan. This should be updated every 5 years and sent to Counter Fraud

and Probity Services at BSO for review. The PHA shall notify the Department of any subsequent changes to the policy or response plan.

2.11.2. The PHA should identify, and assess how it might be vulnerable to fraud (including bribery), and evaluate the possible impact and likelihood of each fraud risk. Fraud should be always considered as a risk in the risk register.

2.11.3. All cases of attempted, suspected or proven fraud shall be reported to the BSO who shall report it to DoF and the Comptroller and Auditor General (C&AG) (see section 4.8 in the Management Statement) as soon as they are discovered, irrespective of the amount involved.

2.12. **Wider markets**

2.12.1. In line with MPMNI the PHA shall seek to maximise receipts and seek out and implement wider market opportunities, provided that this is consistent with (a) the PHA's main functions and core objectives and (b) its corporate plan as agreed with the Department. All such proposals must be supported by a business case and subject to Departmental approval and DoF approval, where appropriate.

2.12.2. The PHA must ensure that services are priced fairly and competition law and the rules on state aid are considered. The PHA must not however acquire assets just for the purpose of engaging in, or extending, commercial activity. If the wider markets activity demands further investment to keep it viable, the PHA must ensure the activity is reappraised.

2.13. **State Aid**

2.13.1. Any funding favouring a particular company or sector or seen to distort competition could be subject to the EU rules and, in certain circumstances, require notification to the European Commission. Article 107(1) of the EU Treaty prohibits in principle any form of preferential government assistance – state aid - to commercial undertakings. The purpose is to prevent distortion of competition within the EU. When designing policies, the PHA should consider early whether state aids rules apply and seek advice from the Department.

2.14. **Fees and Charges**

2.14.1. Fees or charges for any services supplied by the PHA, including services provided between HSC bodies shall be determined in accordance with MPMNI and should be based on a full cost recovery basis. Where it is decided to charge less than full costs, this will require Ministerial and DoF approval and there should be an agreed plan to achieve full cost recovery within a reasonable period. If the subsidy is intended to last the decision should be documented and periodically reviewed**.**

2.14.2. All fees and charges should be disclosed in the annual accounts in line with MPMNI / FReM.

2.15. **Commercial services**

2.15.1. Charges for commercial services should be set at a commercial rate in line with market practice and reflect fair competition with private sector providers. The requirements of competition law and State Aid must be considered. Decisions to set rates at below market practice must have Ministerial and DoF approval**.**

2.16. **Shared services**

2.16.1. Active engagement should be undertaken with the BSO to continue improving, enhancing and extracting value from existing and new services with consideration to consolidating services through shared service provisioning.

2.16.2. The PHA should always use BSO in the first instance where it can provide the relevant service. Where it is not possible to avail of BSO services then Enterprise Shared Services (ESS) should be always be considered as a viable alternative and must appraised in the business case.

2.16.3. All charges should be at cost in accordance with fees and charges guidance in MPMNI.

THE PHA's INCOME

3.1. Grant-in-Aid

3.1.1. Grant-in-aid (GIA) will be paid to the PHA in regular instalments as agreed on the basis of a written application from the PHA showing evidence of need. The application shall certify that the conditions applying to the use of GIA have been observed to date and that further GIA is now required for purposes appropriate to the PHA's functions. The forecast GIA provided by the PHA and included in the Department's spring supplementary estimates cannot be exceeded.

3.1.2. Where GIA is drawn by a service provider party on behalf of the PHA, the PHA should seek assurances throughout the period about monies drawn on their behalf.

3.1.3. The PHA should have regard to the general guidance and principles enshrined in MPMNI that it should seek GIA according to need. GIA should not be drawn down in advance of need.

3.1.4. Cash balances during the year shall be held at the minimum consistent with the efficient operation of the functions of the PHA. GIA not drawn down by the end of the year shall lapse. However, where draw-down of GIA is delayed to avoid excess cash balances at year-end, the Department will make available in the next financial year (subject to approval by the Assembly of the relevant Estimates provision) any such GIA required to meet any liabilities at year end, such as creditors.

3.2. Fines and Taxes as Receipts

3.2.1. Most fines and taxes (including levies and some licences) do not provide additional DEL spending power and should be surrendered to the Department.

3.3. Receipts from sale of goods or services

3.3.1. Receipts from the sale of goods and services (including certain licences), rent of land and dividends normally provide additional spending power. If the PHA wishes to retain a receipt or utilise an increase in the level of receipts, it must gain the prior approval of the Department.

3.3.2. If there is any doubt about the correct classification of a receipt, the PHA shall consult the Department, which may consult DoF as necessary.

3.4. Interest earned

3.4.1. Interest earned on cash balances cannot necessarily be retained by the PHA without Departmental approval. Depending on the budgeting treatment of this receipt, and its impact on the PHA's cash requirement, it may lead to commensurate reduction of GIA or be required to be surrendered to the NI Consolidated Fund via the Department.

3.5. Unforecast changes in in-year income

3.5.1. If the negative DEL income realised or expected to be realised in-year is <u>less</u> than estimated, the PHA shall, unless otherwise agreed with the Department, ensure a

corresponding reduction in its gross expenditure so that the authorised provision is not exceeded. (NOTE: For example, if the PHA is allocated £100 resource DEL provision by the Department and expects to receive £10 of negative DEL income, it may plan to spend a total of £110. If income (on an accruals basis) turns out to be only £5, the PHA will need to reduce its expenditure to £105 to avoid breaching its budget. If the PHA still spends £110, the Department will need to find £5 of savings from elsewhere within its total DEL to offset this overspend).

3.5.2. If the negative DEL income realised, or expected to be realised, in the year is more than estimated, the PHA may apply to the Department to retain the excess income for specified additional expenditure within the current financial year without an offsetting reduction to GIA. The Department shall consider such applications, taking account of competing demands for resources, and will consult with DoF in relation to any significant amounts. If an application is refused, any GIA shall be commensurately reduced or the excess receipts shall be required to be surrendered to the NI Consolidated Fund via the Department.

3.6. Build-up and draw-down of deposits

3.6.1. The PHA shall comply with the rules that any DEL expenditure financed by the draw-down of deposits counts within DEL. The PHA shall maintain and manage cash balances as working balances only. These shall be held at a minimum level throughout the year. Any interest earned on overnight deposits must be returned to the Department.

3.7. Proceeds from Disposal of Assets

3.7.1. Disposals of land and buildings are dealt with in Section 6 below.

3.8. Gifts and Bequests received

3.8.1. The PHA is free to retain any gifts, bequests or similar donations subject to paragraph 3.8.2. These shall be capitalised at fair value on receipt and must be notified to the Department.

3.8.2. Before accepting a gift, bequest or similar donation, the PHA shall consider if there are any costs associated in doing so or any conflicts of interest arising. The PHA shall not accept a gift, bequest or similar donation if there are conditions attached to its acceptance that would be inconsistent with the PHA's function.

3.8.3. The PHA must keep a register detailing gifts they have received, their estimated value and what happened to them (whether they were retained, disposed of, etc). The PHA should liaise with Department as to whether the gifts received need to be noted in annual report and accounts.

3.8.4. Donations, sponsorship or contributions, e.g. from developers should also be treated as gifts and should be treated in line with guidance in Managing Public Money NI on Gifts and accounted for in accordance with FReM requirements.

3.9. Other Receipts

3.9.1. The PHA should ensure that effective control is maintained, and records kept, of receipts from other sources (e.g. provision of fire certificates, reports etc).

3.10. Borrowing

3.10.1. Normally the PHA is not permitted to borrow funds. However if doing so, under exceptional circumstances, the PHA must observe the principles in MPMNI, seeking the approval of the Department and, where appropriate DoF, to ensure it has the

necessary authority and budget cover for borrowing or the expenditure to be financed for such borrowing.

4. EXPENDITURE ON STAFF

4.1 Staff Costs

4.1.1. Subject to its delegated limits of authority, the PHA will ensure that the creation of any new/additional posts does not incur future commitments which will exceed its ability to pay for them.

4.2 Pay and Conditions of Service

4.2.1. Employees of the PHA, whether on permanent or temporary contract, will be subject to levels of remuneration, and terms and conditions of service (including Superannuation) as agreed by the Department and DoF. Current terms and conditions for employees of the PHA are set out in the NHS Terms and conditions of Service Handbook**.**

4.2.2. Annual pay increases of the PHA staff must be in accordance with the annual Finance Director (FD) letter on Pay Remit Approval Process and Guidance issued by DoF. All proposed pay awards must be approved by the PHA Remuneration Committee and Board prior to submission to the Department for approval. All proposed pay awards must have prior approval of the Department and DoF Minister before implementation.

4.2.3. Payments shall be made to Board members in respect of travelling expenses, fees or other allowances in accordance with the relevant (Payment of Allowances to Members) Determination and Direction (Northern Ireland), which the Department may from time to time amend. The PHA shall ensure that a comprehensive set of guidelines on all expenditure on travel and subsistence is in place.

4.2.4. Recruitment exercises to fill vacant or new senior positions in the PHA should proceed only where there are exceptional circumstances which have been agreed by the Permanent Secretary of the Department in advance. This position will be kept under review by the Department.

4.2.5. Any change to the remuneration of Senior Executives must have prior approval of the Permanent Secretary of the Department and the DoF Minister.

4.3. Pension Costs

4.3.1. The PHA's staff shall be eligible to join the Health and Social Care (HSC) Pension Scheme.

4.3.2. Staff may opt out of the HSC Pension Scheme provided by the PHA. However, the employer's contribution to any personal pension arrangement, including a stakeholder pension, shall be limited to the national insurance rebate level.

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

5. NON-STAFF EXPENDITURE

5.1. Economic Appraisal

5.1.1. The PHA is required to apply the principles of economic appraisal, with appropriate and proportionate effort, to all decisions and proposals concerning spending or saving public money, including European Union (EU) funds, and any other decisions or proposals that involve changes in the use of public resources. For example, appraisal must be applied irrespective of whether the relevant public expenditure or resources:

- involve capital or current spending, or both;
- are large or small;
- are above or below delegated limits.

5.1.2. All business cases must be approved internally in line with the scheme of delegation. Those Business cases above the delegated limits must be submitted for Departmental approval prior to any expenditure being committed. Business cases submitted to the Department for approval must be approved by the PHA's Board and signed off by its Accounting Officer.

5.1.3. All business cases for external consultancy, including those below delegated limits, must be submitted to the Department in advance of any expenditure. All business cases for Direct Award Contracts should be advised on by the CoPE and appropriately approved in advance of expenditure.

5.1.4. Delegations do not remove the need for appraisal or evaluation. All expenditure, including that below delegation limits, must be appraised and evaluated with effort that is proportionate to the resources involved, with due regard to the specific nature of the case. NIGEAE provides more detailed guidance on the application of appropriate and proportionate effort.

5.1.5. Business cases and appraisals should be prepared in accordance with the following guidance, using the pro forma templates or full business case as required:

- The Northern Ireland Guide to Expenditure Appraisal and Evaluation (NIGEAE);
- The HM Treasury Guide, The Green Book: Appraisal and Evaluation in Central Government;
- Departmental circulars;
- Business cases below delegated limits will be subject to an annual test drilling exercise by the Department and DoF.

5.2. Capital Expenditure

5.2.1. Subject to being above an agreed capitalisation threshold, all expenditure on the acquisition or creation of fixed assets shall be capitalised on an accruals basis in accordance with relevant accounting standards.

5.2.2. Proposals for large scale capital projects or acquisitions will normally be considered within the PHA's corporate and business planning process. Applications for approval within the corporate/business plan by the Department, and DoF if necessary, shall be supported by formal notification that the proposed project or purchase has been examined and duly authorised by the Board. Regular reports on the progress of projects shall be submitted to the Department in accordance with current instructions.

5.2.3. Approval of the corporate/business plan does not obviate the PHA's responsibility to abide by the economic appraisal process.

5.3. Capital Projects

5.3.1. The Accounting Officer or appropriate officer as notified to the Department may authorise capital or IT expenditure on discreet capital projects of up to the agreed

delegated limits. Capital or IT projects over this amount require the approval of the Department and where necessary DoF.

5.3.2. The principles of appraisal, evaluation and management apply equally to proposals supported by information communication technology (ICT) as to all other areas of public expenditure The appraisal of Information Technology (IT) projects should include the staffing and other resource implications.

5.3.3. Any novel and/or potentially contentious projects, regardless of the amount of expenditure, require the approvals of the Department and DoF.

5.3.4. Transfers of assets between government departments should generally be at full current market value; assets transferred under a transfer of functions order to implement a machinery of government change are generally made at no charge.

5.4. Transfer of Funds within Budgets

5.4.1. Unless financial provision is subject to specific Department or DoF controls (e.g. where provision is ring-fenced for specific purposes such as contractually committed projects) or delegated limits, transfers between budgets within the total capital budget, or between budgets within the total revenue budget, do not need Departmental approval. The one exception to this is that, due to HM Treasury controls, any movement into, or out, of depreciation and impairments within the resource budget will require Departmental and DoF approval. [*NOTE: Under resource budgeting rules, transfers from capital to resource budgets are not allowed*.]

5.4.2. Virement of funding from capital to resource budgets shall not be permitted without prior approval from the Department, DoF and the Executive.

5.5. Lending, Guarantees, Indemnities; Contingent Liabilities; Letters of Comfort

5.5.1. The PHA shall not, without the prior written consent of the Department (and, where necessary, DoF), lend money, charge any asset or security, give any guarantees or indemnities or letters of comfort, or incur any other contingent liability (as defined in Managing Public Money Northern Ireland), whether or not in a legally binding form.

5.6. Grants or loans by the PHA

5.6.1. Unless covered by a delegated authority, all proposals to make a loan to a third party, whether one-off or under a scheme, together with the terms and conditions under which such a loan is made, shall be subject to prior approval by the Department and, where necessary, DoF. If loans are to be made under a continuing scheme, statutory authority is likely to be required.

5.6.2. The terms and conditions of such grants or loans shall include the requirement on the recipient organisation to prepare accounts and to ensure that its books and records in relation to the grant or loan are readily available for inspection by the PHA, the Department and the Comptroller and Auditor General.

5.7. Gifts Made

5.7.1. Departmental / DoF approval is needed for all gifts above delegated limits. Those exceeding £250,000 (or subsequent updated limits) also require Estimate cover and to be notified to the Assembly. Gifts include transfers of assets or leases at below market value. Public money must not be used to provide for gifts to members of staff. This shall also apply to members of the Board. Gifts by management to staff are subject to the requirements of DAO (DoF) 05/03.

5.7.2. Gifts should be noted in the annual report and accounts in line with MPMNI and the latest FReM requirements.

5.8. Write-offs, Losses and Other Special Payments

5.8.1. Proposals for write offs losses or other special payments including ex gratia and compensation payments outside the delegated limits must have the prior approval of the Department and where necessary DoF. Furthermore it is important to consult with the Department if payments are made, irrespective of delegations, which:

- involve important questions of principle;
- raise doubts about the effectiveness of existing systems;
- contain lessons which might be of wider interest;
- might create a precedent for other departments; or
- arise because of obscure or ambiguous instructions issued centrally.

5.8.2. Losses shall not be written off until all reasonable attempts to make a recovery have been made and have proved unsuccessful and there is no feasible alternative.

5.8.3. The PHA should always pursue recovery of overpayments, irrespective of how they came to be made.

5.8.4. Special payments should only be authorised after careful appraisal of the facts and when satisfied that the best course has been identified.

5.8.5. The PHA should ensure that full, justification is provided together with the necessary legal advice where appropriate and lessons learned clearly identified.

5.8.6. Details of all losses and special payments should be recorded in a Losses and Special Payments Register, which will be available to auditors. The Register should be kept up-to-date and should show evidence of the approval by the appropriate officer as notified to the Department, for amounts below the delegated limit, and the Department, where appropriate.

5.8.7. Losses and special payments should be reported in the annual accounts in accordance with MPMNI and the latest FReM requirements.

5.9. Remedy

5.9.1. The PHA should operate a clear accessible complaints process which should respond promptly and consistently and consider whether a remedy is appropriate in line with MPMNI.

5.10. Leasing

5.10.1. Prior Departmental and DoF approval is required for all property and finance leases as delegated authority has been removed. The PHA must have DEL provision for finance leases and other transactions that are, in substance, a form of borrowing.

5.10.2. Before acquiring a new lease or continuing with an existing lease term, the PHA must, at expiry or break option dates, submit a proportionate business case at least 12 months before either the lease expiry date or landlord /tenant notice date whichever is earlier. The PHA must ensure that the lease demonstrates value for money and that this is appropriately demonstrated in the business case through analysis of options including leasing of alternative property assets and purchase.

5.10.3. Business cases must be submitted for Departmental approval in the first instance. The Department will then seek approval from DoF before expenditure is committed.

5.11. Public Private Partnerships

5.11.1. The PHA should seek opportunities to enter into public/private partnerships where this would be more affordable and offer better value for money than conventional procurement.

5.11.2. All such proposals require Departmental / DoF approval. The PHA must consult with the Department when considering any proposal to enter into such arrangements. Procurement by private finance is only considered suitable for capital projects of £50million and above, because less capital intensive projects seldom justify the relatively high procurement and management costs involved. For instance, PFI solutions are not usually considered appropriate for Information Communication Technology (ICT) projects. Private finance should only be used after the rigorous scrutiny of all alternative procurement options, where:

- the use of private finance offers better value for money for the public sector compared with other forms of procurement; and
- the public sector partner is able to predict the nature and level of its long term service requirements with a reasonable degree of certainty.

5.11.3. The PHA should ensure adherence to DoF guidance on value for money assessments of alternative procurement options.

5.11.4. The PHA should consult with the Department over the accounting and budgeting treatment for any private finance initiative. Where judgement over the level of control is difficult, the Department will consult DoF (who may need to consult with the Office of National Statistics over national accounts treatment).

5.12. Subsidiary Companies and Joint Ventures

5.12.1. The PHA shall not establish subsidiary companies or joint ventures without the express approval of the Department and DoF. In judging such proposals, the Department will have regard to its own wider strategic aims, objectives and those of the Government.

5.12.2. For public expenditure accounts purposes, any subsidiary company or joint venture controlled or owned by the PHA shall be consolidated with it in accordance with guidance in the FReM, subject to any particular treatment required by the FReM. Where the judgement over the level of control is difficult, the Department will consult DoF (who may need to consult with the Office of National Statistics over national accounts treatment). Unless specifically agreed with the Department and DoF, such subsidiary companies or joint ventures shall be subject to the controls and requirements set out in this MSFM and to the further provisions set out in supporting documentation.

5.13. Financial Investments

5.13.1. The PHA shall not make any financial investment without the prior written approval of the sponsor Department and, where appropriate, DoF, nor should it build up cash balances or net assets in excess of what is required for operational purposes. Funds held in bank accounts or as financial investments may be a factor for consideration when grant-in-aid is determined. Equity shares in ventures which further the objectives of the PHA shall equally be subject to Departmental and DoF approval unless covered by a specific delegation.

5.14. Unconventional Financing

5.14.1. The PHA shall not enter into any unconventional financing arrangement without the approval of the Department and DoF. If the PHA is using a new or non-standard technique, it should ensure that it has the competence to manage, control and track its

use and any resulting financial exposures, which may vary with time. In particular, the PHA should consult the Department before using derivatives for the first time. The PHA must evaluate any such financing techniques carefully, especially to assess value for money and any proposal must be assessed in line with MPMNI chapter on funding.

5.15. Commercial Insurance

5.15.1. The PHA shall not take out any insurance without the prior approval of the Department and DoF, other than third party insurance required by the Road Traffic (NI) Order 1981 (as amended) and any other insurance which is a statutory obligation or which is permitted in Managing Public Money Northern Ireland. Decisions on whether to buy insurance should be based on objective cost-benefit analysis, using guidance in the *Northern Ireland Guide to Expenditure Appraisal and Evaluation* (NIGEAE) (supported by additional DoF guidance).

5.15.2. In the case of a major loss or third-party claim, the Department shall liaise with the PHA about the circumstances in which an appropriate addition to budget out of the Department's funds and/or adjustment to the PHA's targets shall be considered. The Department will liaise with DoF Supply where required in such cases.

5.16 Employers Liability

5.16.1 The PHA is listed in exemption Regulations made by the Department of Enterprise, Trade and Investment (now the Department for the Economy), under the Employer's Liability (Compulsory Insurance) (Amendment) Regulations (Northern Ireland) 2009, and therefore is not required to insure against liability for personal injury suffered by its employees.

5.17. Payment/Credit Cards

5.17.1. The PHA, in consultation with the Department, shall ensure that procedures on the issue of payment cards (including credit cards) are in place. No payment/credit cards should be issued without the prior written approval of the PHA's Accounting Officer.

5.18. Hospitality

5.18.1. The PHA shall ensure that a comprehensive set of guidelines on the provision of hospitality is in place. Reference should be made to Departmental guidance.

5.19. Use of consultants

5.19.1. The PHA must notify the Department of any occasion when it intends to use consultants, for what purpose, and submit consultancy business case in advance of any expenditure being committed. Prior Departmental/ DoF approval must be sought in line with current delegated limits. The PHA shall also comply with current Departmental and DoF guidance on the Use of Consultants.

5.19.2. The PHA will provide the Department with a quarterly statement on the status of all consultancies completed and/or started in each financial year.

5.19.3. Care should be taken to avoid actual, potential, or perceived conflicts of interest when employing consultants.

6. MANAGEMENT AND DISPOSAL OF ASSETS

6.1. Asset Management Strategy

6.1.1. Each public sector organisation is expected to develop and operate an asset management strategy underpinned by a reliable and up to date asset register which should be reviewed annually by the PHA's Accounting Officer as part of the corporate planning process.

6.1.2. The PHA must ensure effective use, maintenance, acquisition and disposal of the public sector assets under its control.

6.1.3. The PHA shall keep an up to date asset register of all the capital assets it owns and uses.

6.2. Asset transfer between public bodies

6.2.1. Public sector organisations may transfer property among themselves without placing the asset on the open market, provided they do so at market prices and in appropriate circumstances and this is accounted for in compliance with MPMNI and FReM.

6.3. Machinery of Government changes

6.3.1. Some assets transfer due to machinery of government changes. The relevant legislation (Transfer Order) should prescribe the terms of any such transfer.

6.3.2. The PHA should maintain information asset registers as part of their asset management strategy.

6.4. Register of Assets

6.4.1. The PHA shall maintain an accurate and up to date register of fixed assets.

6.5. Disposal of Assets

6.5.1. The PHA shall dispose of those assets that are surplus to its requirements in compliance with current policy. Assets should be sold for best price, as advised by Land & Property Services. Assets shall be sold by auction or competitive tender as advised by Land & Property Services (unless otherwise agreed by the Department) and in accordance with the principles of MPMNI provided that the PHA is satisfied that the articles are spent, redundant or surplus to requirements.

6.5.2. Other than at a public auction, no article shall pass into the possession of any member of staff of the PHA or member of the Board without approval of the Department.

6.5.3. All receipts derived from the sale of assets (including grant financed assets, see below) must be declared to the Department, which will consult with DoF on the appropriate treatment.

6.6. Recovery of Grant – Financed Assets

6.6.1. Where the PHA has financed expenditure on capital assets by third parties, the PHA shall set conditions and make appropriate arrangements to ensure that assets are not disposed of without the PHA's prior consent.

6.6.2. The PHA shall ensure that any grants to third parties for the acquisition of assets should normally include a clawback condition under which they can recoup the proceeds if the recipient of the grant later sells the asset.

6.6.3. The PHA shall ensure that, if the assets created by grants made by the Board cease to be used by the recipient of the grant for the intended purpose, a proper proportion of the value of the asset shall be repaid to the PHA for surrender to the Department. The amount recoverable shall be calculated by reference to the best possible value of the asset and in proportion to the NI Consolidated Fund's original investment(s) in the asset.

7. BUDGETING PROCEDURES

7.1. Setting the Annual Budget

7.1.1. Each year, in the light of decisions by the Department on the PHA's updated draft corporate plan, the Department will send to the PHA:

- a formal statement of the annual budgetary provision allocated by the Department in the light of competing priorities across the Department and of any forecast income approved by the Department; and
- a statement of any planned change in policies affecting the PHA.

7.1.2. The PHA approved annual business plan will take account both of its approved funding provision and any forecast receipts, and will include a budget of estimated payments and receipts together with a profile of expected expenditure and of draw-down of any Departmental funding and/or other income over the year. These elements will form part of the approved business plan for the year in question (Section 4.2 of the Management Statement).

7.1.3. Any Grant-in-Aid provided by the Department for the year in question will be voted in the Department's Estimate and will be subject to Assembly control.

7.2. General Conditions for the Authority to Spend

7.2.1. Once the PHA's budget has been approved by the Department (and subject to any restrictions imposed by Statute/the Minister/this MSFM or any other circulars, directives, and best practice guidance that may issue from, or by way of, the Department), the PHA shall have authority to incur expenditure approved in the budget without further reference to the Department, on the following conditions:

- The PHA shall comply with the delegations issued by the Department in HSC(F) 52-2016 (Appendix 1) or subsequent revisions). These delegations shall not be altered without the prior agreement of the Department and DoF;
- The PHA shall comply with the conditions set out in paragraph 2.3 above regarding novel, contentious or repercussive proposals;
- Inclusion of any planned and approved expenditure in the PHA's budget shall not remove the need to seek formal Departmental (and, where necessary, DoF) approval where such proposed expenditure is above the delegated limits, or is for new schemes not previously agreed;
- The PHA shall provide the Department with such information about its operations, performance, individual projects or other expenditure as the Department may reasonably require (see paragraph 7.3 below); and
- The PHA shall comply with NI Procurement Policy and carry out procurement via a recognised and approved CoPE.

7.3. Providing Monitoring Information to the Department

7.3.1. The PHA shall provide the Department with information on a regular basis which will enable the satisfactory monitoring by the Department of:

- The PHA's cash management;
- its draw-down of any grant-in-aid;
- the expenditure for that month;
- forecast outturn by resource headings; and
- other data required for the DoF Outturn and Forecast Outturn Return.

Other information requirements are listed at **Appendix 2**.

8. BANKING

8.1. Banking Arrangements

8.1.1. The PHA's Accounting Officer is responsible for ensuring that the PHA's banking arrangements are in accordance with the requirements of Chapter 5 of *MPMNI*. In particular, the Accounting Officer shall ensure that the arrangements safeguard public funds and that their implementation ensures efficiency, economy and effectiveness. This responsibility remains even with the current banking pool arrangements. Accounting Officers are responsible for the credit risk to which public funds are exposed when held in commercial banks. It is important that they manage this risk actively, so that it is kept to a minimum. This means using the most efficient and cost effective money transmission methods and securing the best terms possible from banks. The PHA should seek the advice of the Department before opening new bank accounts.

8.1.2. The PHA's Accounting Officer shall therefore ensure that:

- these arrangements are suitably structured and represent value-for-money, and are reviewed at least every two years, with a comprehensive review, usually leading to competitive tendering, at least every three to five years;
- sufficient information about banking arrangements is supplied to the Department's Accounting Officer to enable the latter to satisfy his/her own responsibilities;
- The PHA's banking arrangements shall be kept separate and distinct from those of any other person or organisation; and
- adequate records are maintained of payments and receipts and adequate facilities are available for the secure storage of cash.

9. COMPLIANCE WITH INSTRUCTIONS AND GUIDANCE

9.1. Relevant Documents

9.1.1. The PHA shall comply with the following general guidance documents:

- This document (both the *Financial Memorandum* and the *Management Statement*);
- *Managing Public Money Northern Ireland* (*MPMNI*);
- *Public Bodies - a Guide for NI Departments* issued by DoF;
- *Government Internal Audit Standards*, issued by DoF;
- *Managing the Risk of Fraud* issued by DoF;
- *The Government Financial Reporting Manual (FReM)* (Treasury document) issued by DoF;
- Relevant DoF Dear Accounting Officer and Finance Director letters;
- Relevant Dear Consolidation Officer and Dear Consolidation Manager letters issued by DoF;
- *Regularity, Propriety and Value for Money*, issued by Treasury;
- The Consolidation Officer Letter of Appointment, issued by DoF;
- *PFI - Working Together in Financing our Future: Policy Framework for Public Private Partnerships in Northern Ireland"* available at: http://webarchive.proni.gov.uk/20141007005953/http://www.ofmdfmni.gov.uk/maindoc.pdf .
- Other relevant instructions and guidance issued by the central Departments (DoF/The Executive Office (TEO)) including Procurement Board and CPD guidance;
- Specific instructions and guidance issued by the Department;
- Recommendations made by the Public Accounts Committee, or by other Assembly/Parliamentary authority, which have been accepted by the Government and which are relevant to the PHA.

10. REVIEW OF FINANCIAL MEMORANDUM

10.1. This Financial Memorandum will normally be formally reviewed every five years, or following a review of the PHA's functions as provided for in the Management Statement.

10.2. The Department of Finance will be consulted on any significant variation proposed to the Management Statement and Financial Memorandum.

APPENDIX 1

HSC(F) 52-2016 Revised HSC & NIFRS Delegated Limits and requirements for Departmental / DoF approval

1. DoF has updated some of the delegated limits per (DAO (DPF) 06/12) providing guidance on the revised arrangements for Departmental delegations, following the restructuring of the new nine Departments, and the associated requirements for DoF approval. The revised DAO can be found at: https://www.finance-ni.gov.uk/sites/default/files/publications/dfp/daodfp0612_revised%20280716_0. pdf . The principles of DAO (DFP) 06/12 still remain and reminds organisations of the guidance contained in MPMNI relating to the authority for expenditure, regularity, propriety and value for money and the requirement to ensure that the principles of appraisals are applied when expending resources. The relevant extracts are included at **Annex A**.

2. This circular sets out the delegations between DoH and Health and Social Care bodies and NIFRS and conveys delegated authority to commit and incur expenditure subject to the restrictions set out at T**able A** below and per **Annex B and Annex C.**

3. The main changes to delegated limits are:
   - Capital Projects
     - DoH delegated limit excluding hospital schemes has increased from £1m to £2m
     - Trusts delegated limit, excluding hospital schemes, has increased from £500k to £1.5m
     - New delegated limit introduced for PHA lead Research and development of £1.5m
     - Trusts delegated limit for hospital schemes has also increased from £500k to £1.5m
   - Gifts has increased from £100 to £250 for all bodies;
   - Ex-Gratia Financial Remedy Payments (i.e.those made to complainants through an organisation's internal complaints procedures/processes increased from £250 to £500;
   - Overpayments - Foregoing the recoupment of overpayments of pay, pensions and allowances ; Pensions from £500 to £1,000;
   - Clinical negligence – delegated limit increased from £500k to £1m;
   - Delegated limit for all leases for Office / warehouse / storage accommodation is nil for all bodies;
   - DoH Delegated limit for EU Peace IV and In VA Programmes has increased from £2m to £5m. Delegated limits for all bodies remains NIL.

4. The table below summarises the main financial delegated limits where the Department has given delegated authority to HSC and NIFRS to spend within those limits. This must be read in conjunction with **Annex B** and **Annex C which contains a full list of delegations for which HSC bodies and NIFRS have NO delegated authority other than those listed below.**

5. All proposed expenditure which is set to exceed the HSC/NIFRS delegated limit must receive the appropriate prior approval before commitment to spend.

TABLE A

Area of Delegation	HSC/NIFRS Delegated Limit	DoH Delegated Limit
Use of External Consultants	HSC Bodies - £10,000 NIFRS - £10,000	£75,000
Capital Expenditure (excluding hospital schemes)	HSC Board &Trusts - £1,500,000 BSO £250,000	£2,000,000
	PHA - £50,000	
	PHA R&D - £1,500,000	
	NIBTS - £200,000	
	Other HSC Bodies - £10,000	
	NIFRS - £250,000	
Hospital Schemes – New Build, Extension, Refurbishment and Equipment involving capital expenditure	HSC Board &Trusts - £1,500,000 BSO - £250,000 PHA - £50,000 NIBTS - £200,000 Other HSC Bodies - £10,000	£5,000,000
IT Projects	HSC Board; Trusts; BSO; PHA; £250,000	£1,000,000
	NIBTS - £200,000	
	NIMDTA - £20,000	
	Other HSC Bodies - £10,000 NIFRS - £250,000	
Gifts	£250	£250
Losses – write off of cash losses and cash equivalents, bookkeeping losses, exchange rate fluctuations, fruitless payments and constructive losses, property in stores or in use due to any deliberate act	HSC Bodies £10,000 NIFRS - £1,000	n/a*
Losses -. The write off of losses relating to pay, allowances, superannuation benefits, social security benefits, grants, subsidies and the failure to make adequate charges for use of public property or services and loans - as per guidance in MPMNI	All HSC Bodies and NIFRS - Nil**	Nil**
Losses - Waived of Abandoned claims	HSC Bodies £10,000 NIFRS - £1,000	£100,000
Special payments / Ex-Gratia Payments	All HSC Bodies - £10,000 NIFRS - £1,000	£100,000
Overpayments - Foregoing the recoupment of overpayments of pay,	All HSC Bodies and NIFRS - £1,000 (pay & allowances)	£20,000

Area of Delegation	HSC/NIFRS Delegated Limit	DoH Delegated Limit
pensions and allowances	£1,000 (pensions)	
Overpayments - Foregoing the recoupment of overpayments of grants	All HSC Bodies and NIFRS - Nil**	Nil**
Special severance payments	All HSC Bodies and NIFRS - Nil**	Nil**
Ex-Gratia Financial Remedy Payments (i.e..those made to complainants through an organisation's internal complaints procedures/processes)	All HSC Bodies and NIFRS - £500	£500
Ex-Gratia Payments to be made as a result of a recommendation from the NI Public Services Ombudsman	All HSC Bodies - £10,000 NIFRS - £1,000	£50,000
Compensation payments for Clinical Negligence (to include interim payments if overall settlement is expected to exceed delegated limits) To include agreement of Periodic Payment Orders (PPOs)	HSC Bodies £1.000,000 NIFRS n/a	£2,000,000
Compensation payments following legal advice (This would include all personal injury and public liability claims)	HSC Bodies - £25,000 NIFRS - £1,000	£100,000
Compensation payments without legal advice	All HSC Bodies and NIFRS - Nil	£10,000
Extra-Statutory and Extra-Regulatory payments	All HSC Bodies and NIFRS - Nil	£100,000
Confidentiality Agreements	Nil	Nil
Grants: Revenue Capital	All HSC Bodies and NIFRS £500k per annum £200k in total	£500k per annum £200k in total
Leases for office accommodation/ warehousing / storage	All HSC Bodies and NIFRS Nil	Nil
Pay remits	All HSC Bodies and NIFRS Nil	Nil
Revenue Business cases	NIFRS - £250,000 All other HSC Bodies – fully delegated	Nil

* DoH has full delegated authority

** Prior DoH and DoF approval required in all cases

6. It is mandatory for HSC bodies and NIFRS to obtain prior Departmental approval for expenditure above those limits outlined above and per Annex B & C attached. Failure to obtain the required DoF approvals will result in regularity and propriety issues. Any expenditure which falls outside a Department's delegated authority and which has not been approved by DoF is deemed irregular and could result in qualified accounts and investigation by PAC.

7. Where expenditure proposals exceed the Department's delegated limits, DoF Supply will act as the approving authority.

8. All expenditure which is novel, contentious, repercussive or which could set a potentially expensive precedent, irrespective of size, even if it appears to offer value for money taken in isolation **must** have Departmental and DoF approval before expenditure is committed.

Further Guidance

9. For further details on these categories of expenditure, including approvals procedures, HSC Bodies and NIFRS should refer to Managing Public Money Northern Ireland[3] and NIGEAE[4], as well as current Departmental finance guidance on:
   - The use of professional services (including consultants)
   - Losses and special payments
   - Claims handling (including clinical negligence and personal injury litigation)
   - Fraud
   - Capital

Process for approval of expenditure

10. Any payments / expenditure that require Departmental approval must be submitted through Financial Policy and Accountability Unit, who will act as a single point of contact through whom all liaison with DoF on significant financial matters, including approvals, should be conducted. This is to ensure that appropriate Departmental approvals have been obtained and that regularity, propriety and VFM have been adhered to.

11. It has been agreed that the Infrastructure Investment Director will be the contact point for all such submissions concerning capital.

Should you have any queries please contact the following.

Charles Barnett [redacted]
Sharon Allen (Capital) [redacted]

Action Required

12. HSC Bodies and NIFRS to note the requirements to obtain prior Departmental approval before committing expenditure outside the delegations conveyed by this letter. This circular should therefore be circulated as appropriate throughout your organisation, and schemes of delegation revised and updated accordingly.

Yours sincerely

PAULA SHEARER
Financial Policy, Accountability and Counter Fraud Unit

[3] https://www.finance-ni.gov.uk/articles/managing-public-money-ni-mpmni
[4] https://www.finance-ni.gov.uk/topics/finance/northern-ireland-guide-expenditure-appraisal-and-evaluation-nigeae

Annex A

Extract from revised DAO (DFP) 06/2012

Expenditure Appraisal and Evaluation

1. FD(DFP) 20/09 draws departments' attention to the Northern Ireland Guide to
    a. Expenditure Appraisal and Evaluation (NIGEAE), which contains DoF's core guidance on the appraisal, evaluation, approval and management of policies, programmes and projects. The principles of appraisal should be applied, with proportionate effort, to every proposal for spending or saving public money, or proportionate changes in the use of public sector resources. For example, appraisal must be applied irrespective of whether the relevant public expenditure or resources:
    b. involve capital or current spending, or both;
    c. are large or small;
    d. are above or below delegated limits.

2. Appraisal is a systematic process for examining alternative uses of resources. It is designed to assist in defining problems and finding the solutions which offer the best value for money. It is a way of thinking expenditure proposals through, right from the emergence of the need for a project through its implementation, to post-project evaluation. It is the established vehicle for planning and approving projects and other expenditures. Good appraisal leads to better decisions and use of resources. It facilitates good project management and project evaluation. Appraisal is not optional; it is an essential part of good financial management, which is vital to decision-making and crucial to accountability. But it must also be proportionate.

3. It is important to begin applying appraisal early in the gestation of any proposal which has expenditure or resource implications. The justification for incurring any expenditure at all should be considered. Appraisal should be applied from the emergence of a need right through to the recommendation of the most cost-effective course of action. It should not be regarded merely as the means to refine the details of a predetermined option.

4. It should be noted that delegations do not remove the need for appraisal or evaluation. All expenditure, including that below delegation limits, must be appraised and evaluated with effort that is proportionate to the resources involved, with due regard to the specific nature of the case. NIGEAE provides more detailed guidance on the application of appropriate and proportionate effort.

Implementation of delegated authority

5. This DAO restates a number of working arrangements which are intended to facilitate the efficient implementation of delegated authority and the achievement of accountability and value for money. They are part of the internal controls of a department and should facilitate an Accounting Officer in signing the Governance Statement.

Management Arrangements

6. Departments should nominate a senior official, preferably the Departmental Finance Director, to assist in the discharge of all aspects of the delegation arrangements within the department. This official should act as a single point of contact through whom all liaison with DoF on significant financial matters, including approvals, should be conducted, unless alternative arrangements are agreed with DoF. Departments should inform DoF of the name and job title of this point of contact and notify DoF of any subsequent change.

7. Expenditure above delegated limits generally requires specific DoF approval. The normal procedure for seeking DoF approval is to submit a suitable business case to the appropriate DoF Supply Division in accordance with the guidance in NIGEAE.

8. All cases presented to DoF for approval must confirm that the department is content with the regularity, propriety and value for money of the project and the project has the necessary approvals within the departmental Accounting Officer's delegated arrangements. Where it is clear to DoF that a case has been submitted without proper departmental approval procedures being followed, the case will be returned without consideration.

9. It should be noted that where DoF approval is required, expenditure should not be committed until DoF approval has been granted. Where DoF's approval has not been sought, DoF will not generally grant retrospective approval where the relevant expenditure has already been committed or the works have commenced.

10. The practice of consulting DoF informally during the course of development of a project is strongly encouraged, particularly where the project is deemed to be complicated, novel or contentious. However, such informed consultation does not remove the need for a department to formally submit the project for DoF approval if that is required. DoF will not confirm its formal view of any proposal unless the department has provided confirmation of its Accounting Officer's view (under the responsibility of the Accounting Officer) on the regularity, propriety and value for money of the relevant proposed expenditure.

Appraisals and Post Project Evaluations

11. All departments should ensure that their operating procedures and guidance on conducting economic appraisals comply with NIGEAE, are recorded in a Finance Manual, that this Manual is kept updated regularly, and that those who are involved in the economic appraisal process have access to it.

12. The Departmental Finance Director should ensure that commensurate Post Project Evaluations (PPEs) are completed in accordance with the principles set out in NIGEAE that lessons learnt are shared within the department (and, where appropriate, with other departments). A copy of the PPE should be forwarded to DoF Supply if it formed a condition of the approval. Departmental Finance Manuals should ensure that appropriate procedures are established for PPEs.

Review of Processes

13. Each department should carry out an annual review (independent of the spending areas) of the processes in relation to the appraisal of cases and PPEs that fall within its delegated limits, to ensure that the proper processes are being followed and the delegation limits set out in this DAO adhered to. If a department has evidence-based confidence in its internal controls, it may decide to implement a cycle of reviews, taking a different part of the department each year.

Review of Economic Appraisals/PPEs

14. In addition to the annual review of processes described at (viii) above, departments should conduct ad hoc 'test drilling' of economic appraisals and PPEs that fall (a) within their delegated limits and (b) within the delegated limits given to their sponsored bodies, to ensure that the appropriate appraisal standards have been applied in accordance with NIGEAE guidance and that decisions have been taken on a proper basis. The review should be undertaken independent of the spending area. A department may undertake a cycle of reviews concentrating on the higher risk areas. A report of the findings of the examination of individual cases should be provided by departments to the Departmental Accounting Officer and to DoF Supply on an annual basis, by 30 June each year. This

should provide further assurance to the Departmental Accounting Officer in signing off the Annual Governance Statement.

15. Departments should submit to DoF Supply a list of all appraisals above the level agreed with their Supply Officer. Supply may request a sample of those cases for review, to confirm the effectiveness of departments' control systems (in line with the criteria in MPMNI A.2.3.8). Any necessary corrective action identified should be implemented within an agreed timescale.

Annex B

AREAS REQUIRING DoF APPROVAL FOR ALL DEPARTMENTS

	Details	Reference
Where DoF approval (in writing) is required:		
Use of Resources		
1	Public statements which might imply a willingness on the part of the Executive to commit resources or incur expenditure beyond agreed levels	MPMNI Box A.2.3.A
2	Guarantees, indemnities or general statements/ letters of comfort which could create a contingent liability	MPMNI Box A.2.3.A
3	All expenditure which is novel, contentious, repercussive or which could set a potentially expensive precedent, irrespective of size, even if it appears to offer value for money taken in isolation	MPMNI Box A.2.3.A Box 2.3
4	Expenditure that could create pressures which could lead to a breach of: 1. Departmental Expenditure Limits (DELs); 2. resource limits or capital limits; or 3. Estimates provision.	MPMNI Box A.2.3.B
5	Expenditure that would entail contractual commitments to significant levels of spending in future years for which plans have not been set	MPMNI Box A.2.3.B
6	Legislation with financial implications as per guidance in MPMNI	MPMNI A.2.2.1
7	New services under the sole authority of the Budget Act	MPMNI A.2.5.15
8	Loans – on borrowing from the Northern Ireland Consolidated Fund for Contingencies	MPMNI A.2.5.9 MPMNI A.2.5.11
Accounting Officers		
9	Appointment of the permanent head of each central government department to be its Accounting Officer	MPMNI 3.2.1
10	Appointment of an Accounting Officer for a Trading Fund (TF)	Financial Provisions NI Order 1993 and MPMNI 3.2.2
Internal Management		
11	Gifts – Giving any individual gift in excess of £250. **Refer to Table A for HSC and NIFRS Delegation**	MPMNI A.4.12.3
12	Insurance – Decision to purchase commercial insurance.	MPMNI 4.4.1 – 4.4.2

	Details	Reference
13	Losses – The write off of losses relating to pay, allowances, superannuation benefits, social security benefits, grants, subsidies and the failure to make adequate charges for use of public property or services and loans - as per guidance in MPMNI - **Refer to Table A for HSC and NIFRS Delegation**	MPMNI Annex A.4
14	Losses - Waived or Abandoned claims above £100,000 and Special payments e.g. ex gratia over £100,000. To include the foregoing the recoupment of overpayments of pay, pensions and allowances over £20,000 and the recoupment of overpayments of grants. **Refer to Table A for HSC and NIFRS Delegation**	MPMNI A.4.10.2 & Box A.4.10.A MPMNI A.4.11
15	Payments – Advance payments excluding those allowed under the guidance in MPMNI	MPMNI A.4.6.5
16	Payments – Deferred payments excluding those allowed under the guidance in MPMNI	MPMNI A.4.6.9
17	Payments - Special severance payments - **Refer to Table A for HSC and NIFRS Delegation**	MPMNI A.4.13.9
18	Payments – Financial Remedy Payments over £500 (ie payments made to complainants through an organisations internal complaints procedures/processes) and payments over £50,000 to be made as a result of a recommendation from the Northern Ireland Public Services Ombudsman	MPMNI A.4.14.8
Funding		
19	Banking – Proposals to open an account outside the pool or any proposed changes to Banking Pool arrangements	MPMNI 5.8.2 MPMNI A.5.7.3 MPMNI Box A.5.7.B
20	Banking – Requests for indemnities that commercial banks may seek to replace their normal arrangements	MPMNI Box A.5.7B
21	Borrowing from the Private Sector for all Arms Length Bodies (ALBs)	MPMNI 5.7.1
22	Borrowing on terms more costly than those usually available to government	MPMNI A.5.6.11
23	Borrowing – foreign borrowing	MPMNI A.5.6.12
24	Foreign Currency - Any proposals to negotiate contracts in foreign currencies other than the euro, yen or US dollar	MPMNI A.5.7.13
25	Income - Use of income and cash by departments to meet expenditure needs if there is no specific legislation	MPMNI A.5.3.1 MPMNI A.5.3.5
26	Income & Receipts - Increases to the amount that can be treated as an accruing resource	MPMNI A.5.3.8 MPMNI A.5.3.9

	Details	Reference
	during a financial year in order to finance a comparable increase in expenditure as per in-year monitoring/budgeting guidance	
27	Liabilities – Departments seeking statutory authority to accept liabilities	MPMNI A.5.5.5
28	Liabilities – Assuming statutory liabilities including the liabilities of any sponsored bodies in excess of £1 million for any single transaction	MPMNI A.5.5.14
29	Liabilities – Reporting non-statutory, where required, to the Assembly	MPMNI A.5.5.23
30	Liabilities – Reporting a contingent liability in confidence by writing to the Chair of the PAC	MPMNI A.5.5.28
31	Liabilities – Departments should consult DoF about reporting a liability during recess and outside Assembly sessions during a dissolution	MPMNI A.5.5.30 MPMNI A.5.5.34
32	Loans – proposals to make voted loans and premature repayment	MPMNI 5.6.1 MPMNI A.5.6.2
Fees, Charges and Levies		
33	Charges - Primary legislation to empower charging	MPMNI 6.2.1
34	Charges - Restructuring charges using the Fees and Charges (NI) Order 1988 No. 929 (N.I.8) in line with guidance in MPMNI	MPMNI Box 6.2
35	Charges - Public sector supplier moving away from full cost charging	MPMNI A.6.4.8
36	Interdepartmental Transactions – where the transaction may require legislative procedures or where DoF agreement is required under statute	MPMNI A.6.6.3
Working with Others		
37	Agency framework documents and the methods of financing an agency	MPMNI 7.4.2 & Box 7.2
38	All Management Statements and Financial Memorandums (MSFM) or other relationship documents	MPMNI 7.7.6
39	The establishment or termination of an NDPB	Public Bodies: A Guide for NI Departments
40	The establishment and operation of a Trading Fund including sources of capital	Financial Provisions NI Order 1993 and MPMNI A.6.6.3, MPMNI 7.5.2, 7.5.4 & Box 7.3
41	Provision of funding by way of an Endowment Fund	A.5.1.10
42	Grants to Councils under the Local Government (Finance) Act (NI) 2011	Local Government (Finance) Act (NI) 2011
Other Delegations		
43	Wider market projects where the full annual cost or aggregated annual income from such	MPMNI A.7.6.6

	Details	Reference
	services exceeds, or is expected to exceed thresholds agreed by DoF	
44	Assets - Transfer or disposal of assets at less than market value.	
45	Assets – to appropriate any sums realised as a result of selling an asset above the deminimis level in the DoF Budget/In-year Monitoring Guidance	
46	Assets – to allow an organisation to retain receipts arising from the sale of assets funded by grant or grant-in-aid above the deminimis level in the DoF Budget/In-year Monitoring Guidance	
47	Compensation payments without legal advice - Individual compensation claims settled out of court over £10,000. - **Refer to Table A for HSC and NIFRS Delegation**	
48	Compensation payments following legal advice - Individual compensation claims settled out of court over £100,000 where the legal advice is that the department will not win the case if contested in court. - **Refer to Table A for HSC and NIFRS Delegation**	
49	Consultants – Expenditure on external consultancy projects over £75,000 Expenditure on external consultancy assignments co-funded by the Strategic Investment Board over £150k – **Refer to Table A for HSC and NIFRS Delegation**	FD(DOF)07/12 Minute to Principal Finance Officers dated 19 April 2004
50	Estimates – form and content of Main and Supplementary Estimates.	Supply Estimates in Northern Ireland – A Guidance Manual
51	Virement	Supply Estimates in Northern Ireland – A Guidance Manual
52	Fraud – any departure from immediate reporting (not including National Fraud Initiative (NFI) for which separate arrangements have been agreed	FD(DFP) 02/13
53	IT projects over £1 million **Refer to Table A for HSC and NIFRS Delegation**	CONSIDER AGAINST AGILE
54	Capital Projects - All other expenditure on Capital Projects involving over £2million of Central Government expenditure unless other delegations specifically allow - **Refer to Table A for HSC and NIFRS Delegation**	
55	Projects - All PFI + 3PD projects at key stages as stipulated in NIGEAE	NI Guide to Expenditure Appraisal and Evaluation MPMNI A.7.5.4 FD(DFP) 20/09 FD(DFP) 17/11

	Details	Reference
56	Receipts – repayment of CFERs from the Northern Ireland Consolidated Fund	
57	Redundancy – All staff redundancy schemes not covered by existing regulations or which are more generous than existing NICS scheme.	
58	EU - All expenditure over £5 million under the EU Programmes for which the Special EU Programmes Body is responsible rather than with a threshold of £2 million.	Letter to Finance Directors & EUSG Members 2 March 2011
59	Pay Remits - **Refer to Table A for HSC and NIFRS Delegation**	FD Letter - Pay Remit Approval Process and Guidance
60	All leases for Office Accommodation (including supporting storage or warehousing) – both new and existing extension or renewal beyond break points. Excluding offices outside Northern Ireland - **Refer to Table A for HSC and NIFRS Delegation**	Letter to Accounting Officers 28 July 2014

Annex C

Specific DEPARTMENT OF HEALTH delegations

Ref Number	Details	Reference
	Where DoF approval (in writing) is required:	
1	Hospital Schemes – Ne Build, Extension, Refurbishment and Equipment involving capital expenditure over £5 – **Refer to Table A for HSC and NIRFS Delegation.**	
2	Third Party Development schemes for health and social care / service provision.	
3	All grants/awards to the Voluntary and Community Sector: Revenue Grants £500,000 per annum, Capital Grants £200,000 – **refer to Table A for HSC and NIRFS Delegation**	
4	Medical/Clinical Negligence settlements over £2m – **refer to Table A for HSC and NIRFS Delegation**	
5		
6		

Ref number	Details	**Reference**
Where DoF approval (in writing) is required:		
5	Staff redundancy schemes.	
6	Provisions concerning appointment of officers.	Fire Services (NI) Order 1984
7	Doctors Qualifications.	HPSS Order 1972 Article 107(6)
8	Doctors Rights/Working Conditions.	HPSS Order 1972 Article 107(6)
9	Requirement to maintain list of Doctors/Dentists by Boards / Departments.	HPSS Order 1972 Article 107(6)
10	Terms of Service for Medical Professionals.	HPSS Order 1972 Article 107(6)
11	Prescription Charges.	HPSS Order 1972 Article 98 (2) Schedule 15
12	Optical Charges.	HPSS Order 1972 Article 98 (2) Schedule 15
13	Dental Charges.	HPSS Order 1972 Article 98 (2) Schedule 15

APPENDIX 2

Core Departmental Information Requirements

1. *INFORMATION TO BE PROVIDED ROUTINELY DURING THE FINANCIAL YEAR*
   - 1.1 Minutes of Board and all Committee meetings (to be forwarded to the Department as soon as possible following each meeting)
   - 1.2 Internal audit reports where substantive assurance not achieved (immediately following report)
   - 1.3 Inspection/review reports (immediately following receipt of report by the PHA)
   - 1.4 Monthly financial monitoring returns (to enable the Department to exercise both Estimate and budgetary control)

2. *OTHER INFORMATION TO BE PROVIDED*
   - 2.1 Corporate/Business Plan (to be forwarded to the Department, in draft form, prior to sign-off by the PHA in February/March)
   - 2.2 Internal audit work plan for the forthcoming year (to be forwarded in February/March)
   - 2.3 Internal audit report for the previous year (to be forwarded in May/June)
   - 2.4 Business Continuity plan (to be updated at least annually, and forwarded to the Department thereafter)
   - 2.5 Risk register (to be updated at, least annually, and forwarded to the Department in March/April)
   - 2.6 Assurance Framework (to be updated, at least annually, and forwarded to the Department in March/April)
   - 2.7 Mid-year Assurance Statement, end of year Governance Statement (to be forwarded to the Department in October/November and May/June respectively)

DELIVERING THE BAMFORD VISION

The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability

ACTION PLAN 2012-2015

Integrated Projects Unit

November 2012

Department of Health, Social Services and Public Safety
www.dhsspsni.gov.uk

Ministerial Foreword

The Northern Ireland Executive's response to the findings of the Bamford Review led to the publication in October 2009 of the 2009-2011 Bamford Action Plan. That plan contained agreed actions and timescales for Northern Ireland Government Departments and Health and Social Care sectors.

I am pleased to publish this follow-on 2012-2015 Action Plan that will continue to progress the enhancements to mental health and learning disability service started through the previous Plan.

The Evaluation of the 2009-2011 Action Plan, published in May 2012, establishes that over the last two years the joint working across Government Departments and the HSC sector has achieved much, and 80% of the actions have been delivered. It also highlights areas where services can still be improved and the need for more of a focus on outcomes rather than outputs.

The follow-on 2012-2015 Action Plan has been based on the lessons learnt from the 2009-2011 Evaluation, consultative workshops, new research and evidence based practice and the views of service users and their carers.

Government Departments have endorsed these actions which are to be delivered by end 2015. The Bamford Vision for these services though will only be fully realised through the commitment not just of health and social care staff, and an inter-governmental and agency approach, but also through the drive of service users, carers and the voluntary and community sectors.

The implementation of this Action Plan will continue to be monitored through the Interdepartmental Senior Officials Group on Mental Health and Learning Disability and monitoring reports will be published on a regular basis.

I believe it is important that Government and those who commission and deliver services are informed and guided by the views of those who use these services. The evaluation of this follow-on 2012-2015 Action Plan will therefore focus primarily on service user outcomes rather than outputs. An Outcome Evaluation Model for this Action Plan is being developed.

I would like to particularly thank the Bamford Monitoring Group of the Patient and Client Council for their invaluable assistance in the formulation of this Action Plan and their Outcomes Paper.

The Bamford Vision set out a 10-15 year timescale for the enhancement of mental health and wellbeing, and for learning disability services. A strong foundation has been established and a positive change is evident but we still have much to do in order to deliver that Vision.

I want to reiterate the commitment of the full Northern Ireland Executive to the ongoing development of mental health and learning disability services to meet the needs and expectations of those who use and rely on them.

EDWIN POOTS, MLA

Minister for Health, Social Services and Public Safety

CONTENTS

SECTION A

SECTION A

1 SETTING THE SCENE

The Bamford Review of Mental Health and Learning Disability

1.1 The Bamford Review of Mental Health and Learning Disability, an independent review of legislation, policy and service provision, concluded in August 2007. Broadly the Review called for:

- continued emphasis on promotion of positive mental health
- reform of mental health legislation
- a continued shift from hospital to community-based services
- development of a number of specialist services, to include children and young people, older people, those with addiction problems and those in the criminal justice system
- an adequate trained workforce to deliver these services.

1.2 The Review envisaged a 10-15 year timescale for full implementation of its recommendations.

Bamford Action Plan 2009-2011

1.3 The Northern Ireland Executive accepted the broad thrust of the Review's recommendations. The Executive's response to the findings of the Bamford Review, *Delivering the Bamford Vision*, was consulted on in 2008. This led to the publication in October 2009 of the Bamford Action Plan 2009 –2011.

1.4 The 2009-2011 Plan set out the Executive's commitment across Departments to improving the mental health and well-being of the population of Northern Ireland and to improving services for those with a mental health need or a learning disability in line with the policy articulated in *Delivering the Bamford Vision*. The Action Plan contained agreed actions with associated timescales to be taken forward by a range of Northern Ireland Government departments and agencies, in particular the Health and Social Care sector.

1.5 An inter-Ministerial group, chaired by the Minister for Health, Social Services and Public Safety, was established to oversee the work and structures put in place to support this group. The structures put in place also provide a formal forum for the voice of service users and carers through the Bamford Monitoring Group.

1.6 Departments other than DHSSPS continue to make a substantial contribution to progressing the Bamford Vision, as evidenced by the Action Plan in Section B. The structures supporting cross-sectoral work on Delivering the Bamford Vision are shown

below.

1.7 This Action Plan, covering the period 2012-2015, follows on from the 2009-2011 Action Plan. Some of the actions in this Plan continue work already started during 2009-2011, while others address issues raised by the Bamford Review which were not possible to progress during the 2009-2011 Plan. The plan also includes a number of issues which were not considered by the Bamford Review but which fall under the broader vision of the Review

1.8 In preparing this Action Plan, those who use the services and their families and carers have had opportunity to influence the Plan through:

- two initial workshops held in September 2011 to gather views on the key areas for renewed action;
- two workshops in March 2012 jointly hosted by the Inter-Departmental officials group and the Bamford Monitoring Group to consider how cross-sectoral working could be improved; and
- continued close working with the Bamford Monitoring Group.

Transforming Your Care

1.9 *Transforming Your Care*, TYC, – a review of health and social care in Northern Ireland published in December 2011 has many parallels with the Bamford Vision in respect of mental health and learning disability service provision and enhancement including;

- Early intervention and health promotion,
- A focus shift to community care,
- Promotion of recovery practices,
- Personalisation of care,
- Resettlement,
- Service user and carer involvement,
- Advocacy,
- Provision of clearer information, and
- Respite provision.

1.10 The Evaluation of the 2009-2011 Bamford Action Plan and the TYC Review both also acknowledge the many improvements in mental health and learning disability services over the last few years and the ongoing need to continue to drive forward more rapid progress.

1.11 The TYC Review reflects the Bamford Vision, with both committed to delivering the best outcomes, increasing independence, choice and service improvements for people with mental ill-health or a learning disability. This will enable accelerated service enhancement in line with the needs and expectations of service users and carers in a coordinated and consistent manner.

Bamford Implementation Structures 2012-2015

2 WHERE WE ARE NOW

The Bamford Vision

2.1 *Delivering the Bamford Vision* set out the broad direction in which mental health and learning disability priorities were to be addressed across Government and the health and social care sector in particular. The 2009-2011 Action Plan contained 80 mental health and 67 learning disability actions, with some actions common to both, to be undertaken over the period of the Plan. Many of the actions were supported by additional resources committed in the Comprehensive Spending Review for that period.

Evaluation

2.2 Progress on the Plan has been monitored on a regular basis and a more detailed evaluation carried out during 2011. This shows that about 80% of the actions committed to in the 2009-2011 Plan have been carried out. This was achieved despite a reduction in the anticipated allocations to the health and social care sector and the wider public sector in 2010/11 due to the generally worsening financial climate. The full evaluation report can be accessed at:

http://www.dhsspsni.gov.uk/show-publications?txtid=56444

2.3 The evaluation report acknowledges that some actions were preparatory steps in modernising and improving services, through developing strategies and new models of service delivery, and recognises that people who use the services may not yet have seen much difference in the actual provision of services.

2.4 Significant work and investment has however gone into:

- Inter-Departmental working across education, housing, training and employment, as well as within the health and social care sector, to ensure that as far as possible, people with a learning disability or a mental health need are supported within their communities;
- developing a range of strategies and plans for future service developments;
- improving mental health and learning disability services, with an emphasis on community based early intervention and a significant investment of new funding to support this;
- detailed preparations for the drafting of the new mental capacity legislation.

Learning

2.5 Despite this work and additional investment, there is still a long way to go in achieving the goal of improving the lives of people with a mental health need or a learning disability and their families and carers. Reports from the Bamford Monitoring Group, which was established to represent the views of these groups of

people, indicate that:

- generally, people recognise that the Bamford Vision is beginning to make a positive difference to their lives, but there is frustration with the slow pace of change.
- people are concerned that funding and the other resources necessary to realise the Bamford Vision may be reduced due to the financial cutbacks.
- there is a perceived major deficit, at a regional level, in the provision of advice and information services for those who use and rely upon mental health and learning disability services.
- people with mental health needs, learning disabilities, parents, carers and communities want to be involved in the planning, design, delivery and evaluation of services in Northern Ireland.
- service users and carers believe there to be a considerable lack of cross-sectoral working on realising the Bamford Vision. This has the potential to be a major barrier in the delivery of essential services and cause stress to individuals, families and carers.

2.6 Much, therefore, remains to be done and there are many challenges to be faced in a difficult financial environment.

3 THE CHALLENGES AHEAD

Challenges

3.1 In committing to the delivery of the first stage of the Bamford reforms through the 2009-2011 Action Plan, the Executive was aware of the challenges for the future that would have a major influence on the implementation of that plan and future plans. These included demographic change, particularly our longer life-spans with increasing complexity of needs, and the levels of public sector funding that could be directed towards supporting the reform and modernisation of mental health and learning disability services, taking account of all the other pressures on public sector funding.

Our Ageing Population

3.2 These challenges remain. Numbers of older people continue to increase, and this is addressed in this Action Plan for 2012-15 mainly through two strands of work on dementia services and on the needs of people with a learning disability as they and their carers grow older.

Finances

3.3 As a result of the 2008-2011 Comprehensive Spending Review DHSSPS allocated an additional £44m to mental health and learning disability services, as outlined below, with a further £3m made available to support mental health promotion and suicide prevention over the three year period.

DHSSPS proposed additional funding for mental health and learning disability 2008/09- 2010/11

3.4

	2008/09 £m	2009/10 £m	2010/11 £m	Total 3 year 2008/09 to 2010/11 £m
Learning Disability	7.00	2.00	8.00	17.00
Mental Health	12.75	1.85	12.40	27.00
TOTAL	19.75	3.85	20.40	44.00

3.5 The widespread constraints in public spending in 2010/11 impacted on the amounts planned for mental health and learning disability as set out in the table below. The amounts allocated were reduced from £27m to £17.1m for mental health and from £17m to £12.4m for learning disability.

DHSSPS actual additional funding mental health and learning disability

3.6

	2008/09 £m	2009/10 £m	2010/11 £m	Total 3 year 2008/09 to 2010/11 £m
Learning Disability	7.00	2.00	3.40	12.40
Mental Health	12.40	1.90	2.80	17.10
TOTAL	19.40	3.90	6.00	29.50

3.7 While these reductions, along with the general requirement to deliver annual efficiency savings, have had some effect on the Health and Social Care sector's ability to deliver on actions in the 2009-2011 Action Plan, the evaluation of the Action Plan shows that actual spending by the HSC Trusts on mental health and learning disability services increased between 2007/08 and 2010/11 by sums considerably more than those actually allocated as additional funding by DHSSPS.

3.8 By the end of 2010/11, expenditure on mental health services had risen by £32.31m from the baseline of £195.69m in 07/08

Mental Health Expenditure

3.9

	07/08 £m	08/09 £m	09/10 £m	10/11 £m
Hospital	95.81	109.49	107.04	103.46
Community and Social Services	99.88	111.96	117.26	124.54
Total actual spend	195.69	221.45	224.30	228.00
Increase over 2007/08 baseline		25.76	28.61	32.31

3.10 Learning disability service data demonstrates corresponding increased resourcing over and above the Bamford CSR uplift. By the end of 2010/11, expenditure on learning disability services had risen by £39.88m from the baseline of £200.20m in 07/08.

Learning Disability Expenditure

3.11

	07/08 £m	08/09 £m	09/10 £m	10/11 £m
Hospital	40.14	42.67	42.23	42.98
Community and Social Services	160.06	172.64	186.03	197.09
Total actual spend	200.20	215.31	228.26	240.08
Increase over 2007/08 baseline		15.11	28.06	39.88

3.12 A wide range of Departments and agencies also fund programmes and services which benefit people with mental ill-health or a learning disability. Most of these benefit a wider range of people; it is not therefore possible to identify how much of this funding directly impacts Bamford services.

3.13 Funding will continue to be a significant challenge in the period to 2015 and beyond. There is continuing pressure to achieve efficiencies. The only additional funding to the Health and Social Care sector earmarked for mental health and learning disability services over the budget period 2011-2015 is £9.20m - £2.80m for mental health and £6.40m for learning disability - to continue the resettlement programme. This contrasts sharply with the financial outlook at the start of the 2009-2011 Action Plan, when much more significant increases in funding were anticipated.

3.14 New actions or initiatives will require further financial analysis and their implementation will be subject to resource availability and prioritisation within the respective organisation(s). However, it is acknowledged that much can be achieved through reform, modernisation, and redesign of commissioning arrangements and service provision. In the context of health and social care services, such an approach is underpinned by *Transforming Your Care* (December 2011) and its associated consultation document *Vision to Action*[1].

New Challenges

3.15 A further challenge relates to emerging issues. It is now 10 years since the Bamford Review started its work. Over time service provision and inter-relationships between services change and evolve and the priorities attributed to particular issues by those who use the services, their families and carers and the general public change. Issues are emerging now which were not highlighted in the Bamford review, but need to be addressed. While not strictly a response to the recommendations of Bamford Review, actions proposed on such emerging issues will be taken forward in the broader framework of reform and modernisation envisaged by Bamford and in

[1] *Transforming Your Care*(December 2011) and *Vision to Action* - A consultation document(October 2012 – 15 January 2013)

keeping with the Bamford ethos of support and care which is person-centred and enabling.

4 THE WAY FORWARD

The Bamford Vision

4.1 The Executive's Vision for the Future set out in the 2009-2011 Action Plan remains valid today and will continue to guide the service improvements across Government.

THE BAMFORD VISION

To make the Bamford vision a reality, the NI Executive will promote the mental wellbeing of the population as a whole. The Executive will also promote the health and wellbeing, and maximise the independence and full participation of people of all ages with a mental health need or a learning disability, underpinned by legislation and public services to include reform and modernisation of mental health and learning disability services.

People with a mental health need or a learning disability using public services should expect to:

- *be encouraged and supported to look after their own health, both mental and physical, and build up emotional resilience;*
- *be supported, as far as possible, in their own homes and communities, making best use of self-directed help;*
- *be supported, through effective collaboration between Government Departments and their agencies, in their life choices and in day to day activities of engaging in education, training, work and leisure;*
- *be consulted on and be able to influence the provision of services to meet their needs;*
- *be encouraged to access help at as early a stage as possible; and*
- *be supported towards personal fulfilment and full citizenship.*

4.2 This is the vision for the future, supported by all Government Departments.

4.3 The actions in this Action Plan consist of:

- actions carried forward from the 2009-2011 Action Plan due to the work not

being completed;
- actions which are a consequence of the actions completed in the 2009-2011 Plan;
- new areas of work which had not been addressed in the previous Plan, some of which were highlighted in the 2008 consultation on the Executive's response to the Bamford review, but could not be made a priority in the 2009-2011 Plan.

4.4 As indicated earlier in Chapter 3, the actions in this Plan also take account of the financial outlook. Only actions which can be taken forward within the existing budgetary allocations are committed to in the Plan.

Work areas which support the Bamford Action Plan

4.5 The 2009-2011 Action Plan reinforced the message that mental health and learning disability issues are affected by actions much wider than just the provision of services which bear those labels. It was recognised, for example, that action in relation to tackling domestic and sexual violence contributes to the emotional wellbeing of many in our community. Work on promoting Personal and Public Involvement (PPI) throughout the health and care sector will promote the inclusion of people with a learning disability or a mental health need and improve services by making them more responsive to the needs of service users. Similarly work to support families and carers and the general drive to increase uptake of Direct Payments impact on people using mental health and learning disability services in parallel with other groups of people.

4.6 While work continues in all of the areas mentioned in 4.4, this new Action Plan does not include this work as specific actions in the Tables in Section B. The tables concentrate instead on actions which are focused on mental health and learning disability issues.

4.7 In addition many of the actions from the 2009-2011 Action Plan which were completed will continue to have an effect during the lifetime of this new Action Plan. These actions however are not repeated in this new Plan. For example, findings from the workforce study carried out as part of the 2009-2011 Action Plan will be taken forward as an integral part of the work to develop mental health and learning disability services in general as well as in actions relating to specific services being addressed within this new Plan.

4.8 Work which was carried out to improve information on the use of mental health and learning disability services will help those commissioning and providing services to improve service delivery. Further work is indicated in the Action Plan however in relation to provision of information for those seeking to access services; this has been highlighted by the Bamford Monitoring Group as an area where improvement is needed.

Criminal Justice Services

4.9 A High Specialist Support Services sub-group under the HSC Bamford Taskforce provides a coordinated approach across Health and Social Care and Criminal Justice Systems, CJS. The sub-group seeks to improve services provided to people with mental health and/or a learning disability who are, or have been, in recent contact with the CJS. Membership includes representatives from DOJ, DHSSPS, the HSC sector, PSNI and service uses and carers.

4.10 The cross sectoral working ethos of the sub-group has achieved much already and continues to focus on developing care pathways, quality and outcome measures, specialist learning disability services and a regional inter-agency training approach.

5 THEMES

5.1 The 2009-2011 Plan reinforced key Bamford messages by grouping the actions under five themes:

BAMFORD THEMES

1. *Promoting positive health, wellbeing and early intervention*
2. *Supporting people to lead independent lives*
3. *Supporting carers and families*
4. *Providing better services to meet individual needs*
5. *Developing structures and a legislative framework*

5.2 These will continue to be the themes within which the Bamford agenda will be progressed through this 2012-2015 Action Plan.

Promoting positive health and wellbeing

5.3 Promoting positive community and personal health and wellbeing was central to the Bamford Review's vision. DHSSPS continues to lead on the development of a new 5 year cross-sectoral Mental Health & Wellbeing Promotion Strategy to be issued for public consultation in late 2012. The new strategy for the period 2013 to 2018 will focus on building the mental and emotional resilience of the whole population and of specific "raised risk" groups. As with previous work on this issue, it will require effective collaboration across departments and sectors.

5.4 The new Mental Health and Wellbeing Promotion Strategy will have strong links with the Protect Life strategy on suicide prevention, which has been refreshed to run to March 2014. Action on these two strategies, with their emphasis on cross departmental/ sectoral commitment, will form a key strand of work within this Bamford Action Plan for the coming years.

5.5 The importance of promoting emotional wellbeing in children and young people, equipping them with coping skills and providing support where necessary, is recognised in a series of actions to be undertaken by Department of Education.

5.6 Helping people with a learning disability maintain their physical health is also recognised in this theme, through continued implementation of the Directed Enhanced Services and targeted action on dental services.

Supporting People to Lead Independent Lives

5.7 Leading a fuller life through active participation in the community and being able to engage in meaningful day-time activities was a key theme within the Bamford Review

reports, particularly the Equal Lives report on people with a learning disability. The Office of the First Minister and Deputy First Minister continues to lead cross-sectoral work on promoting social inclusion for people with a disability. Work also continues on improving access to work, on training for work and on access to public transport, recognising their role in helping people be more independent.

5.8 The Bamford Review called for a renewed impetus to resettle into the community the substantial number of people who remained unnecessarily in long stay mental health and learning disability hospitals. The resettlement programme will continue during the period of the 2012-15 Action Plan, supported by funding earmarked for that purpose. At the same time processes will continue to ensure that patients admitted to hospital in more recent times are discharged back into the community as soon as their assessment and/ or treatment is completed.

5.9 Direct Payments can be used to increase choice and promote independence. They provide for a more flexible response to meeting the needs of the service user as users can opt to purchase services themselves by means of a Direct Payment from the HSC Trust in order to tailor their support package to their individual needs.

5.10 It is still DHSSPS policy to offer Direct Payments as an alternative to direct service provision, but a recent court judgement means that there is no legal basis to enter into a direct payment arrangement with an individual who lacks capacity. It is the Department's intention to amend existing legislation to make provision for another individual to receive Direct Payments on behalf of a person with eligible needs who lacks capacity to consent to such payments. It may, however, take some time to effect the necessary legislative change, so arrangements are being put in place to ensure that Direct Payments can continue to be offered in the interim period.

5.11 Direct Payments can increase choice to some extent. Many people who use mental health and learning disability services have said that they would like to be given greater freedom to arrange a package of support and care that truly suits their individual needs and their family circumstances. While there may be benefits to those who use services, there may also be drawbacks which would not make personalisation suitable for everyone. Over the life of this Action Plan, DHSSPS will undertake work to consider how best the policy of "self directed support" or "personalisation" can be progressed in Northern Ireland. This is reflected in the Action Plan in Section B.

Supporting Carers and Families

5.12 The contribution made by many families and other informal carers in supporting people with a mental health need or a learning disability is immense. Work continues on the recommendations contained in the earlier Joint Review of Support Provision for Carers, including provision of information for carers, both in booklet form and on the NI Direct website, and promoting the use of the Carers Support and Needs Assessment component of NISAT. RQIA will commence a review of the implementation of the DHSSPS Standards for Adult Social Care Support Services for Carers across relevant HSC services in 2012, which will inform future work to support

carers. The work on personalisation referred to in paragraph 5.10 also has the potential to provide better support for families and carers.

5.13 Investment in respite services, with associated targets for increased provision in the 2009-2011 Action Plan, recognised the value of respite provision to carers and to service users. However attempts to monitor the targets highlighted difficulties with defining respite provision and with measuring consistently the extent of provision. The HSC Board has been engaged in a substantial exercise to bring fairer approaches to assessment for and provision of respite services. This work will continue during this Action Plan period and will take into account the issues raised in the recent Bamford Monitoring Group report on respite services.

5.14 Stakeholders have also highlighted that increased emphasis on managing mental health periods of crisis within the community puts an added burden on family and carers. Carers' needs have to be recognised and appropriate support and information provided as part of the further development of these services.

Providing Better Services

5.15 The publication of the mental health Service Framework in 2011 and the anticipated publication of the Service Framework for learning disability will serve to improve health and social care services through setting standards. Community mental health and learning disability services will continue to be built up, so that fewer people need to be admitted to hospital. Work will continue on many of the service improvement areas started in the 2009-2011 Action Plan:

- developing early interventions, including psychological therapies;
- building up specialist services, eating disorder, perinatal mental health and forensic services;
- ensuring timely discharge from hospital after assessment and treatment.

5.16 In view of the Bamford Monitoring Group's findings in relation to service users and carers being able to access information on services, work will continue on a service mapping project for mental health services with the aim of providing information to people who wish to access the services in their area. This project will then be extended to learning disability services.

Research

5.17 In 2011, 5 reviews of current research and research evidence were commissioned by HSC R&D Division in areas prioritised by key stakeholders including clinicians, commissioners, researchers and service users. The completed reviews were disseminated widely including a launch event in November 2011. Eight research questions, for which no robust evidence is yet available, led from these reviews and formed the basis of a further call for substantive research projects which closed in March 2012. Following the evaluation panel, five projects were funded. These projects, the titles of which are listed below, will run for a period of 18-36 months.

- A natural experiment investigating differences in how residential facilities support people with intellectual disabilities with challenging behaviour and/or mental health problems.
- Effective family support models during the transition of adults with intellectual disabilities (ID) into old age.
- Transitions & outcomes for care leavers with mental health and/or intellectual disabilities.
- Parental Alcohol Use and Resilience in Young People in Northern Ireland: A study of Family, Peer & School Processes, and
- Improving pathways and care for young people in NI with mental health problems in the transition from CAMHS to adult services (IMPACT).

Developing Structures and a Legislative Framework

5.18 The structures supporting work on Delivering the Bamford Vision as set out in Chapter 1 will remain in place. There is however a need to address the concerns expressed by the Bamford Monitoring Group and by other stakeholders that cross-sectoral working is not seen at local level and that lack of joined-up working causes frustration for those who uses the services and for families and carers.

Workshops

5.19 To inform preparation of this Action Plan, two workshops were held in March 2012 under the auspices of the Inter-Departmental Senior Officials Group, IDSOG, and the Bamford Monitoring Group, BMG, to consider how cross-sectoral working could be improved to benefit those who use mental health or learning disability services.

Workshop themes

5.20

5.21 In response to issues raised at these workshops the IDSOG will sponsor work on local level cross-sectoral issues, involving the relevant stakeholders along with representatives from the Bamford Monitoring Group. This is reflected in the Action Plan in Section B.

Children and Young People's Strategic Partnership

5.22 A new regional cross-sectoral group will also contribute to delivering the Bamford agenda for children and young people through the HSC Board. The Children and Young People's Strategic Partnership (CYPSP) was established in January 2011. The HSC Board has a statutory duty to establish and lead the CYPSP and publish a Northern Ireland Children and Young People's Plan; the first of these has been issued for consultation. The Partnership and its Plan is multi-agency and multi- sectoral. The purpose is integrated planning and commissioning to improve outcomes for our

children and young people, including those who have a disability.

5.23 Of particular relevance to the Bamford agenda will be three regional sub groups of the CYPSP:

1) children and young people with emotional and behavioural difficulties;
2) children and young people with disabilities;
3) transition for young disabled people from childhood to adulthood.

Mental Capacity Legislation

5.24 The need for new legislation was a key recommendation arising from the Bamford Review, which called for the development of a single legislative framework for the reform of the current Mental Health (NI) Order 1986 (the 1986 Order) and the introduction of new mental capacity legislation in Northern Ireland. The 2009-2011 Action Plan included an action to take forward work on new legislation, but recognised that it would be later than 2011 before new legislation could be introduced.

5.25 Preparation of a draft Bill is under way, with a previous intention of introducing the Bill into the Assembly in 2012 and enactment in 2013. A major element of this legislative reform will be to embed a set of principles in the legislation, as recommended by the Bamford Review. The Bill will also provide for substitute decision-making on behalf of those unable to make decisions for themselves provided safeguards set out in the Bill are engaged. However a recent decision by DHSSPS and the Department of Justice to extend the scope of the Bill to those subject to the criminal justice system has meant that the Bill's introduction to the Assembly is now scheduled for December 2013 with enactment following, at the earliest, in 2015.

5.26 The draft Bill will also include a new statutory right to an independent advocate in certain circumstances. To pave the way for this new right, draft policy guidance for commissioners of advocacy services was published earlier this year; further work on the new statutory right will be taken forward during the period of this Action Plan.

6 LEARNING DISABILITY

Core Values

6.1 The Bamford Review based its recommendations relating to people with a learning disability on 5 core values of:

- Social inclusion – people with a learning disability are valued citizens and must be enabled to use mainstream services and be fully included in the life of the community;
- Citizenship – people with a learning disability are individuals and each has a right to be treated as an equal citizen;
- Empowerment - people with a learning disability must be enabled to actively participate in decisions affecting their lives;
- Working Together – conditions must be created where people with a learning disability, families and organisations work well together in order to meet the needs and aspirations of people with a learning disability;
- Individual Support - people with a learning disability will be supported in ways that take account of their individual needs and helps them to be as independent as possible.

6.2 These core values will continue to influence the development of learning disability services as we move into this new Action Plan.

Service Framework

6.3 A Service Framework for Learning Disability, published in September 2012, sets out clear standards of care that people can expect. This Framework aims to improve the health and wellbeing of people with a learning disability, their carers and families, by promoting social inclusion, reducing inequalities in health and social wellbeing and improving the quality of health and social care services, especially supporting those most vulnerable in our society.

Children and Young People with a Learning Disability

6.4 Work will continue across the health and social care and education sectors to ensure that children with a learning disability are supported and encouraged to develop to their full potential and to participate as fully as possible in school. The Education and Library Boards have statutory responsibilities in this regard. Recognising that transition to adulthood can be a particularly daunting time for young people with a learning disability, work will continue across Departments and their agencies to support young people during this period of their lives. The transitions sub-group of the Children and Young People's Strategic Partnership will play a significant role in this work.

Older People with a Learning Disability

6.5 Equal Lives, the Bamford Review report on learning disability, recognised that increasing numbers of people with a learning disability were living to old age, but that this brought added challenges. Family carers also grow older and become unable to continue with the caring role. Accommodation and day time activities may no longer be suited to the person's interests and physical abilities. Dementia can start at an earlier age than for most other people. This Action Plan includes a commitment to develop a plan to support people with a learning disability who are living with elderly carers where there is a risk of that caring arrangement breaking down.

Resettlement

6.6 There are currently around 200 long-stay patients in learning disability hospitals who no longer require hospital treatment and who could be resettled into the community. As with mental health, work will continue over the period of this Action Plan to seek alternative care arrangements for as many of these people as possible with the current funding of £6.4m identified for this and to identify options to achieve the long term objective to complete the resettlement programme by 2015. The principle of betterment will continue to inform decisions.

7 MENTAL HEALTH

Community focus

7.1 The overarching vision of the Bamford Review that people with a mental illness should be treated in the community unless there is a clear clinical reason not to do so has been widely accepted by users and carers and by those who provide services to them. However, the reform and modernisation of mental health services needs continued impetus to ensure the necessary shift in investment from hospital based services to community based services is achieved. The objective of redirecting mental health spend so that 60% of total spend goes towards community based services was not achieved during the 2009-2011 Action Plan and will continue to be an objective in this Plan.

Supporting Recovery

7.2 Further development of a range of community mental health services is required to enable people to be treated close to family networks. This should be complemented by a smaller inpatient service. The full range of services needs to be firmly based in a recovery ethos, whereby people are rehabilitated to live as fulfilling and independent lives as possible, even with limitations caused by illness. Since those who use the services should determine their own recovery goals, full involvement of those who use the services and their families and carers is a key requirement to promoting a recovery ethos. Since recovery can mean many different things, some of which are not necessarily related to the complete alleviation of the symptoms of the illness, the voluntary and community sector is well placed to complement statutory health and social care sector provision in supporting people's recovery.

7.3 The Action Plan in Section B includes a commitment to undertake a programme of work that will facilitate an enhanced culture of recovery across all mental health services. This is likely to include, among other things, the development of training initiatives, establishing effective communication systems with service users and carers and audit and evaluation mechanisms.

7.4 Reflecting what recovery means to those who use mental health services will also be a major influence in the work to measure outcomes and evaluate the success of the Bamford Vision, as outlined at Chapter 8. There is a range of measures of recovery outcome. One of the rapid reviews under the research programme in the 2009-2011 Action Plan recommended a number of these for further consideration.

Service Framework

7.5 Implementation of the Service Framework for Mental Health and Wellbeing, published in 2011 will be instrumental over the period of this Action Plan in improving the mental health and wellbeing of the population of Northern Ireland, reducing inequalities and improving the quality of health and social care in relation to mental

health.

7.6 The Service Framework sets standards in relation to the prevention, assessment, diagnosis, treatment, care, rehabilitation of individuals and communities who currently have or are at greater risk of developing mental illness. The standards adopt a lifespan approach that will enable each individual to be seen in their own context at their own point in life.

Stepped Care

7.7 The stepped care model of providing the right level of services to the right people at the right time will continue to shape the development of mental health services. Early interventions in primary care will continue to be promoted, including better access to psychological therapies.

Resettlement

7.8 There are currently around 150 long-stay patients in psychiatric hospitals who no longer require hospital treatment and who could be resettled into the community. Work will continue over the period of this Action Plan to seek alternative care arrangements for as many of these people as possible.

7.9 A total of £2.8m has been allocated for the current spending review period, but the total cost to complete the mental health resettlement programme is significantly greater. Work will continue on options to achieve the long term objective to complete the resettlement programme by 2015.

7.10 The ongoing resettlement programme has also helped to identify an emerging group of people (about 100) in mental health inpatient facilities with quite challenging behaviours who require further longer term rehabilitation before they could be considered for community placement. These patients were identified in a review by the Department in 2010 which recommended 3 twenty bedded dedicated low secure units for Northern Ireland be established to facilitate such rehabilitation. Work will now be carried out to implement a regional approach to the provision of these facilities.

Children and Young People

7.11 In response to an RQIA review of Child and Adolescent Mental Health (CAMH) services, work is under way to develop policy guidance on a service model for these services. This policy guidance will confirm the preferred model for the organisation and delivery of Child and Adolescent Mental Health Services (CAMHS) in Northern Ireland and will also adhere to the overall strategic direction for CAMHS within the Bamford Review. A stepped model is proposed, building on the existing tiered approach, but making service delivery more user-centred. This is similar to the approach being adopted in adult mental health services. This stepped care approach will be more patient focussed and able to deliver the appropriate level of care that best meets the child or young person's assessed needs.

Older People

7.12 Work will continue to improve dementia services in line with the recent strategy, with its emphasis on ensuring that people with dementia are treated with awareness and respect, especially by those providing services, and that they are supported to maintain their independence for as long as possible. Older people with functional mental illness will benefit from the improvements being made to adult mental health services.

8 MONITORING AND EVALUATION

Evaluation of 2009-2011 Plan

8.1 The evaluation of the 2009-2011 Action Plan has shown progress, but recognises that much more needs to be done. The evaluation has also been mostly factual outputs – the actions were achieved or not achieved. It was also restricted in the extent to which it has been possible to reflect on whether those who use the services and their families and carers have seen any difference in the services delivered or in the way they are delivered to them.

Monitoring

8.2 The IDSOG will continue to monitor the implementation of the actions within this Plan. The Group will now publish its monitoring reports at regular intervals throughout the life span of this Plan in order that progress can be tracked by all stakeholders.

Outcomes over outputs

8.3 The qualitative/quantitative balance of the future evaluation of this Action Plan will reflect requests from those who use these services. The evaluation will therefore focus primarily on user outcomes over the more quantitative aspects of service delivery reflected in the monitoring reports.

8.4 The Bamford Monitoring Group under the Patient and Client Council has drafted a service user Outcomes Paper, enclosed at Annex A. This Paper is derived from the reports, feedback from conferences and workshops held by the group in the past 2 years and on the broad themes identified at the BMG/IDSOG Workshops in March 2012. The Paper proposes outcome measures for consideration within the context of the future evaluation of this Action Plan. These proposed outcome measurements should also enable the evaluation of this Plan to reflect more fully the views of those who use and rely on mental health and learning disability services.

8.5 This will be augmented by work being taken forward by the HSC Bamford Task Force to measure outcomes, and the development of indicators supporting Service Frameworks for both mental health and learning disability services.

8.6 All of this work will be underpinned by the principle that Delivering the Bamford Vision is about improving the lives of men, women and children who have a mental health need or a learning disability.

SECTION B

2012–2015 BAMFORD ACTION PLAN

In this Action Plan actions are shown within each of the 5 themes outlined at paragraph 5.1. Within each theme, actions which impact both mental health and learning disability services are shown first, followed by actions impacting only on learning disability and then actions which will impact only on mental health services.

HEALTH AND WELLBEING

Joint actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
1A	DHSSPS	Publish and Implement a revised cross-sectoral Promoting Mental Health Strategy	DHSSPS, with contributions from relevant Departments - led by DHSSPS Investing for Health Group	Publish a revised cross-sectoral Promoting Mental Health strategy, taking account of lessons learned from previous work	March 2013	Better mental wellbeing in the population
1B	DHSSPS		PHA	Implement Action Plan from Promoting Mental Health Strategy	Ongoing	
2	DE	Develop final proposals for Early Years Strategy	DE .	Early Years (0-6) Strategy implemented; early years providers deliver high quality experience for every learner.	November 2012	Children receive a high quality pre-school experience that promotes their healthy development and lays the foundations for the achievement of good outcomes in the longer term.

3	DCAL	Implement a 10 year Strategy for Sport and Physical Recreation	DCAL	A greater emphasis on the mental benefits of regular participation in sport and physical recreation	Ongoing	Improved opportunities for people to gain the mental well being benefits of participation in sport and physical recreation
4	DE	Promote an anti-bullying culture within schools in partnership with the NI Anti-bullying Forum	Pupil Support Unit	All schools have in place an effective approach to tackling all forms of bullying	Ongoing	Pupils and parents are confident that their concerns about bullying will be dealt with in an appropriate and timely manner

Learning Disability Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
5	DHSSPS	Ensure that persons with a learning disability have equal access to the full range of primary health care services	HSC Primary Care, Acute Hospitals, Multi-Disciplinary Learning Disability Teams, Other Providers	Full implementation of Learning Disability Directed Enhanced Services across region	March 2015	Improve the health status of people with a learning disability in key areas such as nutrition, obesity, exercise and mental health.

Mental Health Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
6A	DHSSPS	Progress the next phase of the suicide prevention strategy	DHSSPS	Carry out evaluation of the effectiveness of the implementation of the "Protect Life" strategy 2006, at both a local and regional level.	December 2012	Fewer people attempt to or take their own life
6B				Publish the next phase of the suicide prevention strategy, based on the latest available evidence and findings from the evaluation.	December 2013	

7A	DHSSPS	Develop and implement New Strategic Direction on drugs and alcohol Phase 2, and Strategy Evaluation	DHSSPS	Complete actions from NSD Phase 2 Implementation	December 2015	Reduce levels of harm related to Alcohol and Drug Misuse
7B				Undertake a regional commissioning framework across all four tiers of service delivery for young people, families and adults	March 2013	Consistent approach to service design and delivery
7C				Implement commissioning framework recommendations	December 2015	Evidence based services in place to meet regional and local needs

7D				Work in partnership with the Drug and Alcohol Co-ordination Teams to ensure a co-ordinated response to address current and emerging needs	Ongoing	Improved co-ordination through partnership working at locality and regional levels
8	DHSSPS	Respond to the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness in Northern Ireland 2011	PHA	Implementation of recommendations	March 2013	Minimise occurrence of suicide and homicide by people who access mental health services in NI.

9	DETI	Specialist health and safety inspectors and business advisors to provide advice and, where necessary, enforcement in high stress risk work sectors	HSENI	Organisations in sectors, in which employees are at a high risk of suffering from workplace stress related ill health caused by or made worse by their work, provide appropriate support	Ongoing	Reduce stress-related ill-health and associated absenteeism in high stress-risk work sectors and increase productivity.
10	DE	Promote a focus on pupils' emotional health and wellbeing through a programme of awareness raising and staff capacity building for all schools	DE – Pupil Support Unit	All schools proactively promote pupils' wellbeing as part of their raising standards agenda.	Ongoing	A caring and supportive environment exists in all schools and all pupils and staff benefit from the active promotion of positive mental health.
11	DE	Maintain access to counselling support which is independent of the school for all pupils of post primary age	DE – Pupil Support Unit	Counselling support remains accessible in all secondary and special schools	Ongoing	All pupils of post primary age have access to counselling support which is independent of the school.

SUPPORTING PEOPLE

Joint Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
12	OFMDFM	Publish a strategy for the implementation of recommendations arising from the PSI report on Disability.	OFMDFM	Publish a strategy document based on the recommendations arising out of the PSI Report on Disability, taking into account each strategic objective in relation to the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).	June 2013	Improved social inclusion of people with disabilities across a wide range of areas and activities examined by the PSI Group including:• Access to Employment;• Children, Young People and their Families;• Housing, Transport, Information and Access.
13	DHSSPS	Resettle long stay patients from learning disability and mental health hospitals	HSC DHSSPS DSD	Resettle all long stay patients	March 2015	More people able to live independent lives safely in the community

14	DSD	Scope existing supported housing capacity/suitability to maximise resources	NIHE	Commissioning programmes for new provision will consider examining capacity/suitability to maximise existing resources	Ongoing	Ensure that suitable, safe and supported housing is available for those with a mental health need or a learning disability who require it
15	DSD DHSSPS	Ensure new build supported housing programmes are "future proofed" to ensure longevity/sustainability in terms of the tenants	HSC DSD DHSSPS NIHE	Needs assessments to take into account longevity/sustainability	Ongoing	Ensure that suitable, safe and supported housing is available for those with a mental health need or a learning disability who require it
16	DEL	To support and develop the Employment Advisor Teams to deliver services to people with mental ill-health or a learning disability	DEL Disability Employment Service.	Pilot roll-out of Employment Service Pathway Teams	December 2012	To deliver a more individually tailored service to all ESA clients.

17	DEL	Maintain support arrangements and extended eligibility for participants with disabilities on the Training for Success programme.	DEL's Training Programmes Branch	Maintained access and support arrangements.	Ongoing	Support provided, as necessary, to those with disabilities to facilitate access to and participation in training.
18	DEL	Widen Participation in Higher Education Strategy	DEL's Higher Education Widening Participation Branch	NI Executive has agreed the Widening Participation Strategy. To commence action/projects in support of the WP initiatives targeted at students with disabilities.	Ongoing	Provision of targeted support at students with disabilities who are at risk of being excluded from higher education.
19	DEL	Establish and progress effective Partnership Agreements and joint working arrangements with post-primary schools, further education, training and apprenticeship providers, HSC Trusts and organisations who act as advocates for young people with a variety of barriers, including disabilities.	DEL's Careers Service	Improved to careers services leading to better outcomes for clients.	Ongoing	Improved careers decision making and increased participation in education, training and employment

20	DEL	Lead on the implementation of a cross-departmental Strategy - "Pathways to Success" - for those young people Not in Education, Employment or Training (NEET).	The NI Executive agreed a cross-Departmental Strategy. A NEET Advisory Group will be established comprising officials from the main Departments involved, representatives from the voluntary/community sector, education and health and social care sectors, local government and the business sector.	Subject to economic conditions, help to prevent young people falling into the NEET category; and help reduce the number of young people within the NEET category by, for instance, improving their opportunities to move out of poverty. . The Strategy has committed to put in place a system to scope and develop more robust measurement metrics in relation to those who are at risk of falling into or in the NEET category.	Tracking system in place by 2014.	A reduction in the number of young people most at risk of remaining outside education, employment or training (NEET); a group which will include those with mental health and learning difficulties.
21	DEL	To develop Careers Service delivery to support the above mentioned "Pathways to Success" Strategy (for NEETs).	DEL's Careers Service	Case management of 17/18 year olds	June 2013	Increased participation in education, training and employment by 16-24 age group

22	DEL DE	Continue to work in partnership with DE to increase the level of information sharing in respect of relevant pupil data being shared with DEL's Careers Service including electronic sharing of pupil data via C2K.	DEL's Careers Service in conjunction with DE.	Improved service to young people. Data Sharing Agreements in place with schools, data sharing delivered via C2K.	Ongoing	Improved information sharing should lead to more focused support for young people moving into education, training and/or employment.
23	DEL	Continue to provide specialist support, as appropriate, for young people considering participating in Training for Success (TfS).	DEL's Training Programmes Branch	Improved service to young people.	Ongoing	Ongoing provision of appropriate targeted support to enable young people with significant barriers to enter, engage and achieve the best possible outcomes.
24	DEL	Incorporate provision within the design of the new Work Connect Programme to meet the employment needs of those who are claiming Employment Support Allowance and who have mental ill-health and learning disability.	DEL's Disability Employment Service (DES)	To monitor and review the level of participation and success of the new Work Connect programme.	March 2013	Providing targeted support to enable adults with significant barriers to improve their employability and, if appropriate, enter employment.

25A	DHSSPS	To support the uptake of self-directed support and individual budgets in line with Transforming Your Care	DHSSPS	Produce a Departmental high level vision for self directed support	March 2013	People will have options to choose the most appropriate services for their needs
25B			HSC	Increase the number of people with self-directed support and individual budgets	March 2015	
26	DE	Take forward and implement Review of Special Educational Needs & Inclusion	DE	Following July 2012 agreement by the Executive of a Policy Memorandum: draft instructions for OLC for primary legislation; draft subordinate legislation for consideration by Education Committee; draft new statutory code of practice for consultation. Following commencement of new legislation, begin to implement agreed legislation and statutory code over a 5-year transitional period.	Ongoing from 2012 until legislation is commenced and transitional arrangements put in place	Pupils with special educational needs supported to achieve to their full potential through early identification of need and early intervention

27	DHSSPS	Implement "Developing Advocacy Services - A Policy Guide for Commissioners"	HSC	Implement Advocacy Services Action Plan	March 2013	Principles and standards which should lead to greater parity and consistency in the commissioning and delivery of advocacy services.
28A	DHSSPS	To support the employment of experts by experience in the commissioning and delivery of mental health and disability services.	HSC	To move to a position where service users and carers are employed in the commissioning and delivery of services	Ongoing	Services meet the needs and expectations of those who use and rely on them.
28B				To move to a position where service users and carers are involved in the process of recruitment and selection.		

Learning disability Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
29	DRD	Investigate how information provision on transportation issues can be improved for people with learning disabilities	DRD, Imtac Translink	Implement measures in the Accessible Transport Strategy (ATS) action plan 2012-2015 in relation to the provision of information for people with learning disabilities	March 2015	Address a wide range of the barriers that impede the use of the transport system by people with a learning disability

30	DRD	Examine options for improving the provision of travel training schemes	DRD	Evaluate pilot scheme in Ards & North Down area and consider regional rollout of the scheme.	March 2015	Address a wide range of the barriers that impede the use of the transport system by people with a learning disability
31	DRD	Review the training of staff to ensure that its content covers the needs of people with a learning disability.	DRD	Learning disability awareness training in place for: 1. DRD staff 2. PSV licence holders under the terms of the Certificate of Professional Competence. 3. All Translink (non-driver) staff	Ongoing	Address a wide range of the barriers that impede the use of the transport system by people with a learning disability

Mental Health Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
32	DHSSPS	Promote recovery orientated practice throughout all mental health services	HSC in collaboration with voluntary and community sector	Introduce a range of actions/initiatives to facilitate an enhanced culture of recovery across all mental health services (to include the development of training initiatives, effective communication systems with service users/carers and audit/evaluation mechanisms)	March 2015	An improved and consistent understanding of recovery throughout mental health services, ensuring that a recovery based approach becomes embedded in the value base of practitioners and services and enabling service users to maximise their abilities, independence and their general health.

33	OFMDFM	Establish an initial assessment of the mental health needs of victims and survivors through a Comprehensive Needs Assessment	OFMDFM	Assessment of mental health needs for victims and survivors.	February 2013	Better planning of services for victims and survivors.
34	DEL	Continue to deliver specialist employment provision to address the employment needs of those clients who have disability related barriers to finding and sustaining work.	DEL's Employment Service, including the Disability Employment Service (DES)	Individuals with a disability, including mental ill health and learning disability are assisted via DEL programmes to enter and stay in work.	Ongoing	Increased participation on specialist programmes including Condition Management Programme, Work Connect, Workable and Access to Work, as well as local ESF Disability Employment projects.

35	DEL	Enhance and develop the services to assist clients who transfer from Incapacity Benefit to Job Seekers Allowance.	DEL's Employment Service, including the Disability Employment Service (DES)	To help ex- Incapacity Benefit clients to move towards and into employment through participating in the Condition Management Programme. To monitor and review the level of participation and success of the new Job Seekers Allowance clients .	March 2013	To assist clients with Mental Health conditions better manage these to improve their ability to participate on appropriate provision and to find and keep a job.
36	DCAL	"Health in Mind" programme to improve the quality of life of 25,000 adults affected by mental ill-health through the provision of information, learning and reading activities	DCAL (Libraries NI)	By project end: 40,000 people have accessed improved information about mental health; 20,000 people affected by mental ill health, their families and carers have improved knowledge and skills to enable them to access and use relevant information; 3.000	October 2014	People affected by mental ill health and their families have improved access to information and support

SUPPORTING CARERS

Joint Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
37	DHSSPS	Enhance the arrangements to meet demand for respite including emergency respite and short break care	HSC	Implement recommendation of HSCB Phase II respite report. Agreed description of respite and measurement and reporting mechanisms	March 2013	Enhanced flexibility of emergency respite and short break care targeted to meet specific, individual assessed need. Better range of options for short break/respite consistently across Trusts which meets assessed needs of individuals.
38	DHSSPS	To provide support to all carers in order that they may continue in their caring role	HSC	All carers offered carers assessment.	March 2015	The needs of the person cared for and the carer are identified through a carer-centred assessment process.

Learning Disability Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
39A	DHSSPS	Carry out a scoping exercise to ascertain future caring requirements for people with a learning disability living with elderly carers where there is a risk of a breakdown in caring arrangements	HSC	Report on the future caring requirements of people with learning disabilities who have elderly carers	March 2013	Identification of future service need/provision.
39B		Develop a rolling, costed plan to support those with learning disability living with elderly carers where there is a risk of a breakdown in caring arrangements		Annual costed plan developed in each Trust.	September 2014	Arrangements in place to support and maintain existing community and family arrangements

BETTER SERVICES

Joint Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
40	DHSSPS	Monitor/review departmental capital budget	DHSSPS/HSC	Progress relevant business cases from Trusts to achieve future agreed pattern of provision	March 2015	People can access services in appropriate and fit for purpose buildings
41	DHSSPS	Complete research into priorities highlighted by Bamford rapid reviews	DHSSPS PHA HSC Universities	To improve services developed in priority areas	October 2015	To provide new and effective interventions relevant to Northern Ireland
42	DHSSPS	To ensure Personal and Public Involvement, (PPI), in planning, commissioning, delivery and evaluation of services in line with guidance.	DHSSPS, HSC in collaboration with voluntary and community sector and the Patient and Client Council	Evaluate and review leadership, accountability and monitoring arrangements	March 2013	Future policies and services will seek to address the needs and expectations of service users and their carers

43	DSD	To carry out a qualitative research study into our customers who have a disability to allow us to obtain an insight into the thoughts and behaviours of this specific group of customers	SSA	To gain an insight into our disabled customers in terms of the challenges they face and the impact that disability has on their lives.	Ongoing	Contribute to a greater understanding of the use and impact of disability benefits; Increase the understanding of the difference made to people's lives by receipt of disability benefits; Inform and support the development of policy and strategy relating to disabled customers.
44	DSD	To develop and implement a strategy for increasing the uptake of benefits	SSA	A benefit uptake strategy.	March 2015	To maximise the uptake of benefits by targeting those likely to be eligible for unclaimed benefit
45	DSD	To work in Partnership with organisations and government departments which are impacted by Universal Credit.	SSA	Information is shared and input sought	Ongoing	All impacted organisations attend various Universal Credit governance (e.g. Programme Board, Steering Groups, Checkpoint meetings etc). Impacted organisations are also involved in the development of customer journeys, migration planning, staff communications, etc and are embedded into the programme team working in the Design Centre.

46	DHSSPS	To improve access to advice and information on services and support available	HSC and PHA	Develop a central point of access for information	March 2015	People with mental health problems, learning disabilities and carers have access to information about services and support in their area
47	DHSSPS DE	Improve services for children with challenging behaviours and their carers	HSC Board	Implement regional guidelines on the management of challenging behaviours	March 2015	Consistent service provision across region.

Learning Disability Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
48A	DHSSPS	Develop and implement a Service Framework for learning disability services	DHSSPS	Publish service framework.	December 2012	Improve the standards of care that people who use services, their family and carers can expect to receive against agreed performance indicators

48B	DHSSPS		HSC	Implementation of service framework	Ongoing from December 2012	
49	DHSSPS	Maintain direction of HSC funding towards community based services	HSC Board to lead in collaboration with Trusts and PHA	At least 80% of HSC spend on learning disability services should be on community services	Ongoing	Community services will promote integration of individuals into society
50	DHSSPS DSD	Enhance provision of person – centred day opportunities (including employment provision) for people with a learning disability that facilitate integration into the community	DHSSPS HSC DSD (benefits)	Enhanced access to a range of opportunities in education, training, employment and social activity	Ongoing	Opportunities tailored to the needs of people with a learning disability promoting their inclusion in society Regional model produce by March 2013
51	DHSSPS	Complete and maintain a map of learning disability services across Northern Ireland	PHA/ HSC Board in collaboration with HSC and voluntary and community sector	Compile mapping information on all learning disability services provided	December 2013	New services can be better targeted and gaps in existing services can be filled

52	DE	Improve transitions planning for all children with statement of special educational needs	DE, Education and Library Boards, DHSSPS and HSC, CYPSP	A Transitions plan tailored to meet the needs of the young person. Collaborative working and multi agency planning to facilitate improved planning and delivery at local level.	Ongoing	Children and young people supported in making effective transitions, making good progress and achieving to their full potential.
53	DHSSPS	Development of UK wide framework for learning disability nurses	DHSSPS and other 3 UK Government departments	Publication of action plan	March 2014	Learning disability nurses utilise and develop their specialist knowledge and skills to ensure the best possible health outcomes for people with learning disabilities
54	DHSSPS	Develop a plan for community forensic learning disability services taking account of service to be provided with available resources and which makes full use of other forensic arrangements in place	HSC	Prioritised action plan to be taken forward within available resources	February 2013	Improved community forensic service for those with learning disability.

55	DHSSPS	Community Dental Service to undertake an annual oral health assessment for each L.D. client and produce an individual oral health plan, referring as appropriate for care.	HSC	LD clients regularly examined and treatment arranged	Ongoing	Oral health issues addressed and preventive strategies employed
56	DHSSPS	Community Dental Service to provide training/ training materials for staff in day care facilities re significance of oral health issues.	HSC	Deliver training interventions and educational resources.	Ongoing	Increased awareness of significance of diet, tooth brushing and use of Fluoride toothpaste
57	DHSSPS	Improve the experience of people with LD using acute general hospitals based on the GAIN Guidelines "Caring for people with a learning disability in general hospital settings"	HSC	Implement reasonable adjustments to support the pathway through acute care. Initiate staff training and development of easy read information. Develop coordinated links between hospital and community services.	March 2015	Improved delivery of safe and effective care within general hospital settings
58	DHSSPS	Implement a regional Bed Management Protocol for those with a learning disability.	HSC Board to lead in collaboration with HSC Trusts	Regional implementation of agreed Bed Management Protocol	March 2013	Safer and more effective access to inpatient care for those with a learning disability

Mental Health Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
59	DHSSPS	Re-direct HSC funding towards community based services	HSC Board to lead in collaboration with Trusts and PHA	60% of HSC spend on mental health services should be on community services.	March 2015	Better services for those in need provided within their community
60	DHSSPS	Implement the Mental Health Service Framework across HSC:	PHA	Review HSC performance against proposed framework indicators - this should include service user/carer input in terms of both development of indicators and monitoring of actual service performance.	Ongoing	Agreed standards of care that people who use services, their family and carers can expect to receive. Develop service improvement plans where progress against performance indicators is measured
61	DHSSPS	Provide information on children's, adolescent and adult mental health services for use by the public, GPs and other clinicians.	PHA/ HSCB	Develop and publish IT based resource on all Trust websites	April 2013	Identification of all general and specific MH services available.

62	DHSSPS	Implement service model for CAMHS services	HSC	Implementation of CAMHS action plan	Ongoing	Young people are able to access consistent and appropriate services across NI
63	DHSSPS	Improve and harmonise model for crisis response and home treatment services	HSC	Implement agreed regional model for crisis response and home treatment	December 2012	People in crisis will be able to receive appropriate care and support to a consistent standard
64	DHSSPS	Enhance availability of psychological therapies	HSC	Implement enhanced services in line with published strategy and available resources.	Ongoing	Improved access to psychological therapies
65	DHSSPS	Improve access to computerised Cognitive Behavioural Therapy programmes	HSC Board in collaboration with HSC	Promote and increase uptake of CCBT programmes	Ongoing	Improved support for those with mild to moderate depression

66	DHSSPS	Introduce legislation to extend the provisions of the Mental Health (NI) Order 1986 to private hospitals	DHSSPS	Provision for private hospitals to treat detained patients	December 2012	People are able to be treated in the most appropriate facility to meet their needs
67	DHSSPS	Evaluate implementation of regional guidance on assessment and management of risk in mental health and learning disability services	DHSSPS, HSC and RQIA	RQIA to review and report on progress to implement regional guidance	December 2012	People who may pose a risk to themselves or to other people or who may be at risk from other people will have such risks assessed and managed in an appropriate way as part of their treatment and care plan.
68	DHSSPS	Enhance medicines management services for vulnerable patients with mental illness living in the community	DHSSPS HSC	Develop a pilot medicines management service	March 2014	Joint working across Mental Health Medicines Management and relevant healthcare providers to enhance pharmaceutical services through education, brief intervention, alert systems and compliance aids where appropriate.
69	DHSSPS	Enhance services for people with a personality disorder	HSC	Implement enhanced services in line with published strategy and available resources.	Ongoing	Better access to appropriate services for people with a personality disorder and support for their carers

70	DHSSPS	Maintain the provision of specific eating disorders in-patient service capacity within each Trust	HSC Board and PHA in collaboration with HSC Trusts	Provision of eating disorder inpatient services available within generic units with in-reach support from community eating disorder service.	Ongoing	Continuity of care from community services for those who need to be admitted to hospital. Fewer people will require admission to a facility outside Northern Ireland
71	DHSSPS	Ensure provision of appropriate low secure and community forensic services in line with 2011 Review	HSC	Develop costed action plan to be implemented as resources permit	March 2013	More appropriate levels of therapeutic support and rehabilitation provided in the least restrictive conditions for those who need forensic services.
72	DHSSPS	Take forward action plan to improve dementia services in line with NI strategy.	HSC with DHSSPS and voluntary and community sectors	Provide range of services advocated in N I Dementia Strategy and associated action plan as resources permit.	Ongoing	Improved services for people with dementia, their families and carers
73	DHSSPS	Improve Perinatal mental health services	HSC/PHA	Implementation of Perinatal Mental Health Regional Integrated Pathway and Training Strategy	March 2015	Better detection and treatment of mental illness during pregnancy and the post natal period

BETTER STRUCTURES

Joint Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
74	DHSSPS	Ensure relevant Inter-Departmental and cross sectoral structures are maintained	DHSSPS (with other Departments)	A co-ordinated approach to improve services in line with Bamford Vision	Ongoing	Better joining up of services across agencies
75	DHSSPS	Sponsor work on cross-cutting issues, involving the relevant agencies at local level along with service users and their carers.	Interdepartmental Group	Establish local-level cross-sectoral working groups under the IDG.	September 2013	To improve joining up of services for people with a mental ill-health or a learning disability.

76A	DHSSPS	New mental capacity legislation	DHSSPS DoJ	Preparation and consultation of draft Bill	October 2013	A consistent approach, with appropriate safeguards, to decisions - about care, treatment, property or assets – which have to be made for those unable to make decisions for themselves, whether because of mental disorder or for other reasons.
76B				Introduction to NI Assembly	December 2013	
76C				Enactment	March 2015	

ANNEX A

Patient and Client Council/Bamford Monitoring Group Outcomes Paper

The Bamford Monitoring Group has reviewed the reports, feedback from conferences and workshops held by the group in the past 2 years to identify the key issues and recurring themes. These are the issues that are most important to people with mental health needs, learning disabilities, parents, carers and families and must be central to the Bamford Action Plan 2012 – 2015.

The key issues / themes are outlined below linked to user / carer defined outcomes and suggested outcome measures required to evidence if the outcomes are being achieved i.e. is the action plan making a positive difference to people's lives?

The Bamford Monitoring Group strongly believes that there is a need to be clear and specific by including outcome measures for outcomes. Outcomes in the 2009 – 2011 Bamford Action Plan were described as "too woolly" and it was often unclear if they were being achieved.

The Bamford Monitoring Group would emphasise several key points regarding the Bamford Action Plan 2012 – 2015 and process of its development:

- Service users and carers must be involved in developing the Bamford Action Plan from the outset. It has been a difficult task to develop the outcomes and measures below.
- It is essential to create a robust process for service users and carers participation in development of future action plans.
- Focusing on measuring outcomes that are relevant to and valued by service users is vital. This is in keeping with a recovery orientated approach and reflects the purpose of services.
- Identifying progress in achieving the Bamford Action Plan must be monitored from an outcomes basis.

Outcome	*Theme / Key Issue*	*User / Carer defined outcomes*	*Linkage to Action Plan Actions*	*User / Carer defined outcome measures* *(Evidencing progress)*
1	***Joined Up Working***	Increase Government Department partnership working	***74, 75***	IDSOG to provide an annual report on specific Inter Departmental initiatives being taken forward under the Bamford review. These should evidence genuine participation and capacity building.
2	***Involvement***	Service users and carers are involved in developing the next Bamford Action Plan.	**42, 74, 75**	People with mental health problems, learning disabilities and carers are involved as partners in developing the next Bamford Action Plan.
3		Service user and carer participation on all Bamford related groups	**42**	IDSOG to initiate audit.
4		Service users and carers are involved in the design, delivery, management, review and development of mental health and learning disability services (across all Government Departments)	***27, 28, 42***	Tool that evaluates involvement and participation required Service users and carers groups / forum / networks in the development of strategy and policy Service User and carer-led evaluation of mental health and learning disability services Staff recruitment panels that include service users and carers. The process should be accessible for people with a learning disability. Service users and carers input into the whole process of recruitment and selection e.g. job description, short listing, and interviewing,

Outcome	*Theme / Key Issue*	*User / Carer defined outcomes*	*Linkage to Action Plan Actions*	*User / Carer defined outcome measures* *(Evidencing progress)*
				Service users and carers carry out training for non-service user and carer members of the interview panel. Service users and carers providing training for mental health and learning disability staff Advocates (Peer) employed in mental health and learning disability to support service users and carers.
5		Service users and carers are directly involved in all aspects of care.	**27, 32, 48, 50, 60, 67, 74**	People with mental health problems, learning disabilities and carers report positive experience of being involved in making decisions about their care and support. All people with mental health problems or a learning disability all have an individual care plan, which they hold personally. This care plan is subject to regular review.
6		All carers should be offered a carers assessment	**38**	Increased number of people supported to access Carer's Assessment All carers offered a Carers Assessment Increased number of people reporting positive experience accessing Carer's Assessment
7	***Information***	There is a central point of access for information and advice about all mental health and learning disability services and support available	**46, 51, 61**	Access to information should be readily available for people with mental health problems and learning difficulties. Increase the number of people with mental health problems, learning disabilities and carers reporting positive experience accessing information about services in their area Increase the number of people with mental health problems and learning disabilities are involved in the development of information about services in their area

Outcome	*Theme / Key Issue*	*User / Carer defined outcomes*	*Linkage to Action Plan Actions*	*User / Carer defined outcome measures* *(Evidencing progress)*
				People with mental health problems, learning disabilities and carers report that staff are able to give appropriate information about services in their area
8	***Employment***	Move to a position where 'experts by experience' are directly employed in commissioning and delivery of mental health and learning disability care.	**12, 16, 20, 21, 22, 28, 34, 35**	Increase the number of people with mental health problems and learning disabilities are directly employed by Government Departments and the HSC sector. Evidence of reasonable adjustment as required by section 75 of the Northern Ireland Order put in place to enable more people to take up employment Appropriate support must be provided to those employed as a service user / carer reps and people who are employed with mental health needs and learning disabilities. Increase the number of people with mental health problems and learning disabilities entering and/or retaining paid employment: Full Time (over 16 hours a week) and Part Time (under 16 hours a week)
9	***Housing***	People with mental health problems and learning disabilities are supported to live independently. People have a choice who to live with and where, in a safe supportive community.	**12, 13, 14, 15**	Increased number of people with mental health problems and learning disabilities living independently year on year. Increased in the amount of supported independent living accommodation available for people with mental health problems and learning difficulties Increased number of people with mental health problems and learning disabilities report positive experience planning and arranging independent living.
10	***Benefits***	The new Welfare Reform system meets the needs of people with mental health problems and learning disabilities ensuring access to appropriate benefits and support	**35, 44, 45**	People with mental health problems and learning disabilities receive appropriate benefits Increased number of people with mental health problems and learning disabilities reporting a positive experience of

Outcome	*Theme / Key Issue*	*User / Carer defined outcomes*	*Linkage to Action Plan Actions*	*User / Carer defined outcome measures* *(Evidencing progress)*
				accessing advice regarding their finances, benefits or debts. Increased number of people with mental health problems and learning disabilities reporting positive experience accessing benefits All benefits staff are trained in mental health and disability awareness Specialist staff receive dedicated specific training to provide appropriate support to people with mental ill-health or a learning disability.
11		People with mental health problems and learning disabilities have support when accessing benefits	**43**	People with mental health problems and learning disabilities have access to advocacy service during benefits assessments/interviews.
12	***Education***	Better and more consistent planning and support is available to support young people on transition from education to adult services, including all young people with a learning disability or mental health problem – not just those with a statement of special educational needs	**26, 52**	Evidence that young people are involved and their views taken into account in decision-making about transition. Evidence that parents are involved in the transitions planning process for their son / daughter. Young people and their families receive appropriate accessible information about: - the transitions process - the options and support available on leaving school This allows young people and their families to make informed choices about the future.

Outcome	*Theme / Key Issue*	*User / Carer defined outcomes*	*Linkage to Action Plan Actions*	*User / Carer defined outcome measures* *(Evidencing progress)*
13		People with mental health problems and learning disabilities are involved in making decisions about courses and subjects available in Further Education Colleges	**18, 19, 21, 22, 50, 52**	Evidence that there are increased numbers of courses for people with mental health problems and learning disabilities in Further Education Colleges Evidence that people with mental health problems and learning disabilities are involved in designing courses and subjects available in FE Colleges Evidence that people with mental health problems and learning disabilities are supported to find and participate in courses
14	***Self-directed Support***	People with mental health problems and learning disabilities have access to and control their own self-directed support.	**25**	Increased number of people with mental health problems and learning disabilities supported to access self-directed support. Increased number of people with mental health problems and learning disabilities supported to become more actively involved in decision making regarding their support. Increased number of people reporting positive experience accessing self-directed support.
15	***Transport***	People with mental health problems and learning disabilities are able to access transport to ensure their independence, choice and opportunity.	**12, 29, 30, 31**	Increased number of people reporting positive experience accessing transport

ANNEX B

Abbreviations

BMG	Bamford Monitoring Group
CYPSP	Children and Young People's Strategic Partnership
DCAL	Department of Culture, Arts and Leisure
DE	Department of Education
DEL	Department for Employment and Learning
DETI	Department of Enterprise, Trade and Investment
DHSSPS	Department of Health, Social Services and Public Safety
DoJ	Department of Justice
DRD	Department for Regional Development
DSD	Department for Social Development
ELB	Education and Library Board
FE	Further Education
HSENI	Health and Safety Executive Northern Ireland
HSC	Health and Social Care
NIHE	Northern Ireland Housing Executive
NISAT	Northern Ireland Single Assessment Tool
OFMDFM	Office of the First Minister and deputy First Minister
PHA	Public Health Agency
RQIA	Regulation and Quality Improvement Authority

DHSSPS
Integrated Projects Unit
Room D2.17
Castle Buildings
Stormont
BELFAST
BT4 3SQ

[redacted]

DELIVERING THE BAMFORD VISION

The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability

ACTION PLAN 2012-15

MONITORING REPORT NOVEMBER 2014

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

INTRODUCTION

1. The purpose of this monitoring report is to highlight progress against the Bamford Action Plan 2012-15. This is to ensure that progress can be tracked by service users and carers of mental health and learning disability services throughout the life span of the Action Plan.

OVERVIEW

2. The Department of Health, Social Services and Public Safety (DHSSPS) published the follow-on Bamford Action Plan 2012-15 in March 2013. This new Action Plan represents the Northern Ireland Executive's continued commitment to the development of mental health and learning disability services in Northern Ireland, and to the promotion of independence and social inclusion for those people within our community.

3. This revised Action Plan has a truly cross-cutting agenda and requires commitment across all parts of Government in Northern Ireland. We continue to be informed and guided by those who use these services, and the Action Plan provides a commitment to working with agencies, service users and their carers at local level.

4. The Bamford Action Plan 2012-15 contains 76 actions under the five main Bamford delivery themes:
    - *Promoting positive health, wellbeing and early intervention;*
    - *Supporting people to lead independent lives;*
    - *Supporting carers and families;*
    - *Providing better services to meet individual needs; and*
    - *Developing structures and a legislative framework.*

5. Implementation of the Bamford Action Plan 2012-15 continues to be monitored through the Inter-Departmental Senior Officials Group and Ministerial Group on Mental Health and Learning Disability. The new Action Plan commits to publishing monitoring reports on a regular basis. The first annual monitoring report was published in February 2014. This is the second annual report.

6. Detailed monitoring information against each action is included at **Annex A**.

7. In general terms, there has been good progress made on the Bamford Action Plan 2012-15. Each of the 76 actions is given a RAG rating at each 6-monthly monitoring round. The definitions of the ratings are listed below:

   Red – Unlikely to be achieved
   Amber – At Risk / Delayed
   Green – On Target

8. Progress at October 2014 indicates that out of the 76 actions, 63 are GREEN, 13 are AMBER. See chart below.

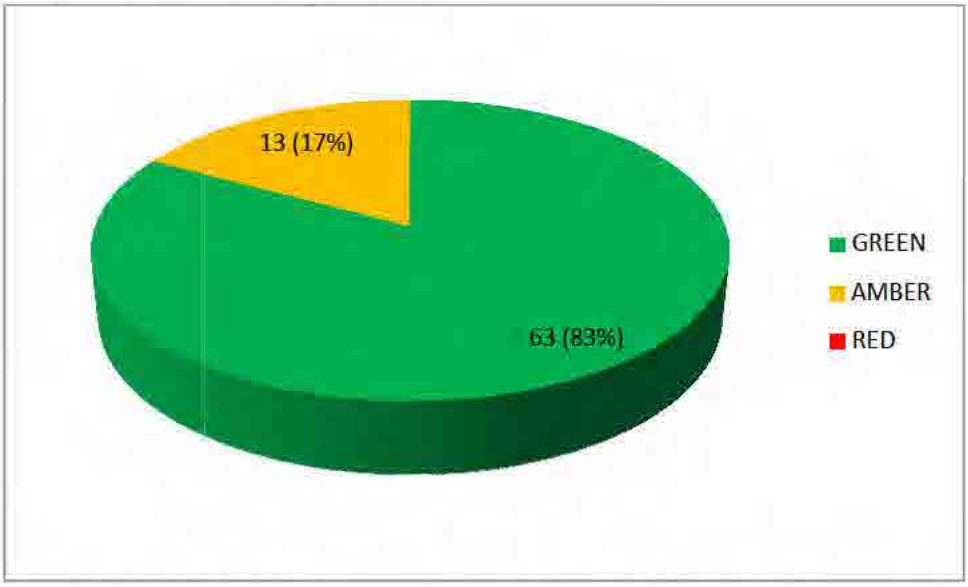


Chart 1: Summary of progress against Bamford Action Plan 2012-15 at October 2014.

9. The Department of Health, Social Services and Public Safety has lead responsibility for the implementation of the Bamford Action Plan 2012-15. However, all actions are assigned to the Department who has responsibility for that particular area of work. Any further queries should be directed to the Department responsible. The relevant contacts are listed below:

Department	Name of contact	Contact Details
Department of Health Social Services and Public Safety (DHSSPS)	Lorraine Brown	Tel: [redacted]
Department of Culture, Arts and Leisure (DCAL)	Tony Murphy	Tel: [redacted]
Department of Education (DE)	Heather Mailey	Tel: [redacted]
Department for Employment and Learning (DEL)	Stephen Jackson	Tel: [redacted]
Department of Enterprise, Trade and Investment (DETI)	Jo Kane (Health and Safety Executive)	Tel: [redacted]
Office of the First Minister and Deputy First Minister (OFMDFM)	Joan Hardy	Tel: [redacted]
Department for Regional Development (DRD)	Keith Walsh	Tel: [redacted]
Department for Social Development (DSD)	Eilish O'Neill (supported housing) Joan O'Hara (benefits)	Tel: [redacted] Tel: [redacted]

ANNEX A: PROGRESS AGAINST BAMFORD ACTION PLAN 2012-15 AT OCTOBER 2014

PROMOTING POSITIVE HEALTH, WELLBEING AND EARLY INTERVENTION

Action No.	Key Action	RAG rating	Progress at October 2014
1	Publish and implement a revised cross-sectoral promoting Mental Health Strategy (*DHSSPS*)	AMBER	A suicide prevention and positive mental health promotion strategy is substantially drafted. The aim is to issue for consultation in March 2015.
2	Develop final proposals for Early Years Strategy (*DE*)	GREEN	This action is completed. Learning to Learn - A Framework for Early Years Education and Learning' was published on 7 October 2013. The overall policy aim of Learning to Learn is that all children have equal opportunities to achieve their potential through high quality early years education and learning experiences. Full implementation is expected to be achieved by 2015/16.
3	Implement a 10 year Strategy for Sport and Physical Recreation (*DCAL*)	GREEN	Sport Matters': The Northern Ireland Strategy for Sport and Physical Recreation, 2009-2019' contains 11 high level Participation targets designed to achieve improvements in sports participation rates. In 2013, DCAL and Sport NI delivered a pilot programme, 'Mental Health and Well-being in Sport' to support the Public Health Agency (PHA) in raising awareness of mental health, break down barriers and perceived stigma within

Action No.	Key Action	RAG rating	Progress at October 2014
			sport on the subject of mental well-being. Funding the Mental Health and Well Being through Sport pilot programme enabled engagement with 5 Governing Bodies of Sport (GBs)and as a result there have been two phases of the programme reaching 85 selected clubs from areas of high social need and within the existing five governing bodies. Additionally, PHA partnership investment enabled Sport NI to deliver 75 mental health awareness training sessions (delivered by Mindwise and Aware Defeat Depression). Reflecting the commitment by Sport NI to further developing mental health and well-being within sport, a working group has been established and will be leading on the development of a longer term strategy to encourage all sports clubs to embrace mental health and well-being
4	Promote an anti-bullying culture within the schools in partnership with the NI Anti-bullying Forum (*DE*)	**GREEN**	DE continues to work with NI Anti-Bullying Forum (NIABF) to promote an anti-bullying culture in schools. A wide ranging joint DE / NIABF work programme has been agreed. This includes a commitment for DE to bring forward new anti-bullying legislation within the current NI Assembly mandate.
5	Ensure that persons with a learning disability have equal access to the full range of primary health care services (*DHSSPS /*	**GREEN**	Learning Disability Directed Enhanced Services (DES) has been implemented. DES aims to ensure that all adults with a Learning Disability have annual physical and mental health checks and follow up by a health promotion nurse if required. An Evaluation report of the DES was completed earlier in 2014 and 3 forums have been established to take forward key work

Action No.	Key Action	RAG rating	Progress at October 2014
	HSCB)		areas.
6	Progress the next phase of the suicide prevention strategy (*DHSSPS*)	AMBER	A suicide prevention and positive mental health promotion strategy is substantially drafted. The aim is to issue for consultation in March 2015.
7	Develop and implement New Strategic Direction on Drugs and Alcohol Phase 2, and Strategy Evaluation (*DHSSPS*)	GREEN	New Strategic Direction (NSD) on Drugs and Alcohol Phase 2, was published by DHSSPS in December 2011. Implementation of NSD is ongoing. The PHA/HSCB have published a draft Commissioning Framework which is informing the commissioning of services and service delivery by the HSC Trusts and the community and voluntary sector. The HSCB have now agreed the reconfiguration of Tier 4 (inpatient) services and this new regional network is being implemented by the HSCB and the HSC Trusts, in partnership with the appropriate independent sector providers.
8	Respond to the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness in Northern Ireland 2011. (*DHSSPS / HSCB)*	GREEN	The recommendations in the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness in Northern Ireland 2011 are being taken forward through a number of measures including Protect Life, the Self Harm Registry, review of Serious Adverse Incidents, Early Intervention and Crisis Response Treatment, the review of risk management guidance, the implementation of the Regional Child and Adolescent Mental Health Service

Action No.	Key Action	RAG rating	Progress at October 2014
			Model and the New Strategic Direction on Drugs and Alcohol.
9	Specialist health and safety inspectors and business advisors to provide advice and, where necessary, enforcement in high stress risk work sectors. (*DETI*)	**GREEN**	HSENI has a newly branded Mental Well-being at Work Advisory Service which has given practical help to over 45 organisations to identify stressors in the workplace putting action plans in place to reduce the stressors and put in place a stress policy. The NISRA wellbeing survey 2014 has generated a lot of interest from the NICS in implementing mental wellbeing action plans. HSENI have introduced a newly rebranded mental wellbeing website and a free one day awareness seminar on the practical usage of the Management Standards, both launched during the EU Healthy Workplaces Manage Stress year. Registration on the HSENI website for the Awareness Seminar has indicated high interest from NI employers with 2 more fully booked seminars to be provided by March 2015.
10	Promote a focus on pupils' emotional health and wellbeing through a programme of awareness raising and staff capacity	**GREEN**	The DE 'iMatter' programme continues to be the overarching vehicle for promoting pupils emotional health and wellbeing. Information about support and advice continues to be disseminated to pupils. The questionnaires to be used by schools to assess their current approach to

Action No.	Key Action	RAG rating	Progress at October 2014
	building for all schools. (*DE*)		promoting mental health are now agreed. Once the related computer based system has been developed and tested a pilot will be run. The target date of completion and piloting of the audit tool is Autumn 2014. A 'Guide to Managing Critical Incidents in Schools' along with a supporting DVD was launched in the on 10 February 2014 and issued to all schools. http://www.deni.gov.uk/index/support-and-development-2/pupils-emotional-health-and-wellbeing/dealing-with-a-critical-incident.htm
11	Maintain access to counselling support which is independent of the school for all pupils of post primary age. (*DE*)	**GREEN**	An independent school based professional counselling service funded by DE, is accessible to young people of post primary age, during difficult and vulnerable periods in their lives in post primary mainstream and special schools. Tendering for new counselling contracts is on-going with the aim of having new contracts in place by January 2015.

SUPPORTING PEOPLE

Action No.	Key Action	RAG Rating	Progress at October 2014
12	Publish a strategy for the implementation of recommendations arising from the PSI report on Disability. *(OFMDFM)*	**GREEN**	This action is complete. This strategy was launched in February 2013. http://www.ofmdfmni.gov.uk/disability-strategy-2012-2015-revised-010313.pdf
13	Resettle long stay patients from learning disability and mental health hospitals (*DHSSPS / HSCB*)	**AMBER**	The resettlement target is largely on track for completion by March 2015 and figures for 2014/15 are in line with the expected profile of plans for this year which expects the majority of resettlements to take place in the 4th quarter. The target for Mental Health patients will be largely met by March 2015. However, a number of patients, including those detained under the Mental Health Order will continue to require hospital admission. The original Programme for Government target was to ensure that "anyone with a mental health problem or learning disability is promptly and suitably treated in the community and no-one remains unnecessarily in hospital." In terms of the resettlement of people with a Learning Disability, there may

Action No.	Key Action	RAG Rating	Progress at October 2014
			be some slippage on the March 2015 target date for the resettlement of some long stay patients from Muckamore Abbey hospital, where a small number of placements are dependent on new-build schemes in which timescales have slipped due to planning and construction delays.
14	Scope existing supported housing capacity / suitability to maximise resources *(DSD)*	**GREEN**	Commissioning programmes for new provision take into consideration capacity/suitability to maximise existing resources.
15	Ensure new build supported housing programmes are 'future proofed' to ensure longevity/sustainability in terms of the tenants. (*DSD*)	**GREEN**	The DSD Housing Association Guide includes specific design standards for housing associations who deliver new supported housing. This ensures that all new social housing adheres to Building Regulations and the Lifetime Homes standard.
16	To support and develop the Employment Advisor Teams to deliver services to people with mental ill-health or a learning disability. *(DEL)*	**GREEN**	All Advisor teams continue to receive ongoing support, advice and guidance from Disability Employment Manager and Occupational Psychologists. All Front-line Advisers have been provided with a desk-aid designed by a Disability Sector consortium. This helps them recognise certain behaviours & traits of people who may have a mental health condition or a learning disability and advises them how to respond to the customer and at the same

Action No.	Key Action	RAG Rating	Progress at October 2014
			time encourage appropriate referral. A further roll-out of training, to include specific sessions on how to help and support clients with disabilities towards and into employment will be delivered to Employment Adviser Teams from January 2015.
17	Maintain support arrangements and extended eligibility for participants with disabilities on the Training for Success programme. *(DEL)*	**GREEN**	DEL provides a guaranteed training place on its Training for Success (TfS) programme for all unemployed young people in the 16-17 age groups (including those with special educational needs). The programme also provides extended eligibility for those with a disability up to age 22. Disability support services, delivered based on identified needs, include: participant coaching/mentoring, interpreter services and disability awareness training.
18	Widen Participation in Higher Education Strategy. *(DEL)*	**GREEN**	"Access to Success" the widening participation strategy was published in September 2012. It contains 11 Key Actions to improve accessibility and participation in higher education, including among students with disabilities. DEL is working with Higher Education institutions and other key stakeholders to develop implementation plans for each of the Key Actions. Actions include: • the launch in March 2014 of "Reach Higher" a single centralised and co-ordinated higher education awareness and aspiration raising

Action No.	Key Action	RAG Rating	Progress at October 2014
			campaign to communicate the benefits of Higher Education to disadvantaged groups, including students with disabilities. • the introduction of the "REACH" programme which aims to expand the range of aspiration and educational attainment raising programmes and • the introduction of Widening Access and Participation Plans in which institutions detail their Widening Participation (WP) strategy, provide a review of their past achievement against regional benchmarks and provide a detailed programme of anticipated progress towards the institution's own targets.
19	Establish and progress effective Partnership Agreements and joint working arrangements with post-primary schools, further education, training and apprenticeship providers, HSC Trusts and organisations who act as advocates for young people	**GREEN**	Partnership Agreements between the Careers Service and Post Primary Schools were issued, agreed, signed and reviewed during 2013/14. Updated Partnership agreements for the 2014/15 academic year and are in the process of being agreed. The target is to have 98% agreed by the end of October 2014. Partnership Agreements are also in place between the Careers Service and further education, training and apprenticeship providers, HSC Trusts and the Youth Justice Agency.

Action No.	Key Action	RAG Rating	Progress at October 2014
	with a variety of barriers, including disabilities. *(DEL)*		
20	Lead on the implementation of a cross-departmental Strategy - "Pathways to Success" - for those young people Not in Education, Employment or Training (NEET). *(DEL)*	**GREEN**	The Pathway to Success (PtS) strategy's aspiration is that, **"by 2020, every young person will not only have an opportunity to access education, training or other preparation for employment but, to the extent that they are able, also avail of that opportunity".** The **NEET Advisory Group (NAG)**, chaired by DEL, brings together key decision makers from Government Departments, voluntary and community, education, health, social care and business sectors and local government. In developing the 'PtS' Strategy DEL also helped establish the independent **NEET Strategy Forum** (NSF) to engage and help join up those organisations in the voluntary and community sector who deliver services in this area. The Forum consists of some 80 members currently, membership is open and Forum members are also represented on the NEET Advisory Group. A formal evaluation of the Strategy has begun and will be available in Dec 2014. 3 key DEL programmes, listed below, make up the key components of the evaluation of the 'Pathways to Success' strategy:

Action No.	Key Action	RAG Rating	Progress at October 2014
			• Local Employment Intermediary Service • Community Family Support Programme • Collaboration and Innovation Fund
21	To develop Careers Service delivery to support the above mentioned "Pathways to Success" Strategy (for NEETs). *(DEL)*	**GREEN**	The Careers service continues to support all 16 and 17 year olds who are not in education, employment or training. 18 – 24 year olds on the Youth Employment Scheme (YES) are being referred to the Career Service for a skills assessment.
22	Continue to work in partnership with DE to increase the level of information sharing in respect of relevant pupil data being shared with DEL's Careers Service including electronic sharing of pupil data via C2K.	**GREEN**	Data Sharing Agreements have been reviewed with DE in August 2014. Revised agreements are in place for 2014/15 academic year. The electronic transfer of pupil data for 2013/14 year 10 was completed in April 2014, with transfer of approximately 24,000 pupil's information. The electronic download of information for 2014/15 is expected to be complete by January 2015.

Action No.	Key Action	RAG Rating	Progress at October 2014
	(DEL/DE)		
23	Continue to provide specialist support, as appropriate, for young people considering participating in Training for Success (TfS). *(DEL)*	**GREEN**	Provision of appropriate targeted support is ongoing. DEL provides Pre-Entry Training Support referral for school-leavers with a disability. These young people are referred by Careers Advisers to receive specialist support by providers specialising in disability and learning support. This process aims to ensure that support needs in training are identified and put in place as soon as possible after commencement of training.
24	Incorporate provision within the design of the new Work Connect Programme to meet the employment needs of those who are claiming Employment Support Allowance and who have mental ill- health and learning disability. *(DEL)*	**GREEN**	Since the launch of the Work Connect Programme, 45% of total participants have reported having a mental ill health disability, 7% have a learning disability and 3% have Autistic Spectrum Disorder (ASD). Out of the 111 starts who found employment, 26% have mental illness and 18% have a learning disability and 19% have ASD.
25	To support the uptake of self-directed support and individual budgets in line	**AMBER**	"Who Cares?" the first stage of the reform of adult care and support was published in September 2012. The document states the need for care and support to be personalised to individual need and focuses on

Action No.	Key Action	RAG Rating	Progress at October 2014
	with Transforming Your Care *(DHSSPS)*		the concept of personalisation. A Project Board has been established and work is ongoing to secure external expertise to carry out essential financial modelling of the cost of reforms. It is anticipated that consultation on stage 2 proposals will be launched in the Autumn 2016. The HSCB has committed to increasing the uptake of direct payments. Mental Health has seen an increase of 26% from 2012/13 to 2013/14 and Learning Disability has seen an increase of 21% for the same period.
26	Take forward and implement Review of Special Educational Needs & Inclusion *(DE)*	**GREEN**	The Special Educational Needs Review proposals relate to all young people with special educational needs, as defined in the 1996 Order, regardless of the particular need. If a child, up to age 19, as a result of mental ill health or a learning disability has special educational needs, then the new framework will include them. The Minister's policy proposals were accepted by the Executive in July 2012. Work is underway to bring forward a draft Bill to the Assembly in the current term.

Action No.	Key Action	RAG Rating	Progress at October 2014
27	Implement "Developing Advocacy Services - A Policy Guide for Commissioners" *(DHSSPS)*	**GREEN**	An Independent Advocacy Code of Practice and Standards Framework was launched in June 2014. Members of the Advocacy Network NI have committed to the code of practice and are using it as part of their induction and training programmes for new staff and volunteers. Work to develop an easy read version is almost complete.
28	To support the employment of experts by experience in the commissioning and delivery of mental health and disability services. *(DHSSPS)*	**GREEN**	Each Trust has a 15 person steering group to implement the Implementing Recovery through Organisational Change (ImROC) Programme – one third of these are service users/carers. Current Bamford Structures, including the Programme Board and the Learning Disability sub group have parents and carers representation, who contribute to commissioning decisions. Three Trusts have appointed mental health service users in the role of peer support workers. There are proposals to establish Recovery Colleges in all 5 Trust areas which will employ peer support workers.
29	Investigate how information provision on transportation issues can be improved for	**GREEN**	The refreshed Travel Safe Guide was published in June 2014 and distributed to voluntary groups, learning disability groups and schools. Translink have reviewed their access guide which is available on the

Action No.	Key Action	RAG Rating	Progress at October 2014
	people with learning disabilities. *(DRD)*		Translink website http://www.translink.co.uk/accessibility/translink-access-guide/ and at Translink Stations.
30	Examine options for improving the provision of travel training schemes. *(DRD)*	**GREEN**	The Transport Buddy pilot scheme has been evaluated and recommendations have been made for a future roll-out of the scheme. A decision on support from DSC funds is awaited
31	Review the training of staff to ensure that its content covers the needs of people with a learning disability. *(DRD)*	**GREEN**	All DRD staff undertake diversity and disability awareness training. This is delivered on a rolling 3 yearly basis. Rural Community Transport Partnership drivers undergo Minibus Driver Awareness Scheme (MiDAS) training which covers issues around people with a disability and how to manage their needs. Translink have provided training to 1720 drivers which covers hidden and learning disabilities and dementia.
32	Promote recovery orientated practice throughout all mental health services *(DHSSPS)*	**GREEN**	The "Promoting Recovery" training programme is on-going. Each Trust now has a Recovery Steering Group which is taking implementation forward locally. The Mental Health Core Care Pathway will be launched in October 2014. A training programme to assist implementation will commence in 2014/15.

Action No.	Key Action	RAG Rating	Progress at October 2014
33	Establish an initial assessment of the mental health needs of victims and survivors through a Comprehensive Needs Assessment. *(OFMDFM)*	**GREEN**	This action is complete. The Comprehensive Needs Assessment was published on the 23rd November 2012 and can be accessed on the Commission for Victims and Survivors website. – www.cvsni.org
34	Continue to deliver specialist employment provision to address the employment needs of those clients who have disability related barriers to finding and sustaining work. *(DEL)*	**GREEN**	The number of people with mental ill health or a learning disability participating in specialist programmes, eg Condition Management Programme, Work Connect, Workable and Access to Work, is being maintained or is increasing. All of these programmes are demand-led.
35	Enhance and develop the services to assist clients who transfer from Incapacity Benefit to Job Seekers Allowance. *(DEL)*	**GREEN**	The Condition Management Programme (CMP) is available to all Job Seekers Allowance clients throughout the Jobs and Benefits Offices/Job Centre Network. All Front-line Advisers have been provided with a desk-aid designed by a Disability Sector consortium. This helps them recognise certain behaviours & traits of people who may have a mental health condition or a learning disability and advises them how to respond to the customer and at the same encourage

Action No.	Key Action	RAG Rating	Progress at October 2014
			appropriate referral, including to CMP. The CMP staff from the Health Trusts also deliver awareness sessions to inform them of the support that they can provide to JSA clients with health problems, especially those with mental ill-health and musculo-skeletal conditions. A further roll-out of training, to include specific sessions on how to help and support clients with disabilities towards and into employment will be delivered to Employment Adviser Teams from January 2015.
36	"Health in Mind" programme to improve the quality of life of 25,000 adults affected by mental ill-health through the provision of information, learning and reading activities. *(DCAL)*	**GREEN**	The project continues to exceed initial targets. Funding is due to end in January 2015, however a funding extension is expected to April 2015. Further strategic development for the programme will include focus on Targeting Social Needs areas, rural areas and linkages with Health Living Centres and other community and voluntary organisations involved in health and wellbeing. A partnership is being developed between Libraries NI and DARD to support the delivery of this programme to rural communities

SUPPORTING CARERS

Action No.	Key Action	RAG Rating	Progress at October 2014
37	Enhance the arrangements to meet demand for respite including emergency respite and short break care *(DHSSPS)*	**GREEN**	Provision of respite is based on a carers assessment, the range and choice of respite has been extended and improved. The number of hours available has increased by 20,000 hours for Mental Health and 11,000 for Learning disability since 2012
38	To provide support to all carers in order that they may continue in their caring role. *(DHSSPS)*	**AMBER**	The HSCB is striving to ensure that all carers are offered a carers assessment. The number of carers assessments offered has increased by 27.5% from 2012/13 to 2013/14.
39	Carry out a scoping exercise to ascertain future caring requirements for people with a learning disability living with elderly carers where there is a risk of a breakdown in caring arrangements and develop	**GREEN**	Research is currently underway into the future care needs of older people with a learning disability and their families and carers. A plan which will consider both housing and care elements will be developed in conjunction with DSD. Phase one for carers of adults aged over 50 is complete and phase two for adults with a learning disability aged over 35 is currently underway. A costed plan for Phase One has been completed and a bid made for

Action No.	Key Action	RAG Rating	Progress at October 2014
	a rolling costed plan to support them. *(DHSSPS/DSD)*		funding.

BETTER SERVICES

Action No.	Key Action	RAG Rating	Progress at October 2014
40	Monitor/review departmental capital budget *(DHSSPS)*	**GREEN**	Mental Health and Learning Disability policy leads regularly liaise with relevant branches within the Department on proposed and current capital schemes.
41	Complete research into priorities highlighted by Bamford rapid reviews *(DHSSPS)*	**GREEN**	All the priority research projects are underway, led by the Public Health Agency, and involving universities, HSC organisations and PPI representatives. The results from the first project, "Parental Alcohol Use and Resilience in Young People in Northern Ireland: A study of Family, Peer & School Processes" is currently undergoing a peer review process and will be published in the near future. http://www.publichealth.hscni.net/publications/bamford-rapid-reviews
42	To ensure Personal and Public Involvement, (PPI), in planning, commissioning, delivery and evaluation of services in line with guidance. *(DHSSPS)*	**GREEN**	DHSSPS issued guidance on effective PPI implementation in Sep 2012. Implementation of this guidance is being led by the PHA through the Regional PPI Forum.

Action No.	Key Action	RAG Rating	Progress at October 2014
43	To carry out a qualitative research study into our customers who have a disability to allow us to obtain an insight into the thoughts and behaviours of this specific group of customers. *(DSD)*	**GREEN**	The research has been completed and published by DSD in December 2013. http://www.dsdni.gov.uk/dla_and_aa_-_the_impact_of_the_benefits_and_an_exploration_of_dla_and_work.pdf
44	To develop and implement a strategy for increasing the uptake of benefits. *(DSD)*	**GREEN**	Maximising Incomes and Outcomes - a 3 year plan for improving the uptake of benefits - was launched by the DSD Minister on 3 July 2013. Progress against year 2 remains on target and should be completed by March 2015.
45	To work in Partnership with organisations and government departments which are impacted by Universal Credit. *(DSD)*	**GREEN**	Various governance structures have been established to include all organisations impacted by Universal Credit in the development of customer journeys, planning and communications. There is also ongoing consultation between relevant Departments to define eligibility for other benefits that are available to those in receipt of Social Security benefit, for example, free school meals. These are known as 'passported' benefits. Work is on-going but has been delayed due to uncertainty around the Welfare Reform Bill.

Action No.	Key Action	RAG Rating	Progress at October 2014
46	To improve access to advice and information on services and support available .*(DHSSPS)*	**GREEN**	Work is on-going on the creation of a new mental health services information hub. It will be hosted on the NI Direct Website. It is anticipated that this will be fully operational by April 2015. Work is also underway on creating a web page for the new Mental Health Care Pathway. This will be linked to the NI Direct Page. In addition a new Children and Adolescent Mental Health services web page has been developed on the Family Support Network. http://www.familysupportni.gov.uk/
47	Improve services for children with challenging behaviours and their carers. *(DHSSPS/DE)*	**AMBER**	This action is being progressed through the Children with Disability Sub Group of the Children and Young Peoples Strategic Partnership Board. Subject to funding the HSCB plan to support the development of community level 3 services which will improve early intervention within schools and with families.
48	Develop and implement a Service Framework for learning disability services. *(DHSSPS)*	**GREEN**	A Service Framework for learning disability services was launched in September 2012. An action plan developed by HSCB is in place for the implementation of the 34 Standards, with oversight by a regional group.
49	Maintain direction of HSC funding towards community based services (*DHSSPS)*	**GREEN**	The percentage of the total learning disability expenditure directed towards community-based services continues to increase. 83% of HSC spend on learning disability services in 2012/13 was in community services and 85%

Action No.	Key Action	RAG Rating	Progress at October 2014
			in 2013/14.
50	Enhance provision of person – centred day opportunities (including employment provision) for people with a learning disability that facilitate integration into the community (*DHSSPS)*	AMBER	Consultation on a Day Opportunities Model ended on 10 January 2014. Implementation has now commenced and is being overseen by a Regional Group which had its first meeting in September 2014. A range of Departments are represented, full implementation is dependent on provision of additional resources in 2015-18.
51	Complete and maintain a map of learning disability services across Northern Ireland (*DHSSPS)*	AMBER	The HSCB will commence development of a web based map of learning disability services following completion of the mental health service mapping exercise (action 61 refers).
52	Improve transitions planning for all children with statement of special educational needs. (*DE)*	GREEN	The Education and Training Inspectorate report, "A Survey Report on Transition Arrangements from Special Schools and Mainstream Learning Support Centres to Post-School Provision" was published on 1 September 2014. DE and DHSSPS are considering the report's recommendations. http://www.etini.gov.uk/index/surveys-evaluations/surveys-evaluations-post-primary/surveys-evaluations-post-primary-2014/a-survey-report-on-

Action No.	Key Action	RAG Rating	Progress at October 2014
			transition-arrangements-from-special-schools-and-mainstream-learning-support-centres-to-post-school-provision-2.pdf DN - For Discussion at Ministerial Meeting
53	Development of UK wide framework for learning disability nurses. *(DHSSPS)*	**GREEN**	Complete. The NI action plan for "Strengthening the Commitment" was launched in July 2014. The action plan will be implemented and monitored by a regional implementation group who will report to the office of the Chief Nursing Officer on an annual basis. http://www.dhsspsni.gov.uk/learning-disability-action-plan.pdf
54	Develop a plan for community forensic learning disability services taking account of service to be provided with available resources and which makes full use of other forensic arrangements in place. *(DHSSPS)*	**GREEN**	A model for community forensic learning disability services has been developed and the HSCB has bid for funding in 2014/15 to take this forward.
55	Community Dental Service	**GREEN**	Oral Health Issues are being addressed and preventative measures

Action No.	Key Action	RAG Rating	Progress at October 2014
	to undertake an annual oral health assessment for each L.D. client and produce an individual oral health plan, referring as appropriate for care. *(DHSSPS)*		employed.
56	Community Dental Service to provide training/ training materials for staff in day care facilities re significance of oral health issues. *(DHSSPS)*	**GREEN**	Regular training is being provided for staff.
57	Improve the experience of people with LD using acute general hospitals based on the GAIN Guidelines "Caring for people with a learning disability in general hospital settings" *(DHSSPS)*	**AMBER**	An RQIA review of the care of people with a learning disability in acute hospitals is at final editing stage. The HSCB and PHA will implement the findings of this review.

Action No.	Key Action	RAG Rating	Progress at October 2014
58	Implement a regional Bed Management Protocol for those with a learning disability. *(DHSSPS)*	**GREEN**	The HSCB is developing a Bed Management Protocol for those with a Learning Disability. The protocol is expected by March 2015
59	Re-direct HSC funding towards community based services. *(DHSSPS)*	**GREEN**	The percentage of total mental health expenditure on community based services continues to increase. 56% of HSC mental health expenditure in 2013/14 was in community services, this compares with 53% in 2010/11.
60	Implement the Mental Health Service Framework across HSC. *(DHSSPS)*	**AMBER**	There has been some progress on some of the standards. A fundamental review of the Mental Health Framework is underway. A revised framework is expected by April 2016.
61	Provide information on children's, adolescent and adult mental health services for use by the public, GPs and other clinicians. *(DHSSPS)*	**AMBER**	Data Collection for the Mental Health Services Mapping was completed in 2013, work is on-going with NI Direct to resolve technical difficulties in relation to hosting the web page. It is anticipated these pages will be fully operational on/before April 2015.
62	Implement service model for	**GREEN**	The Regional Service Model for Child and Adolescent Mental Health

Action No.	Key Action	RAG Rating	Progress at October 2014
	CAMHS services. *(DHSSPS)*		Services (CAMHS) was published by DHSSPS in July 2012, and is being implemented in the HSCB through a Regional Steering Group and Local Implementation Teams in each Trust. Trusts have now established Primary Care and Crisis Resolution and Home Treatment Teams.
63	Improve and harmonise model for crisis response and home treatment services. *(DHSSPS)*	**GREEN**	A review of crisis response and home treatment services has been completed and findings have been analysed. A draft report has been prepared and was presented to the HSCB Mental Health Commissioning team in October 2014.
64	Enhance availability of psychological therapies. *(DHSSPS)*	**GREEN**	Pilot Primary Care Talking Therapy Hubs have now been established in each Trust.
65	Improve access to computerised Cognitive Behavioural Therapy programmes. *(DHSSPS)*	**GREEN**	Over 5000 people have signed up for the Beating the Blues programme, uptake continues to increase.
66	Introduce legislation to extend the provisions of the Mental Health (NI) Order 1986 to private hospitals.	**GREEN**	This action is complete. The Private Hospitals (Mental Health) Regulations (Northern Ireland) 2013 came into operation on 31 March 2013.

Action No.	Key Action	RAG Rating	Progress at October 2014
	(DHSSPS)		
67	Evaluate implementation of regional guidance on assessment and management of risk in mental health and learning disability services. *(DHSSPS)*	**GREEN**	Following consideration by a multidisciplinary group of the emerging themes, such as recovery oriented practice and co-production of care plans which include personal safety, it was agreed that the development of the Regional Mental Health Care Pathway would address the issues by the RQIA. This Care Pathway was launched in October 2014. The Care Pathway will be supported by new regional documentation, including where appropriate to address risk assessment and management within a safety plan, and will initially be implemented in adult mental health services before rolling out across all mental health services
68	Enhance medicines management services for vulnerable patients with mental illness living in the community. *(DHSSPS)*	**GREEN**	• A specialist mental health medicines information website 'Choice and Medication' has been launched for use of all community pharmacists, mental health staff and all NI citizens, hosted on HSCB and CPNI websites. http://www.choiceandmedication.org/hscni/ • A dedicated SHSCT pharmacist has been working with the lead Consultant and home treatment team to establish the role of a specialist community mental health pharmacist within the home treatment team. A pilot is also underway involving a specialist mental health pharmacist in

Action No.	Key Action	RAG Rating	Progress at October 2014
			Belfast Trust. • Reviews of nursing home patients taking mental health medication have been commissioned involving pharmacist prescribing; • A service specification for community pharmacists is under development.
69	Enhance services for people with a personality disorder. *(DHSSPS)*	**GREEN**	Community based Personality Disorder services are operational in all 5 Trusts and Prison Health. A regional clinical network to share services, skills and expertise, including PBNI and Prison Health is in place and continues to take forward work in this area. A Care Pathway for Personality Disorders was launched on the 10th October 2014.
70	Maintain the provision of specific eating disorders in-patient service capacity within each Trust. *(DHSSPS)*	**GREEN**	A Regional Eating Disorders Care Pathway is nearing completion. Work continues to develop local in-patient capacity in terms of staff awareness and training; 3-4 beds are available in each Trust, with in-reach support from community eating disorder teams.
71	Ensure provision of appropriate low secure and community forensic services in line with 2011 Review.	**AMBER**	Community mental health forensic teams are now in place and a centrally funded training programme continues. 3 newly refurbished low secure facilities are now in use. Work is ongoing to prepare a bid for the required resources to support these.

Action No.	Key Action	RAG Rating	Progress at October 2014
	(DHSSPS)		
72	Take forward action plan to improve dementia services in line with NI strategy. *(DHSSPS)*	**GREEN**	• HSCB has been invested in the development and enhancement of memory services/clinics across all 5 Trusts. • A multi-agency/disciplinary working group is taking forward recommendations from the Dementia Strategy relating to memory services. This will result in the development of a service specification, care pathways, development of minimum standards for services and potentially the development of a regional tertiary service. • Funding from OFMDFM and Atlantic Philanthropies is being directed to three major project streams i.e. (i) Awareness raising, information & support, (ii) training including a specific project on delirium and (iii) respite, short breaks and support to carers. • Funding from Atlantic Philanthropies and PHA has been invested in a number of research projects including technology enriched supported housing, medicines management, risk communication, evaluation of a health care passport, pain assessment and management for persons with dementia nearing the end of life and advanced care planning.
73	Improve Perinatal mental	**GREEN**	A Regional Care pathway for perinatal mental health services was

Action No.	Key Action	RAG Rating	Progress at October 2014
	health services. *(DHSSPS)*		launched in December 2012 and is being rolled out. A regional multi-disciplinary group is preparing a report on the recommendations for a service model for NI following audit results on the need for local specialist mother and baby inpatient provision.

BETTER STRUCTURES

Action No.	Key Action	RAG Rating	Progress at October 2013
74	Ensure relevant Inter-Departmental and cross sectoral structures are maintained. *(DHSSPS)*	**GREEN**	The Bamford Action Plan 2012 – 2015 was published in March 2012. Interdepartmental meetings take place twice yearly and monitoring of the plan is ongoing. The Inter Departmental Ministerial Group on Learning Disability and Mental Health also meets twice yearly.
75	Sponsor work on cross-cutting issues, involving the relevant agencies at local level along with service users and their carers. *(DHSSPS)*	**GREEN**	The Patient Client Council and the Bamford Monitoring Group continue to work on a number of cross-cutting issues involving service users and carers. A key project in the last year has been consideration of the needs of elderly carers of people with a learning disability or a mental health problem which included a workshop on this issue June 2014.
76	New mental capacity legislation. *(DHSSPS)*	**AMBER**	Consultation on the civil provisions of the draft Bill (for which DHSSPS is responsible) was completed on 2nd September 2014. The consultation also included a policy statement on the criminal justice provisions (a matter for Department of Justice). It is intended to submit the Bill to the Executive in March 2015 for approval to introduce in the Assembly, with a view to attaining Royal Assent by March 2016.

DHSSPS

Mental Health, Disability and Older People Directorate

Castle Buildings

Stormont

BELFAST

BT4 3SQ

[redacted]

HSC Public Health Agency

MEETING	**DES and Health Facilitation Regional Group for People with Learning Disabilities meeting**
DATE, TIME & VENUE	**Thursday 03 October 2013 at 10 am in Committee Room 2, County Hall, Ballymena**
Present	**Molly Kane PHA (Chair), Louise Adams PHA Intern, Denise Martin PHA, Tracey Colgan Health Improvement PHA (representing Elaine O'Doherty), Dr Richard Orr Directorate of Integrated Care North, Prof. Roy McConkey University of Ulster, Laurence O'Kane University of Ulster, Donna Morgan NHSCT, Neil Kelly BHSCT, Marie Loughran, SHSCT, Megan Oliver, Directorate of Integrated Care Belfast, Laura Keenan, Directorate of Integrated Care Belfast, Margaret Murphy, WHSCT, Deborah Faulkner, WHSCT**
Apologies	**Elaine O'Doherty Health Improvement PHA, Maurice Devine DHSSPSNI, Donna Curley SHSCT, Neil McCaig Directorate of Integrated Care North**
Date of next meeting	**Wednesday 15 January 2014 at 10 am in Boardroom, 1st Floor, County Hall, Ballymena**

Issue	Key Information	Recommended Actions
1. Welcome and apologies	Molly welcomed everyone to the meeting and introductions were given. Apologies noted as above.	**Standing agenda item**
2. Minutes of previous meeting	Minutes were agreed as an accurate record of business conducted.	**Standing agenda item**
3. Matters Arising	***Learning Disability Standards – easy read version*** Molly informed group members that at present due to	**Tracey/Molly**

Issue	Key Information	Recommended Actions
	Elaine O'Doherty's absence it has not been possible to obtain this document. Tracey agreed to try and locate this and forward to Molly for consideration before being circulated to group members.	
4. Evaluation of the enhanced service specialising in health care for adults with a learning disability provided by GMS practices and of health facilitators provided by five HSC trusts. Final Report by Roy McConkey	For the benefit of new group members Roy gave a quick overview of the background to his work with Health Care Facilitators and the process that has been undertaken with various groups within PHA & HSCB with the evaluation report. It was agreed that some minor amendments were required to the recommendations and an Action Plan should be developed at this stage to facilitate taking work forward through the new group. Roy agreed to facilitate this as group member's discussed/agreed minor changes and actions. There was also a discussion about the Department's specification and guidance and Richard will update specification in line with any recommendations from Department and Roy's report and circulate draft regional guidance for the five Trusts. Regional Guidance can be reinforced through specification of enhanced services which will go to GPs. ***Integrated Care Update*** Richard circulated to group members an update of the monthly Health Checks completed in 2012/13 as well as claims returns for the same period. There	**Roy to update report and draft Action Plan** **Richard** **Neil/Richard to provide updates as appropriate to new group**

Issue	Key Information	Recommended Actions
	was a lengthy discussion around working with practices regarding data collection/claims/uptake of health checks. Roy agreed to check 2012/13 figures circulated today with those contained within his report and update if required.	 **Roy**
5. Health Equality Framework (HEF)	The link regarding HEF was circulated via the agenda for todays' meeting. Key areas are on page 14. Denise and Molly gave group members a quick overview of the processes used. Group members felt that this would be something that should be discussed with Maurice Devine. Molly agreed to ask that Maurice be present for the next meeting. Roy expressed concern on how information is collated from all the various areas. He felt collation of data on individual patients would work but queried how information would be transferred to a full case load and across team members. Molly felt that it would be appropriate to include a presentation from the nurse consultants re the HEF at the Learning Disability Conference. Other items suggested included, GAIN audit, Acute setting, RQIA view re services, LD Service Framework. It was agreed that a small working group would be established to develop programme and take this	 **Molly and agenda item** **Working Group meeting to be organised beginning of November 2013**

Issue	Key Information	Recommended Actions
	forward. Members:- Molly, Denise, Louise, Donna, Neil, Laurence, Maurice, Gordon, Margaret, Elaine O'Doherty and an SHSCT representative would be sought from Miceal Crilly.	
6. Trust Action Plans	Molly brought to the attention of group members that the Commissioning Plan requires "All Trusts to develop Action Plans to promote the health of people with a learning disability". Trust members agreed to look into this as Molly stated progress will be monitored on a half yearly basis.	**Trust members**
7. Discussion re future of group and Draft TOR for moving forward	Amendments were agreed to the ToRs and membership to include:- • PHA – Nursing, Health Improvement • HSCB – Integrated Care • Acute – from all five Trusts • Trust Learning Disability Leads • Health Care Facilitators – on a rotational basis for attending • Department – Learning Disability Nurse • University of Ulster • RQIA • CEC • Mental Health representatives – 1 nominee to represent on a regional basis Molly advised that this was the last formal meeting of	**Denise/Louise to update ToRs and circulate.**

Issue	Key Information	Recommended Actions
	the DES and Health Facilitation Regional Group for People with Learning Disabilities Steering Group. Molly also thanked group members for their participation in the steering group and advise that Molly will be writing out to Trusts and appropriate organisations to seek membership for the new group which will have its first meeting in January 2014. Group to now be called Regional Learning Disability Health Care & Improvement Steering Group.	**Molly to contact relevant personnel regarding membership**
8. Feedback from Bamford LD sub group minutes	Molly updated group members that following the last meeting of the sub-group it was agreed that the new group would take forward actions arising from the GAIN audit. The actions arising from this audit and the DES evaluation will form baseline for new health care steering group. Molly also informed the group that there has been an increase in the number of people with learning disability being admitted to prison over the last 18 months and we will need to ensure health care needs of these individuals are addressed also.	**Agenda item for next meeting**
9. AOB	***Modernising Learning Disabilities Nursing Review Strengthening the Commitment: Northern Ireland Action Plan (Sept 2013)*** Molly agreed to circulate this document to group members as some had not received document as yet. Consultation closes on 12 December 2013 and CNO is encouraging responses.	**Molly/Elaine**
Date of Next Meeting Tuesday 15 January 2014 at 10 am in Boardroom, 1st Floor, County Hall, Ballymena		